A New Model for Mental Health Services in the North West of Ireland

Commissioned by:

North Western Health Board

FINAL DRAFT

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Section 1 Planning background in North Western Health Board and scope of service review

Purpose of review and terms of reference

The purpose of this review is to examine the effectiveness of current adult mental health services provided by the North Western Health Board, the deployment of resources, and to make proposals on how NWHB could develop its mental health services to reflect modern evidence-based good practice.

The Sainsbury Centre for Mental Health (SCMH) was commissioned by the North Western Health Board to develop a model for service delivery for adults with mental health problems. The terms of reference for the review were

- SCMH to propose a new service model that is evidence based and is service user and carer orientated.
- SCMH should take into account emerging national policy changes.
- SCMH should make challenging but achievable proposals.
- SCMH should highlight areas of good practice to be built upon.
- SCMH should identify management and service structure developments that would be necessary to support the proposed new service model.

SCMH were also requested to address the interface issues with other care groups especially Older People's Mental Health, but also Child and Adolescent Services, Forensic Mental Health, Substance Misuse and Learning Disabilities Services.

SCMH seek to address this challenge by offering a detailed service model for adult mental health services, proposing additional developments for older people's mental health and identifying areas for resolution in terms of interfaces with other care groups. These recommendations are supported by proposals for an implementation plan that identifies service development priorities as well as organisational and workforce development needs.

Planning background

SCMH acknowledge the priority NWHB has given to the development of mental health services and previous local strategic and service development planning. It is important to recognise that the proposals and recommendations made by SCMH take account of this local context, and therefore it is helpful to provide a brief summary of some previous reviews.

1 Policy direction and local planning in NWHB

A range of recommendations have been documented in the past which are still appropriate. For example, the Inspector of Mental Hospital Report 2002 advocates building a new acute psychiatric unit and the Mental Health Commission of Ireland supports reducing hospital acute beds and developing more community-based services.

Whilst no reports written to date suggest a single comprehensive way forward, the proposals SCMH make build upon these previous planning intentions. SCMH offer a blueprint that not only relates to local context but which introduces new evidence- based service initiatives that makes previous strategic planning more achievable, whilst empowering both the workforce and service users and carers.

A brief overview of *the* past and current policy recommendations is therefore helpful. However before this it is important to highlight what SCMH believes to be the general thrust of emerging national policy.

- One of the central arguments within the SCMH proposals is that the need for the current level of acute in-patient bed provision will be reduced by the development of a comprehensive and appropriately resourced range of community services.
- SCMH believe that new Mental Health Commission will have a major impact on shaping a national strategic direction for the future development of mental health services. In doing this they will be guided by the outcome of an expert group that has been recently established to develop a new national service policy framework.
- SCMH expect that it will wish to see a general direction of reducing the reliance on acute in-patient care whilst developing community-based services.

In summarising previous planning intentions and reviews we have identified issues that are relevant to the terms of reference of this review. The reports cover much more ground than it is possible to describe here. Therefore, SCMH has by necessity been selective in identifying issues that relate to the review brief.

i Report by Inspector of Mental Hospitals, 2002

ii "Into the Millennium and Beyond: A strategy for Mental Health in the North

iii West" (NWHB document), 2000

iv NWHB Service Plan 2003 and 2004.

We also acknowledge the national influence of the following documents:

v Mental Health Act 2001

vi Amnesty International's report, "Mental Illness: the neglected quarter", 2002

vii Quality and Fairness – A health system for you, 2001

viii Primary Care – A new direction (date?)

This section identifies the key points raised in the above reports. The recommendations cited below refer to the points that we view as most relevant to the model being proposed in this report.

2 Report by Inspector of Mental Hospitals (2000, 2002)[1]

Both the 2000 and 2002 reports contain repeat recommendations for NWHB.

2.1 Levels of nursing within SRUs

The "generous" number of nurse-staffing levels within the Supervised Residential Units provides the opportunity to deploy nurses to community-based services[2].

- SCMH make specific recommendations regarding the redeployment of nurses. It is the intention to use nurses where they are needed most – with an increase in community nursing and a reduction to more appropriate levels the number of SRUs and in-patient beds.

2.2 The need for more social workers and occupational therapists

The 2000 report recommended that social workers, OTs and psychologists be recruited. This theme recurs in the 2002 report.

- SCMH supports this recommendation, while stressing that they should be deployed in a way that facilitates multi-disciplinary team working and a psycho-social model of care.

2.3 Bed numbers for the proposed new psychiatric unit at Sligo Hospital

The Inspector's report expressed disappointment on the failure to build a new psychiatric unit at Sligo General Hospital.

- SCMH is aware that there has been disagreement on the design and bed complement of the building, between the Sligo/ Leitrim consultant psychiatrists on the one hand and the Department of Health and North Western Health Board on the other.
- In light of this and the terms of reference of the review, SCMH make specific recommendations on the future number of beds required within the proposed comprehensive, community-based, whole-systems model of care.
- The SCMH model advocates the development of community-based services such as sector teams working alongside GP practices, coupled with the development of specialist teams enabling crisis resolution/home treatment and rehabilitation/assertive outreach, which together provide a meaningful alternative to hospitalisation. With this model, the use of psychiatric in-patient beds is specific to providing high quality focused interventions for people who, through reasons of need or choice, cannot be provided for with alternative services.
- SCMH hope that these proposals for future in-patient care will enable agreement to be reached on hospital reprovision.

3 Into the Millennium and Beyond (2000)

The purpose of this report was to provide a five to ten-year general direction for mental health promotion within NWHB. A number of wide-ranging recommendations were offered in the report. Below are some key recommendations from "Into the Millennium"

[1] Inspector of MH report: http://www.doh.ie/publications/inspect02.html

[2] (p. 186).

that this report will focus on in order to emphasise the issues relevant to the SCMH proposed model:

Key recommendations from “Into the Millennium and Beyond” 2000 include:

3.1 Supervised Residential Units (SRUs)

SRUs – homes for life?

“*There needs to be a review of the evolving role of the SRU with particular emphasis on the policy of respite/ short-term care.”* (“Into the Millennium”, Section 3.3.3).

- There is a clear *a* desire to review the role and function of SRUs, which has been made a specific requirement of this report. The function of SRUs has been cited within other reviews and commented upon by the Inspector of Mental Hospitals and the Mental Health Commission. SCMH interpret this as an acknowledgement that the role and function of SRUs requires a fundamental re-think. SCMH see this as central to the transformation of the service philosophy, model of care and the unlocking of resources to facilitate the transition. We recognise that for some this represents a real challenge and cuts across previous commitments for SRUs to offer a home for life. However, SCMH believe there to be more appropriate ways of providing care for the current residents, which are discussed within our proposals and recommendations.

The need for move-on from SRUs

“The board will examine the difficulties evident in moving people on from SRUs to more independent living where appropriate. (“Into the Millennium”, Section 3.3.4).

- Our view is that the SRUs may have become the “new institutions”. In particular, having a high level of nursing staff providing all basic services for residents, such as preparing even simple meals, is potentially debilitating for the residents. SCMH acknowledge that if some SRUs are to be closed, or changed in terms of remit and level of care offered, then the process for moving people on will need to be well thought out and carefully managed, having regard above all for the interests of the residents. SCMH explore these in the proposals and recommendations.

3.2 Acute services

Discharge care planning

“In discharge care planning, greater focus will be placed on working with the family/ carer of the patient.” (“Into the Millennium”, Section 3.4.7)

- SCMH place great focus on building upon this intention. Care planning - whether for discharge or ongoing care – needs to be made regular and systematic across NWHB. Linked with a team approach is the need to establish a case management system that co-ordinates the work of all services. This would provide comprehensive needs assessment, needs-based interventions and ongoing review. It should also become the method for communicating and co-ordinating care across a complex range of services and a way of empowering service users and carers with in-depth information on their needs and care plan.

3.3 Crisis services development

"Where necessary, weekend and out of hours medical/ nursing support should be provided." ("Into the Millennium", Section 3.4.5)

- SCMH develop this intention further within the proposals and recommendations, as it is our belief that in general crisis services using a multi-disciplinary team approach are a fundamental part of a range of services offering alternatives to in-patient care.

3.4 Special care services

"In order to expand and develop the therapeutic and rehabilitative focus of the Special Care Unit, a greater mutli-disciplinary input will be provided." ("Into the Millennium", Section 3.5.4)

- SCMH believe that, given the proposals around in-patient care and a full community and rehabilitation service, the need for a special care unit in its current form is questionable. Any regional facility offering high levels of care or greater security needs a clear role and function and perhaps needs to provide for a greater population than just the North Western Health Board.

Approach of the review

The process of reviewing mental health services across NWHB has been organised around:

- A steering group for project direction and leadership,
- Consultation with stakeholders
- Service data collection and analysis
- Consideration of a range of policy and planning documents relating to NWHB

1 Steering group

The project has worked through a Project Steering Group established by the Health Board. Its members are listed at Appendix .Its purpose was to ensure a clear, transparent process with very specific objectives, and which has directed and guided the process. This has included

- Stakeholder meetings to discuss the initial project outline and its launch
- Steering group meetings
- Wide circulation of the first draft report
- Feedback to users and carers on the first draft report
- Feedback from key managers on first and second draft reports before presentation to the Health Board in March 2004

From the initial planning stages of the review SCMH has attempted to ensure full consultation:

- The terms of reference were discussed with the Steering Group before the project was launched.

- The terms of reference specified service components to be reviewed and the level and type of stakeholder engagement and the research methodology.

2 Consultation with stakeholders

Interviews by SCMH consultants were held over a two-month period in Autumn 2003 with key stakeholders across the NWHB area, including senior and operational managers, GPs, hospital- and community-based staff, voluntary sector organisations, and service users and carers. For users' and carers' meetings, SCMH was joined by two members of the Irish Advocacy Network.

Local radio advertised public meetings for service users and carers that were held as part of the process, and visits were made to key sites such as work training centres, clubhouses, day hospitals, hospital wards and supervised residential units.

The views sought during this process of engagement involved the following areas:

1 Specific problems and difficulties affecting the current delivery of comprehensive and effective mental health services;

2 Current good practice or service initiatives to be built upon;

3 Specific aims or outcomes desired for any new model of care;

4 Specific organisational and structural models and approaches for new service initiatives such as crisis resolution / home treatment, assertive response, early interventions and rehabilitation/ recovery services;

5 Role and function of any new service initiatives;

6 Future role and function of existing in-patient, supervised residential and Special Care units within any new service model;

7 Ideas on the practical arrangements for implementation, such as the creative use of existing resources, workforce development, how individual services will link together as a whole-systems service, and the interfaces between future adult mental health provision and other care groups such as older people's mental health.

Following the first draft report, additional engagement sessions with Consultant Psychiatrists and service users and carers were conducted.

3 Data collection and analysis

Data was collected to gain additional perspectives into existing services and to aid consideration of service development options. This included

- Benchmarking service and staffing levels internally within the North Western Health Board and with UK services in areas with similar demographics
- Examining budgets and staffing costs.

4 Consideration of a range of policy and planning documents

A number of documents were identified with relevance to the review. These included NWHB planning papers, national policy documents and reviews. In addition, reference has been made to research and other publications that support the evidence base of the review and its proposals.

5 Reporting issues

In such a wide-reaching review many views are encountered, some of which contradict others and some of which may be difficult to reconcile. This is especially so in a complex arena such as the development of mental health services, where there is potential for people to be concerned at the implications of change and the potential impact on personal lives and careers.

In view of this, we think it is worth clarifying certain issues and concerns that became apparent during the review process.

- Themes are described in general terms, and not as site-specific issues.
- Some participants expressed a belief that the SCMH review was based on an agenda of making cost savings. SCMH wish to stress that the brief for this review was to make proposals and recommendations for service improvement and development and to explore the achievability of this within existing resources, and where appropriate identify investment requirements. No budget reduction or cost savings component was specified.
- SCMH acknowledge that the issues focussed on are those of the stakeholders who contributed to the engagement sessions. Although this did not include everyone, we feel confident that the issues arising had general validity, and also it is important that the experiences of stakeholders are articulated as clearly as possible. The proposals and recommendations attempt to respond to these issues.

Section 2 Assessment of current services

Introduction

In making proposals and recommendations, it was important for SCMH to get an understanding from a full range of stakeholders as to the areas of good practice to be built upon as well as the issues that needed to be addressed through further development.

It is important to note that the process of engagement with stakeholders was extensive, and whilst it is not possible to validate all the specific comments made, SCMH does believe the process gave a good account of the main issues to be addressed. SCMH also wish to acknowledge the very considerable effort made by NWHB to organise such a full programme of engagement with all stakeholder groups, and support their courage and commitment in facilitating a full exploration of current service provision.

The section below gives an account of the outcome from this stakeholder consultation, as it is this together with the evidence around the effectiveness of specific service initiatives that provides the basis for much of the proposals and recommendations made.

Current service and organisational strengths and capacities to build on

1 Strategic prioritisation

SCMH believe it important to acknowledge the focus given to mental health by NWHB. There is a real commitment to fully explore the development issues for mental health services and a desire to embrace a challenging service redesign strategy. This commitment goes beyond developing a vision for the future and appears ready and able to undertake effective implementation. The relevance of this is very significant, as in our experience it is only when there is that degree of focus and active support by senior management that service redesign on the scale proposed can be successfully implemented.

2 Commitment of workforce

The quality of mental health services is dependent on the commitment of the workforce to embrace change and update their skills and practice. One of the most striking aspects of the consultation process with stakeholders was the willingness and enthusiasm of the workforce to engage with the review. Many staff attended the launch and initial findings dissemination events, and staff frequently attended consultation sessions on their days off. Much anecdotal evidence was gathered about their hard work and dedication to service users. We were very aware of the many dedicated staff

who have long experience in the service and who are very respectful and caring of service users and carers.

As with every service review SCMH has undertaken, this needs to be tempered by some of the profoundly felt bad experiences of service users and carers within mental health systems. Nonetheless the readiness of the workforce to respond positively to such experiences and embrace new models of working is a real and tangible positive that should and can be built upon.

3 Cognitive behavioural therapy (CBT)

The development of a trained and dedicated cognitive behavioural therapist service across mental health is an innovative development. It is one that mental health services often aspire to, but for a variety of reasons cannot implement. The CBT service provides a preventative service via their therapeutic interventions aimed at empowering service users through increased psychological insight and coping skills. In addition, it is reported that CBTs have managed to reduce their waiting times and can see urgent cases within ten working days. It is this type of innovation and effective management of demand that bode well for the advancement of other modern service developments.

4 Day hospitals, day care and Worklink

In general there was acknowledgement that there was good day hospital provision in terms of the quality of care they provide, the prevailing culture of respect and dignity, and the practical arrangements around key worker systems. There is clearly a commitment from the staff to protect and develop their services.

In addition, there have been some significant developments around day care and employment initiatives. The Clubhouse (for young adults) and Worklink (employment skills) developments were universally praised and provide active demonstration of how local services can embrace new ways of working.

SCMH also note that the NWHB has tried to address the significant issues of rurality in terms of maximising access to day hospitals/ centres and the creative use of SRU facilities and staff to support day care initiatives. It is this type of innovation in developing a resource centre approach, from which a range of services can be provided as in-reach and out-reach that forms the backbone of the proposals around community mental health teams.

5 Relations with primary care

The linkages between primary and secondary care are of central importance in creating clear care pathways for service users and carers. It is also of great importance in terms of managing an effective and appropriate gateway into secondary care services, and in particular responding to crisis situations within primary care for which GPs and other primary care staff are not best placed to manage. An ability to do this, especially beyond office hours, will also be very important in terms of preventing inappropriate hospital admissions.

SCMH acknowledges NWHB strategic ambitions to develop community mental health services that relate to primary care developments and see this as a real positive in terms of the model SCMH proposes. In addition, it is important to recognise that in

many areas there are reported good working relationships between mental health staff and GPs. Again this type of good practice is extremely relevant to the proposals SCMH makes.

6 Supervised Residential Units

SCMH makes proposals around the strategic shift away from the current high levels of supported residential care. This is not only in line with previous Inspector of Mental Hospitals reports but also supported by SCMH benchmarking and concerns about the potential for institutionalisation. There are therefore compelling strategic planning arguments for a reprioritisation of resources away from SRUs. However, there have been significant efforts by management, clinicians and nursing staff to utilise these SRU resources in taking on valuable new roles. There has been an emphasis on developing a rehabilitation potential within the units and proactive steps in adopting a resource centre approach in supporting wider community services. It is with these positive steps in mind that SCMH makes proposals that retain some SRU provision that is clearly linked with a dedicated rehabilitation service.

Considerable credit must also be given to the emerging philosophy of utilising SRUs as a resource centre within local communities from which a range of services can be provided. This concept is built upon in terms of the overall service model advocated by SCMH and specifically within proposals for community mental health teams.

7 Management of in-patient admissions

Many staff spoke of the significant shift in the profile of the service since the closure of the large psychiatric hospitals. In particular we acknowledge the work of the Consultant Psychiatrists to better manage risk within the community, thereby reducing the demand for in-patient admissions. SCMH also recognises the work done in reaching the proposals for new and refurbished admission units which would result in bed reductions from current levels. We return to this theme in our proposals and recommendations, given that with further development of community services there is potential to build upon this experience.

8 Use of medication and information for service users and carers

Service users presented a mixed picture regarding the use of medication, information provided about benefits and potential side effects, and its role within a wider treatment package. Concerns raised included:

- Staff felt that there was generally an over-emphasis on a medical approach to working with clients across the Board. Users feel they are approached from a position of ‘being ill’ rather than experiencing problems, and this tends to lead to a focus on medication compliance
- There is insufficient attention to problem solving and building on personal strengths, a lack of an holistic approach with attention to psycho-social issues of clients. This is felt to be characterised by the shortage of social workers and occupational therapists

However, some positives were also acknowledged in this area: the recognition by medical and nursing staff of the importance of developing effective medication

monitoring and information-giving protocols. SCMH understands that there has been a significant emphasis in developing and sustaining such protocols which will not only lead to more effective treatment regimes but also empower service users and carers by providing the information that helps them be more informed of relevant treatment options.

8 Older People's Community Mental Health Service

SCMH recognises the recent and significant developments in establishing two consultant-led older people's multi-disciplinary community mental health teams. The two teams provide a model and inspiration for the development of a similar team approach for adult mental health. They also provide real evidence of the potential for community approaches to reduce the need for acute in-patient care. The data analysis undertaken by SCMH indicates a relatively low use of in-patient care for older people, given the age profile of the local population. It is this positive impact coupled with demographic need that has led to SCMH making proposals to expand the number of teams from two to three.

9 Mental Health Learning Disability Service

NWHB has been proactive in establishing a consultant-led service for intellectual disability in Donegal. The effective provision of mental health care for people with a significant learning disability requires a specialist service. This provides the basis for NWHB completing an assessment of need for the dedicated provision of in-patient beds, which in turn will help with the proposals SCMH makes around smaller, more focused adult mental health acute units.

10 Child and Adolescent Psychiatry Teams

As with learning disabilities, NWHB has been proactive in developing consultant-led child and adolescent psychiatry teams. Whilst there are interface issues between this and adult services around in-patient care for ages 16 to 18 years, a resolution can be found. SCMH understands that NWHB are actively developing agreed protocols for the effective management of this, often difficult, interface.

An emerging agenda for developing a modern and effective mental health service

Through the engagement process with stakeholders SCMH identified a range of issues that provide a future development agenda.

Many of these issues have already been identified by NWHB and in some cases an active response has been initiated. However we feel it is important to give a brief overview of these issues as they directly relate to some of the proposals and recommendations made.

1 Service user empowerment

1.1 The stigma of mental illness

Many service users and carers identified issues of discrimination and stigma in several areas of their every day life, including within their families and communities, and in social relationships, work opportunities, and housing. This was felt to be a very significant barrier to recovery from episodes of mental ill health and a barrier to social inclusion.

The onus for addressing these issues includes health and social care practice, but also goes beyond this arena to other agencies involved in community and economic development, and needs to be addressed within the overall mental health development agenda. However, within the scope of health and social care agencies the emphasis on developing community based services and alternatives to in-patient care will provide potential for advancing social inclusion and tackle stigma, which is often associated with institutional settings.

1.2 Working in partnership with service users and carers

It is a common feature within mental health service and system reviews that service users and carers report issues of disempowerment which create barriers to recovery. Such experiences typically reflect:

- A difficulty in prioritising the importance of working in partnership with service users and carers.
- An approach to care that often seems paternalistic and which impacts upon choice, active involvement and dignity.
- Poor communication and involvement in individual care planning, leading to a lack of confidence on the part of service users in being able ask questions about their treatment or explore other choices that might be available.
- An absence of service user and carer input to service development and prioritisation.

Engagement with service users and carers as well as with the workforce highlighted the need for NWHB to examine how it will address these common experiences in taking forward its service redesign strategy.

SCMH acknowledge NWHB commitment to this area of development. In particular we support the developments around Worklink, which begins to tackle issues of social inclusion and introduces concepts of recovery. The intention to commission *a* new advocacy services also represents a significant step forward.

The process of engagement with service users and carers as a corner stone of the process for undertaking this current review also sets a standard for continued active involvement, and provides a platform for the future development of real service user and carer empowerment. SCMH believe this provides a foundation for further work in thinking about how such involvement translates into service delivery, both in terms of underpinning philosophies and operational arrangements.

2 Scope of current mental health services

2.1 Low resource baseline for community mental health services

Service users, carers and many staff identified the need to strengthen community services, both in terms of the range of services available and the level of choice in care/ treatment options.

At present, community services are limited in terms of size and multi-disciplinary team working capability. SCMH have concerns that community psychiatric nurses have large caseloads, and can only provide short visits that are often infrequent, and are certainly unable to provide more intensive attendance to support people at home through crises.

Again there are positives to build upon. The development of a significant and well trained cognitive behavioural therapy service together with Worklink and Clubhouse have introduced a more diverse resource base. However, many people interviewed were concerned about the imbalance of resource between community services and building and bed based services. SCMH shares these concerns and see a very significant community service and team working development agenda.

2.2 Availability of suitable housing

It is widely acknowledged that the relatively high provision of in-patient beds and supported residential and group home resources has led to concerns about the accessibility of ordinary and supported housing opportunities. In particular, there is a need to ensure a full range of accommodation options to support:

- people discharged after acute episodes and who have lost or cannot return to their previous accommodation;
- people who could be supported more independently after a period in residential care (such as SRUs);
- people able to live more independent lives given the development of a dedicated rehabilitation team.

SCMH acknowledge that NWHB has already given some priority to this and have developed relationships and actual housing schemes with local housing associations. This provides a firm basis for continued needs assessment and development as appropriate.

2.3 Young people with early signs of mental illness

Many people spoke passionately about the lack of services for younger people. Concerns were also raised about the experiences of younger people admitted to the current in-patient facilities. Developing early interventions through links with primary care and alternatives to in-patient treatment would undoubtedly be more responsive to younger people.

In addition, there are issues of concern locally and nationally about the use of adult in-patient units for people aged 16 to 18, which SCMH comment on within our proposals and recommendations.

3 Care management systems

Service users, carers and staff commented on the fragmented nature of care planning processes. It was felt that there was a lack of a coherent assessment, care planning and recording or review systems in place that assist care co-ordination or enable service user and carer involvement. Specifically, this raised issues about the comprehensiveness of procedures and operational policies to ensure that:

- Service users fully understand their care package and specific treatment options
- Service users feel there are clear mechanisms in place to facilitate their full involvement in negotiating care plans and opportunities for review
- Concepts of recovery have equal emphasis to 'illness management'
- There are consistent, comprehensive, assessment processes across NWHB that provide equity of access to services

The absence of a formal system for planning, implementing and reviewing care appears to be a significant development need, and as such forms an integral part of our proposals around multi-disciplinary team working.

3.1 Continuity of care in in-patient wards

The rota arrangements for the staffing of in-patient units was cited by service users and staff as a major area for development. The importance of this in terms of facilitating continuity of care and effective service co-ordination with proposed new community teams is very significant. SCMH acknowledges that this is an area of priority for NWHB and the workforce in general, and consequently believe significant progress can be made and that this will facilitate implementation of any proposals adopted.

3.2 Service users are often unaware of their legal rights

Many users contacted felt that they had little or no awareness of their legal rights, in particular:

- No awareness of the circumstances of their detention (when involuntary)
- Users often reported difficulty finding channels of communication to deal with these issues, although the Health Board is seen as committed to developing an advocacy service
- In the course of user consultations for this project at least two separate individuals made a personal plea to be helped to move from where they were presently accommodated (one in a SRU and the other in an acute ward)

3.3 Service accessibility and demography

Most stakeholders commented on issues of accessibility given the rural nature of the North West, with low population density and a wide geographical area. It is a genuine area of concern for both service users and carers in terms of how they might access community-based services, and for staff in terms of providing new community-based interventions.

SCMH acknowledge that NWHB have already done some strategic planning in terms of identifying population catchment areas for new community services that link with primary care developments. In addition the proposals and recommendations made by

SCMH have built into them both in terms of staffing levels and operational design a rurality factor. Nonetheless, it would appear that more work is required in order to identify and agree catchment boundaries and operational arrangements for providing new community based services.

4 Service operation and interfaces

4.1 In-patient services

People interviewed expressed significant concern about the physical environment of the in-patient units. Undoubtedly, these are compounded by issues, already raised, of lack of community alternatives and rota systems.

SCMH acknowledges the considerable local effort to re-provide these facilities and hopes that the proposals and recommendations made here enable final reprovision plans to be signed off.

4.2 Primary care

Despite the many individual examples of good working relationships between primary and secondary care staff, and positive strategic intentions to build future community services around primary care building blocks, there were specific service issues reported. It is useful to identify some of these, as they have led SCMH to make some specific proposals around primary care mental health capacity.

From a primary care perspective, the concerns were often about

- difficulty getting a rapid response from secondary care,
- problems obtaining advice on specific difficult issues

From a secondary care perspective, there were issues of

- appropriateness of referrals from primary care, and
- out of hours responses

It is not uncommon for these service interface issues to exist and a specific service development initiative around this is necessary to ensure a successful resolution can be achieved. The benefits would however be significant both in terms of clear care pathways and resource prioritisation.

4.3 Supervised Residential Units (SRUs)

This report has already identified some positive and innovative thinking around the utilisation of Supervised Residential Units. However, there were many service users and staff who had significant reservations about the level of resource tied up in them and the potential re-institutionalisation of people entering mental health services if SRUs were to remain as a central part of any future service configuration.

Strategically, the provision of such a significant number of SRUs has already been questioned locally and SCMH fully support the importance attached within the scope of this review to consider their future role.

5 Appropriate skills mix

SCMH was struck by the almost universal use of trained psychiatric nurses across the full range of service provision.

Many spoke about the need to develop a more holistic approach to the assessment and care provided within mental health, and many made a connection with the need to develop a more balanced workforce that provides additional mental health staff from a range of professional disciplines and backgrounds.

5.1 Social work

Social work is a very scarce resource. This leads to a feeling among social workers of being constantly under pressure, and other staff to perceive that there is only a minimal service. Carers in particular commented on an absence of family support, which could fall within the responsibilities of the social work service.

Social work is managed in Community Care Division of the Board, and there is a sense that it is poorly integrated with mental health services.

In addition to operational management, the separation means that a social work perspective is weak within the overall philosophy of care for mental health, an issue that is important to note in adjusting the balance of the predominantly medical approach, already noted.

5.2 Support workers

SCMH acknowledges the national picture on the use of support workers within mental health settings and the potential limitations in progressing this outside of that national debate. Nonetheless SCMH believes strongly that the development of support worker capacity could have a major benefit for the quality and diversity of provision as well as for the feasibility of delivering what will amount to an additional range of services.

5.3 Counselling and therapy services

There have been some very innovative developments already mentioned around cognitive behavioural therapy. However there were concerns expressed by service users and carers as well as staff about the limited availability of Psychology and Counselling services. Again this is an area of development that would have a significant impact on the quality and diversity of service available.

5.4 Staff training

Most staff recognise the value and importance of training for both continuing professional development and for engaging in service development. However, there was a sense among some staff that training is becoming more difficult to access and that this could potentially undermine the success of a new service model. SCMH make some specific recommendations about workforce development, which is in direct response to many comments received on its centrality if significant service redesign is to be achieved safely and appropriately.

6 Management and leadership

Stakeholders' views of service management structures suggest a lack of confidence in their current form to drive and facilitate change. Concerns and problems identified include

- A poor track record of delivering change and service improvements, including

  - ~ comprehensive policy and procedures
  - ~ protocols around working/ clinical practice
  - ~ resolution of human resource disputes
  - ~ essential service developments such as acute in-patient unit reprovision
- Management across the professional and service divisions appears fragmented, including:
  - ~ A lack of clarity around roles, responsibilities and accountabilities
  - ~ Confusion over clinical and management responsibility, and over-dependence on consultant psychiatrists to manage the day-to-day service
  - ~ Structures that depend on personalities working together, which in practice is not always evident
  - ~ A lack of a team approach that presents difficulties for developing an integrated service including mental health and social care

SCMH acknowledge the priority NWHB are giving to mental health and the recent moves to significantly bolster strategic management and leadership at a regional level. SCMH build upon this lead within its proposals and recommendations**,** particularly in relation to management capacity to oversee what would be an ambitious service development and redesign agenda. In addition, we make proposals on operational management arrangements, which build upon the obvious commitment of senior managers and clinicians to move services forward. Proposals give greater clarity around roles and responsibilities, *and* which facilitates clear lines of accountability whilst giving focus to the component parts of a new whole-systems approach.

Section 3 Guiding parameters for a new service model

Two perspectives have guided this proposal for a new service model:

(i) The evidence base for effective mental health services

(ii) Local factors in the area of NWHB (as described in Section 2 above)

The evidence base for a new service model

The evidence base for effective mental health services has accumulated through international practice and research. In this evidence base we include references to a selection of publications produced by the Sainsbury Centre for Mental Health, and other organisations, most of which themselves include references to other primary research, and reference to the National Service Framework for Mental Health for England which itself is an evidence-based framework. (More details of SCMH publications can be found at the SCMH website: www.scmh.org.uk).

We consider that this evidence base addresses the parameters of service design in four main areas, as described below.

1 The need for service users and carers to be at the centre of services

Mental Health Service User Movement in England (SCMH, 2003)

This publication examines the shape of the user movement today and looks to the challenges and opportunities ahead. It calls for extra support for user groups and for the development of a more coherent voice for mental health service users on the national stage.

User's Views (SCMH)

This report documents a user-centred approach to mental health services delivery via User Focused Monitoring projects established by SCMH.

On Our Own Terms (SCMH)

"Users and survivors of mental health services working together for support and change"

Breaking the Circles of Fear (SCMH, 2002)

A review of the relationship between mental health services and African and Caribbean communities.

2 Service redesign - achieving appropriate service configurations and processes

Achieving a suitable configuration (range, type and relationships of services) depends on the operation of several services acting together as a whole system. References to

the evidence on service configuration are listed below in relation to a number of the component parts of a whole system.

2.1 In-patient acute services

Acute Problems (SCMH, 1998)

A survey of the quality of care in acute psychiatric wards.

SCMH is now involved in following this up with a 3 year project on improving services in in-patient facilities, called *Acute Solutions*.

National Visit 2 (SCMH)

Improving care for detained patients from black and minority ethnic communities. Report of a visit by the Mental Health Act Commission to 104 mental health and learning disability units in England and Wales.

2.2 Crisis services

Open All Hours (SCMH)

An evaluation of services supporting people with mental health problems over 24 hours of the day

Being there in a Crisis (The Mental Health Foundation and SCMH, 2002)

This report provides case studies of several crisis houses with a wide range of client groups

In addition, SCMH has recently conducted a survey of 8 crisis resolution home treatment services across the UK, designed to test the impact on admission rates to acute care and ability to support smaller stand-alone in-patient units. The survey is in the process of being written up, but initial findings about expected reduction rates are incorporated within the analysis of beds numbers for NWHB.

2.3 Housing

Briefing 24 Getting a move on: Addressing the housing and support issues facing people with mental health needs (SCMH, 2004)

This describes the findings from a survey in London of accommodation needs of people with mental health problems and the wider implications for managing accommodation.

Other informal findings through service development experience at SCMH

The range of housing types and accommodation is generally very variable across the UK, so it is difficult to suggest confidently levels for housing required. However there are some key parameters that can be sketched:

- We would not advocate that NWHB should itself provide housing. Its main provider function should be the care management for users. In the UK many mental health Trusts and local authorities have passed the ownership and operation of special needs schemes to housing associations and voluntary organisations that are better equipped through expertise in these areas than health and social care organisations.

- We would also caution about establishing more hostels or group homes. These are generally not found to be appropriate for people's needs by users themselves, and increasingly providers prefer to shift more into individual supported tenancy management.

2.4 Assertive outreach and rehabilitation

Keys to Engagement (SCMH, 1998)

This report identifies service models that are most effective for supporting people with complex problems including severe mental illness. It includes lessons for the development of rehabilitation services.

Active Outreach (SCMH, 2001)

An independent service user evaluation of a model of assertive outreach practice

2.5 Primary care

Primary Solutions (SCMH, 2002)

This publication published in association with the NHS Alliance reviews the development of mental health services in primary care. It looks at the different structures for how primary and secondary care work together and the skills required by the workforce to meet these challenges

Briefing 24 - Mental Health Promotion – Implementing Standard 1 of the National Service Framework for Mental Health (SCMH, 2004)

Describes mental health promotion and how it can be implemented, with examples.

3 Resource requirements

The bases for quantifying services and staff requirements in a new service model for NWHB are comparisons with other services. Two information bases are used in this review to make these comparisons

(i) service resource and activity benchmarking from a wide range of UK mental health services (covering a population of about 10 million) undertaken by SCMH

(ii) similar information that has been collected centrally across all England as part of the annual monitoring of implementation of the National Service Framework and the NHS Plan.

These are guides to how services compare to average levels of provision elsewhere, but are not definitive statements of desirable resource levels.

4 The roles and tasks of mental health practitioners

The Capable Practitioner (SCMH)

A guide to the full range of skills, knowledge and attitudes required of mental health practitioners, including multi-disciplinary team working.

More Than A Friend (SCMH)

This report comments on the valuable role and contribution of support workers. Within this research study, users reported more of an affinity with support workers than with professionals.

Principles for a new service

Three key principles central to taking forward a new service model have been derived from the evidence base on developing mental health services and the review's engagement with a wide range of stakeholders. These are:

1 Services should be user-centred

Service users' needs must be at the forefront of service provision. Service users are experts in the area of being on the receiving end of psychiatric services, yet have historically not been consulted. Service users should be allowed to participate at every level of service delivery and planning, and staff given the skills to encourage this. This will create more respectful services and ones that are relevant to needs as expressed by service users.

2 Services should shift from hospital-based to community-focused care

The new model proposes a comprehensive service emphasising a shift towards community-focused provision. This would take the form of strengthened *sector-based* community CMHTs and primary care mental health service, with crisis resolution/ home treatment teams, in-patient acute care, specialist rehabilitation, and a range of accommodation suitable for various stages of recovery and care.

The rehabilitation function will be of central importance in the transitional stages of making this change, focusing on the re-integration and resettlement of residents from SRUs, and providing community support to people with complex needs. The teams would also have a significant role in the future management and use of any remaining residential units.

3 A team approach, multi-disciplinary workforce, and a new philosophy of care

Evidence shows that service users prefer working with a range of professions. This may be due to a combination of reasons but results in a balance between effective specialist treatments and practical support that importantly provides for greater time availability, and more plain-spoken language.

In organisational terms this suggests the need for a philosophy of care with the following characteristics:

- a shift away from the current paternalistic and 'care'-oriented philosophy that encourages social exclusion and stigma, not only in the wider community, but also in mental health services themselves
- an emphasis on recovery from mental health problems, the support of service users' strengths, and empowerment of service users and carers

- admissions to hospital being avoided where possible, and suitable crisis and alternative services provided

This implies developing

- A culture that values and builds on the views of service users, carers and a full range of staff, much broader than a medical model and/ or a nursing model.
- A multi-disciplinary workforce more able to respond to a range of needs such as health and social care, housing and therapies, and provide overall better value for money invested.
- A team approach to the delivery of care that maximises individual specialisms but which is co-ordinated around core functions of providing needs-based assessments, effective care planning and management of risk.

Section 4 Proposed service model for adult mental health

Service elements within the model

Moving from principles to structural arrangements for the new service model, SCMH now describe the key elements and changes to existing services in the proposal and recommendations model.

1 Community Mental Health Teams and Primary Care

The basic unit of local services would be Community Mental Health Teams (CMHTs). These would comprise a multi-disciplinary team including a consultant psychiatrist, junior doctors, community nurses, social workers, occupational therapists and other therapy and support workers.

The CMHT would be the main team focusing on people with severe and enduring mental illness, but would also include a dedicated group of staff working with and supporting a primary care mental health service. They would focus on supporting primary care in managing common mental illness and making appropriate referrals to secondary care.

Such teams would bring coherence into the responses that service users would receive, by being the single point of entry into mental health services (except in some emergencies or crises – see later). They would provide

- Assessment of people referred from primary care (and possibly elsewhere)
- On-going support to those with severe, long-term or enduring mental illnesses
- Support, liaison and training to primary care staff to enable support and treatment to be delivered through primary care wherever possible.
- Early interventions expertise and capacity that builds upon a close working relationship with primary care, where it is envisaged that anyone with early signs of mental health problems will first present.

It is important to note that CMHTs sited and built around the primary care population would be the centre of the service. This is where the team would be based, including psychiatrists. We consider effective linkages between primary and secondary care as essential, not just in the effective management of common and severe mental illness but also in developing early intervention approaches and out of hours arrangements.

In addition the model proposes crisis resolution services (see below) on a 24-hour basis that would require linkage with primary care and social service out of hours arrangements.

This needs to be developed further in consultation with mental health service providers and primary care services to promote integration of service delivery.

2 Rehabilitation service

A rehabilitation service would support people with severe and enduring mental illness who require long-term or programmed help and engagement. The target group for this service is likely to include people who

- have living skills deficits associated with enduring mental illness and require support within residential settings
- are re-settled into community accommodation having been accommodated for substantial periods in hospital wards or intensive nursed care facilities such as SRUs, and may need significant and programmed support.

There is one other group that may also be included as target for such a service. This is that 'newer' population of patients with complex problems who may not have spent long periods in hospital or nursed care, but who easily disengage from community services creating risk to themselves and/ or frequent admissions into hospital. For this group a Rehabilitation Service could adopt an assertive response approach with the aim of resolving longer-term problems that result in repeated crises and hospital admissions.

There are two options for developing such a rehabilitation service. Firstly, it could be the responsibility of sectors and, depending on the level of need, CMHTs could, through a team approach, provide this service for a limited number of people. Alternatively it could become a function within the rehabilitation teams.

Given that the model supports a dedicated rehabilitation service, which will if it is to be successful in supporting people returning to community settings need to adopt assertive responses, SCMH sees this as the initial way of developing skills and expertise around assertive outreach.

Consequently SCMH propose the two functions of rehabilitation and assertive response be brought together into single catchment-based teams. This would have several advantages:

- Developing a focused capability on rehabilitation and assertive intervention, within a dedicated team approach is in line with evidence of effectiveness.
- By setting the service up along the lines of intensive/assertive community treatment, it may help the development of the rehabilitation teams be community-orientated and avoid pitfalls of relying on new institutional solutions,
- It provides longer-term team stability, as the need for intensive community support/ assertive outreach is likely to be required even after the completion of a specific resettlement process for service users within Supported Residential Units.

The model advocates the reduction of SRUs to two per catchment area. We see them as an integrated resource that is managed by the rehabilitation team and that supports community services.

3 In-patient services

In-patient services would provide continuing assessment, care planning and treatment for people who need to be in a hospital environment when other less containing facilities are not appropriate or available.

Reasons for admission would need to be clearly defined, but there will also need to be flexibility so that patient choice can be accommodated.

Staffing for in-patient services would be multi-disciplinary and may include liaison or direct linkage into local authority and voluntary sector housing to enable efficient discharge where people need new accommodation.

3.1 Configuration options

Within this model being proposed there are two options relating to in-patient services, and the degree of centralisation or decentralisation of units:

Model 1 Maximum decentralisation to sector level

- All services including in-patient services, as shown in Diagram 1.

Model 2 Centralised single in-patient unit for each catchment area

- Decentralised community services at sector level.
- Crisis resolution/ home treatment and Rehabilitation/ Assertive Outreach would be established as catchment area teams, as in Diagrams 2 and 3.

The key difference between the models is in the centralisation or decentralisation of in-patient services and Crisis Resolution/ Home Treatment.

The diagrams below each show one catchment area of the North Western Region. Diagrams 1 and 2 show three sectors for Sligo/ Leitrim. Donegal, which has a larger population and 5 primary care clusters, would have 5 sectors in either model, shown in Diagram 3 .

Preferred option

SCMH has considered the merits and practicalities of both approaches and makes a clear recommendation for Model 2. The reasons for this include:

- It provides a balance between locally accessible services and specialist services that require team approaches and critical mass that are difficult to justify for small populations.
- It provides for a reduction in bed numbers whilst maintaining in-patient units of a sufficient size to offer high quality and sometimes specialist treatment.
- It provides the required services on a more achievable basis. Developing two catchment area whole systems compared with eight primary care sector whole-systems is both more cost effective and easier to deliver upon.

3.2 The physical environment and siting of in-patient units

Design of Unit

The physical environments of in-patient units are important determinants of the services they provide. Therefore consideration needs to be given to how the physical environment facilitates a number of care functions, including:

- Effective treatment of people at varying stages of mental illness and distress, including people who are acutely ill and those who are recovering.
- Space to provide therapy and meaningful daytime occupation
- Privacy and dignity
- Age and gender needs
- Intensive psychiatric care

All these factors raise issues for the internal design of the facilities and SCMH would stress the need to consider the design elements of any new or refurbished units carefully.

Location of unit

In relation to the siting of units it is important to take into account, not only the internal functions of a specialist mental health unit, but also the connections that it needs with other 'supporting' health services. In particular

- People admitted to psychiatric in-patient care often require medical or other investigations and access to diagnostics
- A&E will occasionally need rapid access to psychiatric assessment and facilities
- Other care groups may require liaison with mental health services for advice or accommodation

These factors suggest that the most appropriate location for siting in-patient mental health units would be on or close to a General Hospital site.

Other factors

The overall service model proposed by SCMH is clearly community focused and based. However the importance of providing good quality in-patient care within a well-designed building is also of key importance. Given such an investment it would also be prudent to consider the site providing additional facilities

- Space to facilitate linkages with community mental health services
- Space to provide a base for the Crisis Resolution Home Treatment Team. SCMH envisage a very close working relationship between the two services involving shared management and possibly staff rotation
- Space to facilitate coming together of professional groups working across a dispersed service for shared learning, professional development and training.

Diagram 1 - Model 1 - Fully decentralised model

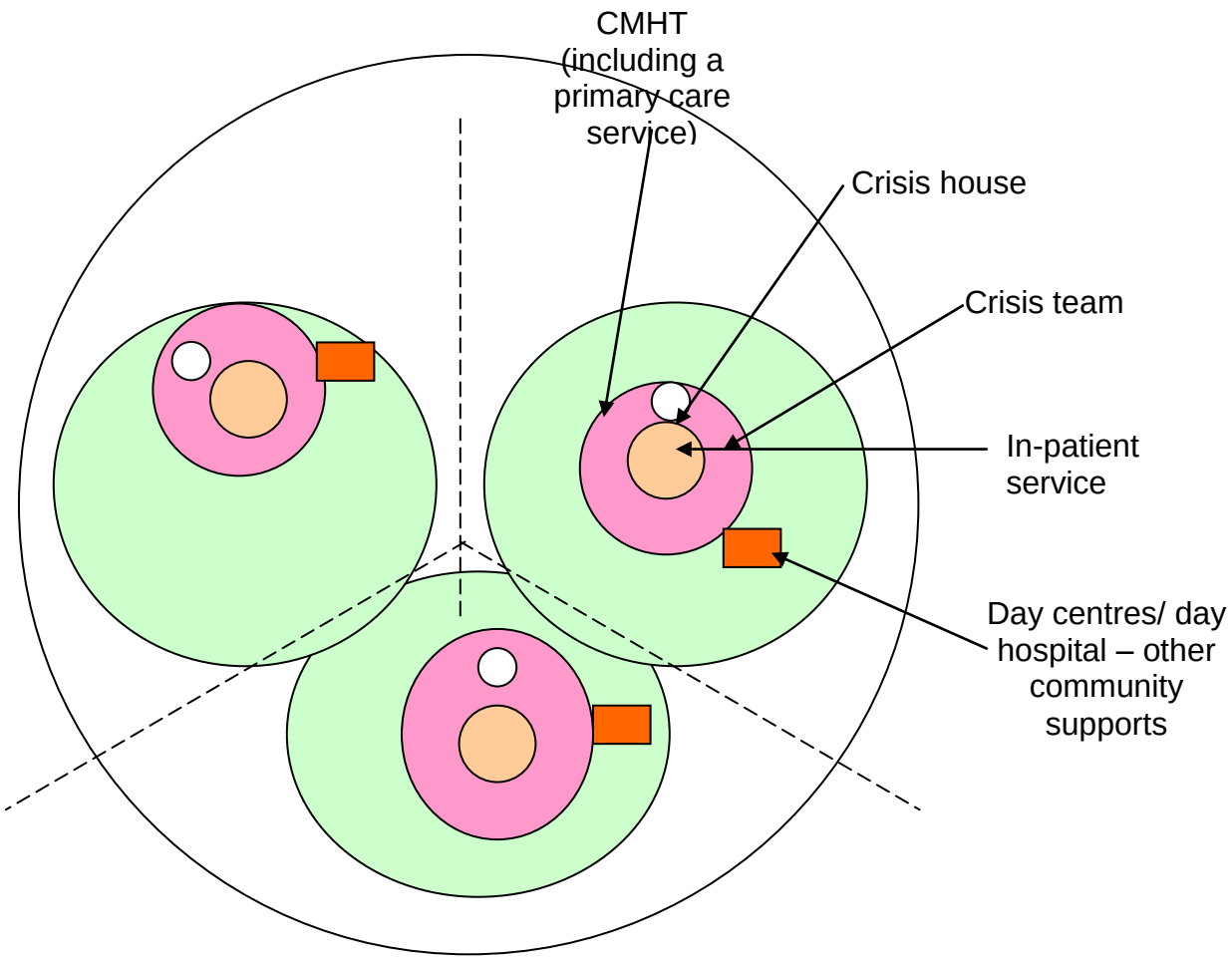


Diagram 2 - Model 2 - Partially decentralised model (3 Sectors)

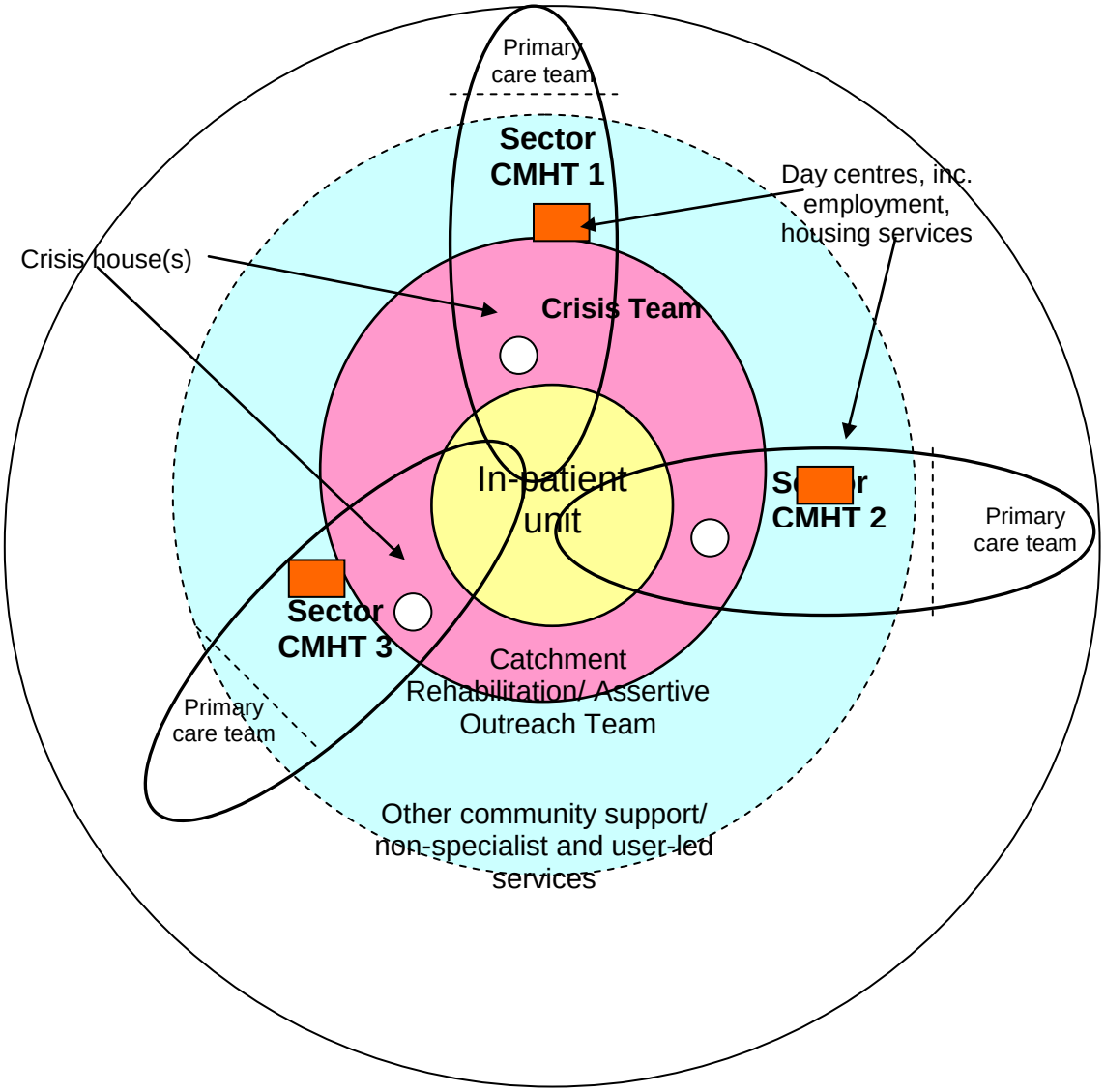
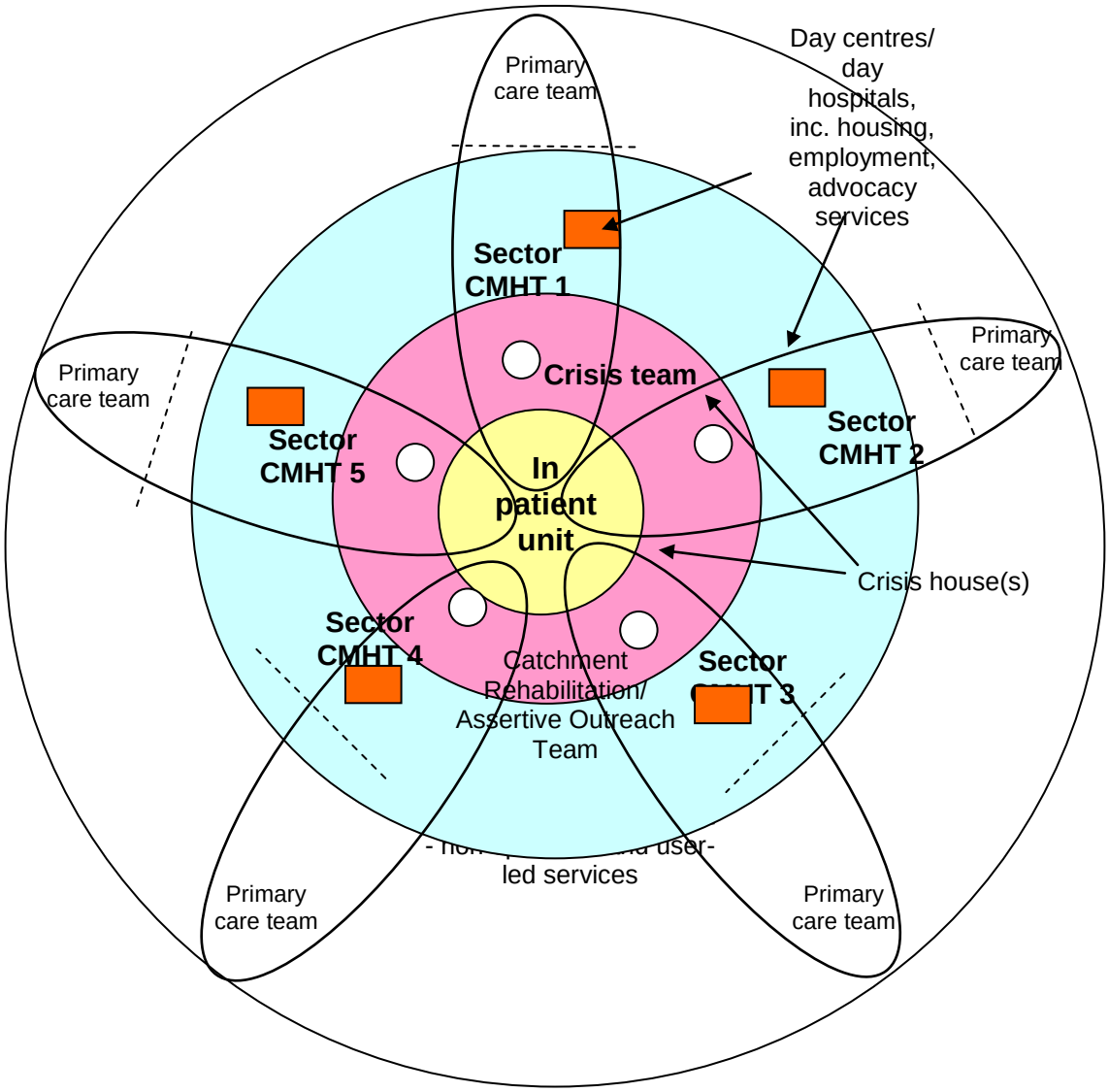


Diagram 3 – Model 2 – Partially decentralised model (5 Sectors)



4 Crisis services

A crisis service would be a 24 hour home and community visiting service to provide:

- Assessment at times of crisis,
- Short-term home treatment and support when assessed as appropriate until a crisis is adequately resolved or until the care co-ordination is passed to another team.
- Access to in-patient care when assessed as appropriate,
- Access to other short-term facilities, such as a crisis house,

This team would work closely with in-patient services and the staff may even have roles that rotate between in-patient and community-based care.

SCMH envisage crisis resolution home treatment teams to be closely linked with in-patient care and share an overall management structure. SCMH also advocate that the team be based at the new in-patient units. This will require revised consideration about the design and administrative space within these new units.

SCMH are aware of Department of Health concerns about excessive administrative space within in-patient units and understand the rationale for restricting this to encourage a more community-orientated service.

However if NWHB adopt the proposals and recommendations made there will be a very significant shift away from in-patient care in a way not envisaged during previous discussion. Given this SCMH would advocate that any new units are built with the needs of this new whole systems approach in mind. This will therefore require space for services such as Crisis Resolution Home Treatment Teams as well as facilitating community services in reach into admission units thereby encouraging continuity of care and more rapid discharge planning.

5 The future of SRUs

This report proposes the decommissioning of most of the SRUs leaving two units managed within a dedicated rehabilitation service for each catchment area. We feel that the SRUs do not serve users in a way that develops their life skills or leads to greater empowerment.

For most residents we believe more appropriate alternatives could be provided, and that as a service they will have a very reduced role in meeting the needs of future service users. It is also our view that they consume a level of resource, which if redeployed, could go a long way to resource the proposed whole systems community model advocated within the proposals and recommendations.

6 Existing SRU residents

With the proposed closure of most SRUs, we acknowledge concerns about the implications for current residents. Consequently, the decommissioning of SRUs will need to ensure residents' needs are fully and appropriately met by a range of new services. We advocate a process that includes:

- A thorough individual needs assessment of all existing SRU residents
- A resettlement process staged over a 3 to 4 year period so that numbers of people to be relocated are relatively small annually

- Partnerships with Older People's Services to provide other accommodation, employment and/ or recreational opportunities. Some of the current SRU resources could facilitate the development of such alternatives

7 Housing

A mixed portfolio of housing and accommodation is required for a comprehensive service. In addition to the two SRUs in each catchment area there will need to be a range of supported accommodation. SCMH stress that these should not create additional residential care but should aim to provide more independent forms of accommodation/ housing facilities. Achieving an appropriate range and adequate number in all categories is likely to require effective partnerships and planning over some time with local housing providers.

8 Secure accommodation and forensic services

This has been identified as an area of weakness within current provision. There is currently a Special Care Unit that appears to provide three conflicting roles, psychiatric intensive care, long term continuing care for complex and challenging behaviour and an emerging rehabilitation service.

The model above provides for a PICU (psychiatric intensive care unit) within the two in-patient units. Rehabilitation is again formalised with the creation of two specialist teams with access to accommodation through the refocusing of the remaining SRUs. This then leaves a function of providing a more secure hospital environment for people with challenging needs and possibly forensic backgrounds.

The population base of the NWHB area in the view of SCMH is too small to warrant such a specialist unit. We acknowledge that there will from time to time be some need for that type of service. We also acknowledge that there is little if any forensic service available across the north of Ireland.

Potentially the NWHB has the opportunity to use the current Special Care Unit resource to develop such a facility as a pan-regional service that would generate income and centre of excellence status. SCMH did pose this as a potential in the form of a question to the NWHB and the stakeholders consulted.

Having considered the idea further as well as initial responses from our first draft report we would not recommend it as a course of action. The basis for this is that as a health economy the proposals made already represent a very significant challenge and this could be one development too many. There are also fundamental questions yet to be answered about the real level of need for such a service given the provisions of psychiatric intensive care beds within the proposals and the current usage of the Special Care Unit. In conclusion SCMH propose that the Special Care Unit be closed at the earliest appropriate opportunity.

9 Day care and employment services

Day care and employment services are an important part of a whole system of mental health care, and hopefully they will be able to respond in the directions suggested by service users (as already described in this review).

Developing community mental health services, rehabilitation services and early interventions will lead to more comprehensive multi-disciplinary assessment of need. Likely consequences are that services will begin identifying currently unmet needs, including younger people experiencing mental health problems for the first time.

Given the dispersed population and limited public transport, an option is to develop day and employment services around the local community mental health teams. Some such services are already in place but will need to be strengthened.

Some day services are supported by staff of SRUs, and given the proposals for SRUs it will be important that that capacity is not lost, and where appropriate built upon.

Service integration

1 Adult mental health services

The objective of the new service model is to provide a coherent and responsive range of services that work well together for service users and carers and to avoid setting up a set of services that have individual merits but which are disconnected from each other. Consequently integration of services is a key objective of the re-design process that needs to be taken into account in establishing the service elements described above. It is intended that each sector would become a 'whole system' of services.

The mechanism for doing this is to create local mental health teams around primary care clusters representing sector sizes of between 25,000 to 30,000. As discussed above this will become the core of future mental health provision and it is envisaged to operate as a resource centre approach that provides services from within its main community base, and outreach from it to more dispersed populations.

With a more centralised approach to Crisis Resolution and Rehabilitation the approach adopted by SCMH has been to increase the size of these teams so that there is the potential for an effective subgroup of staff within each team to develop close linkages with the local mental health teams. This is the meaning of the overlapping circles within the whole systems diagrams.

2 Related care groups

As well as having relevance to the adult mental health service system, integration is an important consideration in relation to the interface of adult mental health services with services for other related care groups, i.e.

- Older People's Mental Health services
- Child and adolescent mental health services
- Drug and Alcohol services
- Learning Disability services

At present SCMH believes that these services are underdeveloped although we acknowledge and are very supportive of NWHB achievement in setting up consultant-led services in these areas. However in this context it is unlikely that the proposed model for an adult mental health system will be able to deliver expected outcomes unless the needs of the other care groups are more fully met within their own services.

Therefore we recommend that a formal review is undertaken of the existing protocols for joint working between adult mental health services and these other care groups, and new protocols are established that reflect the new service model as a priority within the implementation process.

Also we make development proposals for adult services against the following principles or conditions related to the other care group services that we feel are important. These include:

2.1 Older people

- The changes in the proposed model, particularly around sectors and establishment of Primary Care cluster areas will affect older population catchment areas. This needs to be acknowledged in future restructuring processes and provides potential for a further older person's team.
- The only Enduring Mental Illness ward in the Donegal catchment area (St Conal's) is about to be closed and there are no designated beds for this population within Sligo/ Leitrim. Consequently SCMH suggests that this is reflected within our proposals on future bed numbers.
- There is a significant "graduate" population currently within adult services that needs to be considered in terms of where best its current and future needs can be met and the resources required to deliver this. Whilst SCMH is not advocating a specific age barrier to services there does need to be sufficient capacity within older peoples mental health teams to respond to an ageing population. This represents a significant resource input into older people's mental health services which we detail in our proposals and recommendations
- Benchmarking against Royal College of Psychiatry guidelines indicates that adult psychiatry generally has sufficient resource within the system, although Donegal may need some additional input. However, for older people there is a strong case for an additional full time post.

SCMH therefore proposes:

- The provision of functional mental health in-patient needs continues, with adequate provision, within the two proposed in-patient units for adults
- An additional older person's multi-disciplinary mental health team is established with a full time consultant psychiatrist. This will provide for three rather than the current two teams and consequently boundary issues will need further exploration both in terms of linkages with local primary care services and adult community mental health teams, as well as centralised services such as in-patient beds

2.2 Learning disabilities

- It is clearly appropriate that people with a mild to moderate learning disability are able to access mainstream mental health services. However, those with a significant learning disability will present more complex needs and require a specialised service with trained staff. The bed numbers suggested within the proposals do not reflect that need and SCMH would not advocate the use of the adult in-patient units to provide for such needs. It is recommended that NWHB

review the need for such a specialist bed provision *across* against its population base.

2.3 Drug and alcohol misuse

- An appropriately resourced community drug and alcohol service is established that has capacity to provide effective community detoxification programmes and has access to medically supervised detoxification beds that are not located within the new in-patient settings.
- The beds numbers SCMH propose exclude their use for detoxification unless there are significant dual diagnosis needs.

Management arrangements

Proposals for a new management structure are intended to support the service model being advocated. They also aim to address the management and leadership issues identified in Section 2 above.

1 Principles

These proposals are radical alterations to the current management structure, but are based on a number of principles aimed at addressing the current shortfalls:

- Clear responsibility and accountable management
- Separation of clinical decision making from service management
- Management that is functional and complementary to the proposed model of service provision
- Rationalisation of management levels, a flatter and streamlined structure
- Investment in strategic management, service development and project management capacity, that also provides strong leadership and direction.
- Management that supports team working and effective links with geographic building blocks on which the proposed model of service is designed

2 Proposed management arrangements

The proposed management arrangements are at two levels, regional (across all NWHB), and catchment/ sector level (relating to each of the two administrative areas of the Board, Donegal and Sligo/ Leitrim). These are shown diagrammatically in Figure 1 below.

2.1 A regional management structure

Objectives for the regional management structure are to provide:

- overall authority and accountability for the service
- strategic planning and service model implementation
- policy setting
- clinical governance standards
- performance management

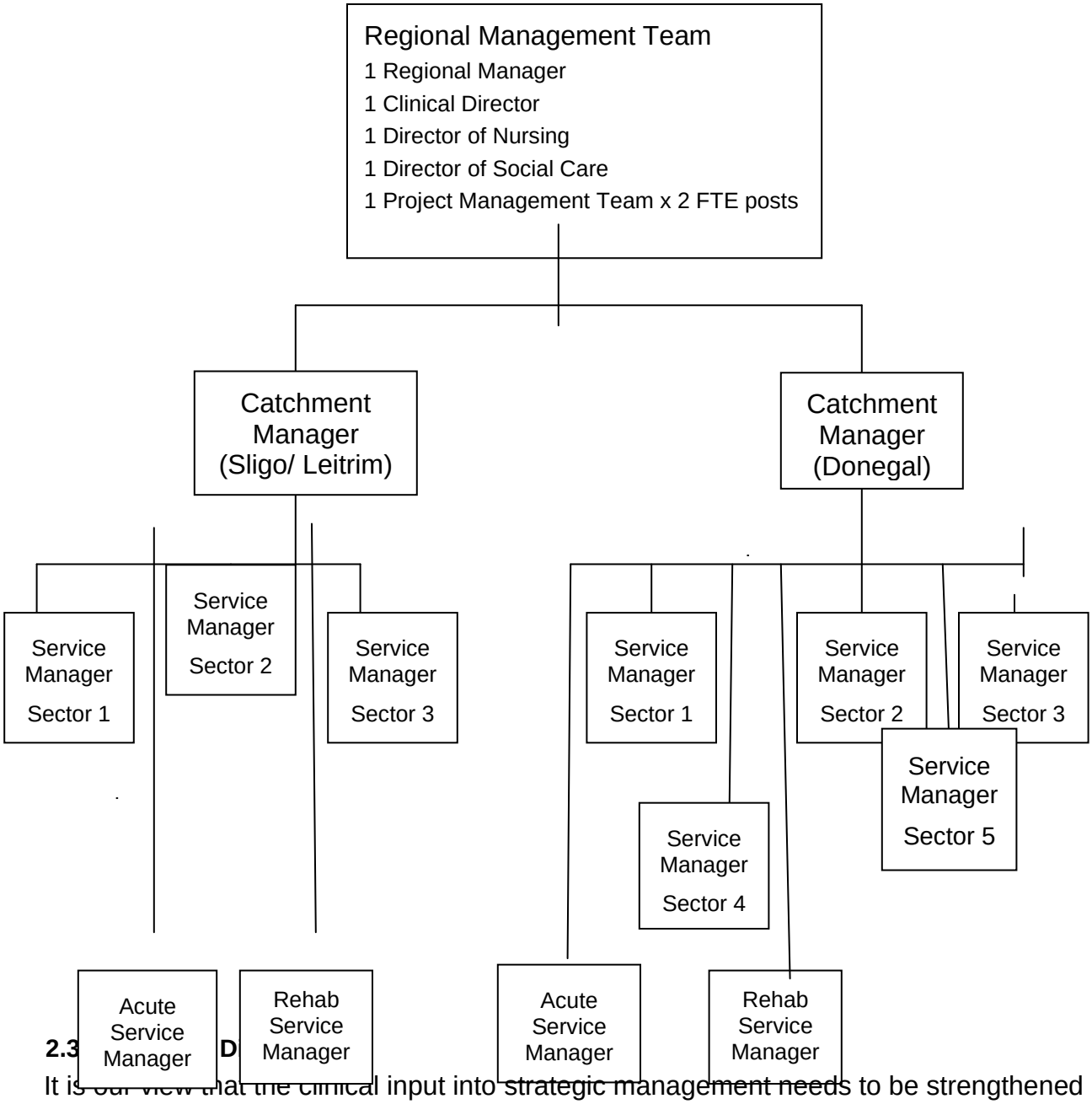
2.2 A catchment/ sector management structure

The key elements of the proposed management structure are intended to enable clinical leadership across the whole system and to provide managerial focus on centralised services, i.e. Acute care/ Crisis Resolution/ Home Treatment and Rehabilitation

In structural terms this suggests the following positions

- 1 catchment area manager with authority and responsibility for all service provision, reporting to the regional manager
- 1 service manager for each community/ primary care sector, who oversees the whole system and manages all professional groups
- 1 service manager for Acute Care/ Crisis Resolution/ Home Treatment service
- 1 service manager for Rehabilitation

Figure 1 Proposed management structure for mental health services



2.3 D

It is our view that the clinical input into strategic management needs to be strengthened and believe there should be one Regional Clinical Director to undertake this role. The post would be important for at least these purposes:

- a single post would facilitate greater equity in resource distribution
- provide consistency around clinical governance across NWHB,
- it would provide clinical expertise at a NWHB level to assist practical and consistent implementation of the proposed model across the region.

SCMH acknowledges some other implications, in particular:

- the post would have placed upon it a greater demand for managerial and strategic planning than the current two director posts,
- potentially an impact on the level of clinical leadership in the two counties at a time of very significant service development and change
- reduced time available for clinical practice

There would of course also be a need for local issues to be adequately clinically managed, and the following issues need to be acknowledged

- A single Clinical Director would not preclude the need for consultant meetings within each catchment. The need for this will be considerable.
- Developing a strong locally based community service potentially can lead to isolated working across what are relatively small groups of consultants. Consequently effective managing of the interfaces with other care groups requires the ability to meet on a regular basis.
- Building in structured/ scheduled time within a physical space and environment conducive to effective communication and which provides learning opportunities both within the consultant group and with junior doctors and other professional groups is essential.

Section 5 Quantification of the model

Having described the principles and elements of the proposed service model the sizes of the service elements and the financial implications now need to be examined.

These are outlined below with explanations for the choices made, with some additional modelling calculations shown in Appendix 3.

The figures and estimates provided here derive from a consideration of the various comparators of other service systems areas available. These are

- SCMH service resources data base (which provides benchmarks of service level provision based on 40 sites in the UK covering over 10 million population)
- Service resource levels using data from 4 specifically selected UK sites in the NSF Service Mapping Atlas that have similar demography to NWHB area. These sites are South Devon, Cumbria, Northumberland and York
- Information from data analysis of rural Leicestershire (conducted as part of another SCMH service review) is used as indicated
- Royal College of Psychiatry Guidelines for bed numbers

In-patient services

As described above in Section 4 we propose to maintain two in-patient units, one in each catchment (Model 2 in Section 4 above) to provide high quality focused care in well-suited environments.

1 Bed numbers

The beds numbers are calculated against a baseline figure, and take account of additional factors. These are:

- The SCMH database average for acute in-patient beds
- A reduction of 30% in usage of acute beds due to the impact of CMHTs, Crisis Resolution/ Home Treatment and Rehabilitation Teams managing two SRUs*, of (30%)*
  - ~ This is based on a survey of the impact of existing Crisis Resolution/ Home Treatment teams (see Appendix 3, Section 4)
  - ~ The potential in NWHB to reduce the number of very short duration admissions (See Appendix 3, Section 4)
- Additional beds for intensive care (Estimate of 3 in each catchment , no benchmark available)
- To include additional beds for functional Older People's mental health service (with 10% reduction on current use, through development of an additional community team and some access to Crisis Resolution/ Home Treatment

Table 1 Acute bed numbers forecast

Catchment	Existing bed use (excluding beds used for OPMH, LD, <20 yrs)	Beds in new model (for adult mental health + OPMH)
Donegal	46.5	30
Sligo/ Leitrim	37.7	23
NWHB	84.2	53

More detailed calculations for this can be seen in Appendix 3, Table 13.

Assumptions to support this analysis are:

- An additional community older people's mental health team would be developed (to enable the reduction of acute bed use for people over 65)
- Detoxification would not be provided on the acute units except where there are significant dual diagnosis needs
- Two SRUs will be maintained in each catchment to provide rehabilitation and follow on from the acute wards (see section below on Supported Accommodation)
- These bed levels should only apply once the community services described above are established.

We have not factored in adjustments for improving occupancy of beds, although this might be possible but we would advise, only slightly. See comparisons in the table below

Table 2 Bed occupancy rates

	Occupancy rate
UK and RCP policy guidance for acute services	85%
Donegal	78%
Sligo/ Leitrim	84%

2 Ward staffing

SCMH strongly recommends that wards are well resourced in nursing and therapist posts as well as having access to staffing backup arrangements.

The following would be the basis for ward staffing

- 1 nurse per patient remains a reasonable standard (based on the benchmark average from the SCMH service database).
- existing occupational therapy support attached to current units
- clinical nurse managers (as appropriate)
- additional backup staff pool

The overall effect on ward staffing is expected to be neutral.

Table 3 Ward staff numbers forecast

Staffing	Acute beds	Staff	PICU beds	Additional staff	Backup pool	Clinical Nurse Manager	Total staff
Staff per bed		1.0		2.0			
Donegal	30	30	3	3	To be determined	To be determined	**46.5**
Sligo/ Leitrim	23	23	3	3			**32.5**
NWHB	53	53	6	6			**79**

Consultant Psychiatrists

Based on RCP guidelines the following total complement of consultants is forecast as requirement, in Table 4 below.

There are two aspects of this resource allocation that need consideration, i.e. how this is divided among

- the sectors of the area
- the new service functions within the model

Table 4 Requirement for Consultant Psychiatrists (based on RCP guidelines)

	Donegal	Sligo/ Leitrim	NWHB
Adult mental health	4.4	3.2	7.6
Learning disability	1.1	0.8	1.9
Rehabilitation	1.0	0.7	1.8
Substance misuse	1.2	0.8	2.0
Liaison	0.5	0.4	0.9
Older Age	1.7	1.2	2.9
TOTAL	**9.9**	**7.2**	**17.1**

Community Mental Health Teams

The staffing composition and numbers for CMHTs is based on SCMH database benchmark averages for the relevant staff groups. Adjustment factors are included, as follows

- a critical mass for each of the CMHT and staff group needs to be assumed
- additional dedicated primary care mental health workers (currently on the basis of 3 per CMHT)
- the numbers of staff estimated for whole catchment areas are divided into sectors to the nearest whole or half-time equivalent.

The resulting staff complement is shown in Table 5.

Table 5 CMHT staffing requirements

	Donegal		Sligo/ Leitrim		NWHB area
Sectors/ CMHTs	5		3		
Staff groups	**Total**	**Per sector**	**Total**	**per sector**	
CPNs	20	4	12	4	32
SWs	9	2	7	2	16
OTs	4	1	2.5	1	6.5
Psychologist	4	1	2.5	1	6.5
Community Support Workers	13	3	10	3	23
Primary care workers	15	3	9	3	24

Rehabilitation Teams

The model proposes 2 Rehabilitation teams in NWHB. They will have a function akin to Assertive Outreach, for which service prescriptions are available in the Policy Implementation Guidance (PIG) in England. The PIG prescribes a minimum team should comprise 8 staff, excluding Consultant Psychiatrist and junior doctors, and that this would be expected to service a caseload of about 90 clients. Consequently the guides to staffing this team are:

- Assumption that Rehabilitation/ Assertive Outreach caseloads of 90 are appropriate for each catchment
- A minimum team of 8 staff (plus Consultant and other psychiatrists)
- At least 2 staff per sector to sustain linkages with the relevant CMHTs

The outcome of this with 5 sectors in Donegal and 3 sectors in Sligo/ Leitrim is shown in Table 6.

Table 6 Rehabilitation/ Assertive Outreach staffing requirement

County	**Staff**
Donegal	10
Sligo/ Leitrim	8
NWHB	18

Crisis Resolution/ Home Treatment Teams

The basis for resource requirement assessment is

- The model will require one Crisis Resolution/ Home Treatment team for each of Donegal and Sligo/ Leitrim in order to provide an adequately speedy service across the whole area it serves

- Each team will need a critical mass to operate effectively, providing 24 hour cover and home treatment

The Policy Implementation Guidance (PIG) in England recommends 14 staff for a team covering a population of 150,000 total population. Both populations for NWHB catchments are less than this, but there are some qualifications to our assessment:

- In view of the rurality of the area we believe additional resourcing should apply, and we opt for the minimum critical mass, i.e. each team should comprise a minimum 14 staff, excluding Consultant Psychiatrists and junior doctors
- For Donegal we would suggest that it ensures that the team fits a ratio of 4 staff for each CMHT area. This allows for the team to have dedicated team members relating to each CMHT area

The resulting staffing requirements are shown in Table 7 below.

Table 7 Crisis Resolution/ Home Treatment staffing requirement

County	Staff
Donegal	20
Sligo/ Leitrim	14
NWHB	34

Supported accommodation

On the basis of SCMH benchmark average provision the following levels and types of accommodation would be recommended

Table 8 Places in supported residential accommodation (forecast and changes required)

	Forecast levels			Change from current levels		
	Donegal	Sligo/ Leitrim	NWHB	Donegal	Sligo/ Leitrim	NWHB
Places in 24 hour nursed care (or SRU)	11	8	19	-93	-62	-155
Places in 24 hr waking staffed residential care	13	10	23	13	10	23
Places in staffed residential care (sleeping/ on-call at nights)	16	12	28	16	6	22
Places in group homes/ hostels	10	7	17	-56	-56	-112
Individual supported tenancies	29	21	51	29	21	51

3 Nursed accommodation

The analysis above suggests NWHB should aim to reduce SRUs to one per catchment, with an additional SRU not necessarily staffed by 24 hour nursed care.

These remaining SRUs would operate within a dedicated rehabilitation service.

4 Individual tenancies

The forecast figures for supported residential tenancies are likely to be below an ideal as the benchmark is based on service levels over recent years but the trend is clearly upwards. It would be wise to include an inflation trend factor to forecast for this type of accommodation.

Summary

The table below summarises the proposed staffing levels for community services

Table 9 Proposed staffing levels - summarised

Staffing figures (adjusted by rounding)					
	Donegal		**Sligo/ Leitrim**		**NWHB area**
Sectors	5		3		8
CMHTs	**Total**	**Per sector**	**Total**	**per sector**	
CPNs	17	5	13	4	30
Sws	9	2	7	2	16
OTs	4	1	2.5	1	6.5
Psychologist	4	1	2.5	1	6.5
Community Support Workers	13	3	10	3	23
Primary care workers	15	3	9	3	24
Other community teams					
Crisis Resolution/ Home Treatment	20		14		34
Rehab/ AO	10		8		18
Psychiatrists	**9.9**		**7.2**		**17.1**

Section 6 Costs of new service model

This section provides initial costings of the new service model to test the feasibility of implementing the model within existing costs. Tables 10, 11, and 12 provide estimate comparisons of future costs against existing costs for community services and in-patient services, and the balance resulting.

Table 10 Additional staffing costs of community services developments

	Staff numbers		
	Donegal	**Sligo/ Leitrim**	**NWHB**
CMHTs			
Manager (AD of Nursing grade)	1	1	
CPNs	4	4	
Primary care workers (CPN grades)	3	3	
Social workers	2	2	
OTs	1	1	
Psychologist	1	1	
Community Support Workers	3	3	
Total numbers	**15**	**15**	**30**
Cost per team (€)	685,410	685,410	
Number of teams	5	3	
Total cost	**€3,427,050**	**€2,056,230**	**€5,483,280**
Rehabilitation			
Manager (AD of Nursing grade)	1	1	
Mixture of Nursing and SW staff	8	6	
Community Support Workers	2	2	
Total numbers	**11**	**9**	**20**
Cost per team (€)	526,698	502,385	
Number of teams	1	1	
Total cost	**€526,698**	**€502,385**	**€1,029,083**

Continued over page

	Staff numbers		
	Donegal	**Sligo/ Leitrim**	**NWHB**
Crisis Resolution/ Home Treatment			
Manager (AD of Nursing grade)	1	1	
CPNs	13	10	
Community Support Workers	7	4	
Total numbers	**21**	**15**	**36**
Cost per team (€)	953,540	677,665	
Number of teams	1	1	
Total cost	**€953,540**	**€677,665**	**€1,631,205**
Older People's Mental Health Teams			
Current service			
Unspecified			
New model			
As for current			
Additional team (1)			446,877
Total			**446,877**
TOTAL COST (all services)	**€4,907,288**	**€3,236,280**	**€8,590,445**
	(excluding OP development)		inc. OP development
COSTS OF CURRENT SERVICES			
Community services and 4 of 6 actual and proposed SRUs	**€2,966,221**		**€6,765,738**
Community services and 6 of 8 actual SRUs		**€3,799,517**	
DIFFERENCE (CURRENT TO PROPOSED)	**€1,941,067**	**-€563,237**	**€1,824,707**

Table 11 Change in costs due to in-patient services

	Staff numbers		
Acute wards	**Donegal**	**Sligo/ Leitrim**	**NWHB**
Current service			
Nurses	41.5	26.5	68
Staff nurses or CNMs	5	6	11
Total	46.5	32.5	79
New model			
Staff per bed	1	1	
Beds	30	23	53
Nurses	30	23	53
Additional nurses for intensive care	3	3	6
Total (Nurses and CNMs)	33	26	59
Remaining resource (for Staff Nurses CNMs and pool)	13.5	6.5	20
	Costs		
Ward staff	**€1,774,049**	**€1,300,322**	**€3,074,371**
Floating night staff budget (St Conal's)	**€0**	**€0**	**€0**
Total	**€1,774,049**	**€1,300,322**	**€3,074,371**
Ward staff (as new model)	€1,774,049	€1,300,322	€3,074,371
Floating night staff budget (St Conal's)	€205,697	€0	€205,697
Total cost per team	**€1,979,746**	**€1,300,322**	**€3,280,068**
Change	**-€205,697**	**€0**	**-€205,697**
Special Care Unit			
Current service			**1,189,733**
New model			0
Change			**-€1,189,733**
Total change (all in-patient services)			**-€1,395,430**

Table 12 Balance of new investments and savings

New investments	€1,824,707
Savings	-€1,395,430
Net outcome	**€429,277**

This is only an initial attempt to cost a very extensive development package against a complex existing resource deployment. The process has indicated an initial shortfall of approximately €430k, although we believe this exercise will require greater refinement by NWHB. However, in looking at the budget figures we think there are a number of current resource commitments which require further clarity and discussion, but which potentially provide an income source to offset this deficit.

The model described is for adult mental health services, but there are significant issues to accommodate including

- the need for strengthening older people's mental health, younger people's mental health services and substance misuse services
- Possibly some double running costs during service development
- Development of other community services such as day care, social inclusion services and other forms of supported accommodation
- The need to establish community services before operating at the bed levels proposed.

Consequently we would caution against any assumption that the service, organisational, and workforce developments can be achieved entirely within existing resources, but remain confident that implementation of the proposed developments is realistic as a significant majority of the model can be funded through redeployment of current resources.

Section 7 Workforce and organisational development

A clear implication of the new service model is the need for organisational and workforce development.

There will be considerable work required in making the new systems function and on acquiring the full range of capacities and capabilities required for an increasingly wide-ranging service. There will be a high volume of training and team development required on a year by year basis across the two catchment areas.

We provide some initial direction for this development in the form of comments on

- Resources required
- An outline workforce planning model

Resources

Development will itself have costs and resource implications. Key aspects in delivering the organisational and workforce development will be the presence of a driver for this development, and resources available for its implementation. Some initial thoughts on this are:

- The project management team should be the driving force behind the development of the workforce/ organisational development plan
- Whilst it is extremely difficult to put an exact cost on such development we make some suggestions
  - ~ 2 FTE project workers should be appointed, at least for the first two years of implementation,
  - ~ We note there are budget headings for 2 Development Officer posts, one in each catchment area, and it may be appropriate that this resource is used to cover the proposed two project officer posts proposed above.
  - ~ In addition the NWHB should look to ring-fence a supporting budget of at least €150,000 per year to pay for specific team building facilitation and training around core skills and competencies attached to the new service roles and responsibilities

Objectives

The development of the workforce and the organisations involved needs to be oriented around key objectives:

- To provide leadership on workforce development issues for mental health services
- To prepare and implement a local workforce action plan and identify the required investment in response to the proposals and recommendations agreed by NWHB;

- To identify the workforce required to deliver both the national and local mental health priorities.

Initially the focus would be on adult services, but it is recognised that similar work is required for services for older people with mental health problems, including dementia and learning disability. This is particularly important given some of the boundary and transitional issues that face individual patients when they move from one service to another.

A Mental Health Workforce Steering Group should be established to identify the detailed workforce numbers and skill mix required to deliver the proposals and recommendations adopted. The group should undertake three separate pieces of work:

- Map the existing mental health workforce by service, professional background and organisational base and identify the workforce gap between current arrangements and the requirement to deliver proposals and recommendations adopted.
- Identify the characteristics of a modernised mental health workforce and current examples of good practice.
- Describe current educational and training opportunities and plan an investment programme for training and development for the future mental health workforce including CPD for all.

The product of this work will be a *Local Workforce Action Plan* across the whole Heath Board area that identifies the numbers and type of staff required to deliver the national and local policy agenda and produces a plan for the training and development of the workforce that contributes to increased capacity and capability of the workforce as part of the roll-out of the service improvement.

The European Foundation Quality Model (EFQM) provides a useful outline. A summary of this approach to planning local mental health workforce development is shown Appendix 4.

Training and education for the mental health workforce

1 Introduction

This strategy is intended to assist the development of all those working in the field of Mental Health across all sectors, statutory and non-statutory. Over the coming years Mental Health service provision is likely to become a ‘mixed economy’ and, if you are to develop the mental health workforce in a meaningful way, it will be important recognise that there could be a plurality of service providers, and an increasing need to introduce choice for service users.

A key part in planning for the future workforce is reviewing the current workforce across the statutory, voluntary and private sector. It is recognised that such a breadth may be initially difficult, but is important.

There will need to be a more inclusive approach to training, education, recruitment and retention, by valuing the diversity of practice and provision. This can be built on

common ground around core principles and standards that will assist providers in meeting the real needs of service users.

If the majority of those working in Mental Health can agree a set of competency- based core service standards, then service users should be able to expect a more consistent standard of care and one which reflects their needs.

The proposals and recommendations envisage many different people delivering mental health care at many different levels across all sectors. The range of workers includes highly trained clinicians, with high levels of knowledge and expertise in their chosen specialist fields, and non-professionally qualified staff. Despite the varying levels of relevant training, all can contribute to a high quality service given access to outlined training programme.

While the skills used may be wide and varied, the skills at the core of high quality mental health practice, no matter the job title or user group, may be thought of in two main (overlapping) bands:

- Service-led / evidence-based practices,
- User-led/ values-based practices

2 Service-led/ evidence-based practice

The proposed model of care highlights the need for treatment, communication, engagement, crisis intervention and risk awareness. More specifically, it calls for those with mental health problems to have equal access to physical and psychological treatments.

The proposed model also necessitates as a priority the ability of mental health workers to assess the level of risk mental health service users are to themselves or others.

The proposals and recommendations place a significant emphasis on the skills and values required by Community Support Workers who are expected to be able to focus *'directly on the needs of service users, working across boundaries of care…'*

Training for this group will need to emphasis communication skills, knowledge of management and treatment approaches, care planning, promoting independence and supporting relationships.

The proposals make significant play on effective community working, and workers should have knowledge of the local community. This does not only demand a knowledge of local support but, in combination with the requirements to promote anti-discriminatory practice, suggests a need to be aware of and to address local needs around discrimination and opportunity.

The proposals recognise the importance of relationships and engagement with service users. Roth and Fogany describe the relationship between user and helper as the *'therapeutic alliance'* and state that this is the single most important variable contributing to the effectiveness of all psychological approaches. Effective communication is viewed as central to relationship building and user well-being.

The emphasis is on verbal communication but there is also a need for good written communication skills. For service users to be involved in the planning of their care, workers need to ensure that information is accessible to them. This includes ensuring

that reports are not only physically accessible but are written using language that is understood by service users.

2.1 User-led/ values-based practice

In addition to the above there should be a recognition of the need for value-based practice. Much is made of the need to include users' voices in the design and running of services. In the user led 'recovery model' value-based practice takes centre stage (Mental Health Today, 2002).

Users have, through this model, voiced the need for services (workers) to engender hope. This is deemed to be more likely when workers have high expectations, take risks and learn from failure and promote self-management and social inclusion.

This model also reports that users view as important workers who have the ability to think calmly under pressure, are able to deal with distress, and can show empathy when faced with strong emotion.

2.2 Skills, values and knowledge

Given the issues highlighted the types of skills, values and knowledge that should be key to mental health work should include:

- evidence based psychological practice (PSI, CBT, Family Intervention)
- complex medication management
- assessment of signs of relapse
- non-discriminatory practice
- social inclusion (e.g. housing, employment, finance)
- developmental risk taking
- risk assessment and management
- the promotion of ordinary lives
- protection of vulnerable adults
- communication and engagement skills
- openness and acceptance
- suicide risk assessment
- promotion of relationships and interdependence
- high expectations
- accurate empathy, genuineness and non-possessive warmth
- accessibility and flexibility
- versatility
- tolerance of uncertainty
- belief in the skills, abilities and potential of others
- health promotion
- managing change
- coping with challenging behaviours
- advocacy

These skills, values and knowledge promote the ‘recovery model’, and ‘working towards ordinary lives’. It would be necessary to prioritise and streamline these key ingredients to develop any potential core training that could be seen as relevant across the mental health workforce. Service user involvement would be essential, both in any potential core-training and reviewing its efficacy.

Appendix 5 summarises the mental health training agenda that is implicit within the proposals and recommendations.

Section 8 Implementation

The new service model represents a fundamental shift in service focus, culture and operational arrangements. In essence it proposes a comprehensive development of community services and a reduction in admission beds and supported residential units.

SCMH recognises that these are challenging proposals but makes the recommendations in the light of a number of factors that suggest the outcomes could be successful:

- In general the workforce is excited about the proposals, and if the workforce development plan is agreed and resourced there should be optimism about implementation of the model
- Costings of the proposals indicate there is only a small deficit on existing budgets *available* to implement a full range of services.

This suggests an optimistic outlook for achieving the intended goals to develop the services and workforce while also managing a balanced budget through the change process.

1 Time frame

A key aspect of successful implementation will be the setting of a plan and timescale in which the change programme should be achieved. We suggest a 3-4 year timescale for implementing the proposed model, an ambitious timescale but one we believe is achievable with the leadership, project management, and adoption of the sequencing outlined as suggested below.

2 Development plan

2.1 Process

Development will require a number of elements and stages. These include:

- Gain senior leadership commitment to deliver the changes, including Board approval
- Establishment of a dedicated project management team and project management arrangements, and immediate recruitment of two project workers

2.2 Stages

The development plan will need to contain

- Identification of stages/ objectives
- Sequencing of implementation (i.e. it will be important that new services are in place in advance of the closure of ‘old’ ones)

Within the plan the following objectives will be key parts:

1 A first priority should be the development of the rehabilitation teams

2 Establishment of the regional management structure

3 A swift conclusion to the decision on reprovision of the two acute units

4 The workforce and organisational development plan should be a priority to work alongside
   ~ There is a significant human resources agenda arising from the new model, with financial implications. Although the report makes initial costings for staff development and retraining agenda, it makes no calculations or statements on how industrial relation issues will be addressed. This will need resolution before some parts of the agenda can be progressed
5 Detailed work on the boundaries for CMHTs to be concluded and planning for CMHT establishment
6 Detailed planning for crisis resolution home treatment service implementation should start with immediate effect
   ~ This should involve a working group to consider a range of practical issues such as operational policies, rota and on call arrangements across a 24 hour period, and staff recruitment and training issues
   ~ It may be useful to contact and visit a range of similar services across the UK as there are a number of variations in operational arrangements
   ~ Identifying a lead clinician would also be useful
7 Ongoing engagement with the workforce and service users and carers must be a priority within any implementation plan, both in terms of maintaining effective communication as well as contributing information and knowledge in work around operational policy and procedures

3 Leadership

The changes required to bring about the anticipated levels of service improvement will require transformation of existing services, not just an incremental increase on current services. Changes will affect service configurations, teams of people, the philosophy of care, budgets, and will challenge staff. However there will also be the prospect of ultimately providing a greatly improved service that everyone can be proud of.

We strongly believe that delivering this degree of organisational and cultural change will require strong, visionary, and innovative leadership. The proposal advocates the strengthening of leadership at a regional level but also recognises that there will also be challenges for senior leaders of mental health services.

There is a growing body of both literature and courses on transformational leadership within mental health[3] that may be available for helping such leadership grow within NWHB.

Appendix 1 Members of review steering group

Mr. John Hayes	Regional Manager
Dr. Tony Sharkey	Clinical Director
Dr. Fidelma Flynn	Clinical Director

[3] SCMH Leadership Training information: http://www.scmh.org.uk/80256BED004B72D9/GenerateFrameset1?OpenAgent&doc=wpEHOK5DTK5D

Mr. John Meehan	Director of Nursing
Mr. Hugh McClafferty	Director of Nursing
Dr. Donagh O'Neill	Consultant Psychiatrist
Dr. Cliff Hayley	Consultant Psychiatrist
Dr. Anne Shannon	Public Health Specialist
Mr. Paddy McGowan	Irish Advocacy Network
Mr. Willie Murphy	Director of Human Resources
Mr. Alan Moran	A/CEO Hospital Care Programme
Ms. Serena Perceval	Consumer Rep
Mr. Eddie Shields	Consumer Rep
Dr. Siobhan McCormack	GP, Sligo Town
Dr. Siofra Nic An Bhreithian	GP, Carndonagh
Mr. Jim Brown	Director of Nursing/Midwifery
Mr. Sean O'Connor	Senior Social Worker

Appendix 2 Population of North Western region

	SLIGO		LEITRIM		DONEGAL		NWHB	
Age	**Pop.**	Adult population (15-64)	**Pop.**	Adult population (15-64)	**Pop.**	Adult population (15-64)	**Total pop**	Adult pop (15-64)
0 – 14	12,089		5,422		32,255		49,766	
15 – 24	9,397		3,435		20,733		33,565	
25 – 34	7,443		3,024		18,667		29,134	
35 – 44	8,314	38,438	3,549	16,231	18,580	88,020	30,443	142,689
45 – 54	7,763		3,533		16,831		28,127	
55 – 64	5,521		2,690		13,209		21,420	
65+	7,673		4,146		17,300		29,119	
Total	58,200		25,799		137,575		221,574	

Source: 2002 Census via http://www.medialive.ie

Appendix 3 Service quantification and resource implications

Acute in-patient beds

1 Method of forecasting requirements

Forecasting bed requirements is not an exact science. In the UK there are several initiatives ongoing around the future role and function of acute care within new whole system service models, and there is ongoing research and evaluation into the impact of crisis resolution home treatment and assertive outreach services on the use of acute care. There is no doubt that these will in time contribute further to our understanding of mechanisms for predicting the need for in-patient beds.

The method of benchmarking used here employs a database developed by SCMH comprising surveys of resource levels in many services across the UK (covering 10 million population in about 40 areas), and has been used on numerous occasions to provide advice (on bed numbers and other service components) in various parts of the UK.

The forecast calculations can be seen in Table 13 below.

2 Irish issues and comparisons

The Irish Department of Health has stated that there is currently no nationally accepted formula for assessing acute bed numbers, and there is no Irish Division interpretation of the RCP 'Not Just Bricks and Mortar'.

However, below in the next section we show the forecasts that arise from our interpretation of the RCP formula.

It is worth nothing that Foyle Health & Social Services Trust are proposing to replace an existing 56 bedded unit which includes 2 x 24 bed admission units and 8 ICU beds by a new purpose built facility which will accommodate;

- a 24 hour, 7 day crisis team with home treatment.
- an acute admission facility (30 beds)
- acute day care facility
- a community bases crisis house as an alternative to hospital.

The crisis service will service a population of 165,000.

Table 13 Current and projected acute bed numbers

	Current resources (excluding actual use of beds for OPMH, LDs, <20) (actual units)			**Projected resources at SCMH benchmark levels (actual units)**			**Projected resources at Rural cluster benchmark levels (actual units)** (for comparison, but not used)			**Reduction on acute beds due to CR/ Home Treatment and CMHTs**			**Additional beds for PICU** (No benchmark available - this is estimate)			**Older People's beds (in addition) (based on 10% reduction of current use)**			**FINAL PROJECTED RESOURCE LEVELS (actual units)**		
Target reduction										30%	30%	30%				10%	10%	10%			
	Donegal	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**	**Donegal**	**Sli/ Leit**	**NWHB**
Accommodation																					
Acute beds	46.5	37.7	84.2	30	22	53	23	17	40	9	7	16	3	3	6	5.4	3.9	9.3	30	23	53
Places in 24 hour nursed care (rehab wards - equivalent to SRUs)	104	70	174	11	8	19													11	8	19
Places in 24 hr waking staffed residential care	0	0	0	13	10	23													13	10	23
Places in staffed residential care (sleeping/ on-call at nights)	0	6	6	16	12	28													16	12	28
Places in group homes/ hostels	66	63	129	10	7	17													10	7	17
Individual supported tenancies	0	0	0	29	21	51													29	21	51

3 Royal College of Psychiatrists guidelines

The Royal College of Psychiatry ('Not Just Bricks and Mortar', 1998) proposes a formula of 40 beds per populations of either 125,000 or 200,000 depending on deprivation. Using this guidance suggests a range of beds. We have calculated with some additional assumptions, i.e. that:

- deprivation in NWHB is average. We have therefore used the mid-point of the scale
- Crisis Resolution/ Home Treatment teams will reduce acute beds use by 30%. (This figure is based on a SCMH survey of existing Crisis Resolution/ Home Treatment teams in England, used for informing Leicestershire on a similar reconfiguration exercise to this one in NWHB)

Table 14 Forecast figures for acute beds (RCP guidelines plus assumptions)

County	Population	Beds forecast		
		Range	At mid point	After 30% reduction for Crisis Resolution/ Home Treatment
Donegal	128,000	26-41	34	24
Sligo/Leitrim	90,000	18-26	22	16
NWHB	218,000	44-67	56	30

It is important to mention that the RCP report also makes a range of recommendations on size, design and location of units. One of these is that "In optimal conditions we would consider a minimum of 40 beds – two 15 bedded wards and one 10 bedded unit - which would be adapted so that the intensive care of severely disturbed patients could be located there". This causes some difficulties for the outcome figures shown above.

However, we have discussed with RCP and The Institute of Psychiatry representatives as well as a number of specific units across the UK, and our conclusions are that the issue of unit size when smaller than that advocated by the RCP centre on availability of back up staff and support infrastructure, especially access to therapy and meaningful day time occupation. Our proposals and recommendations specifically require these resources to be in place.

Whilst this approach is useful it is ultimately not the basis on which SCMH makes its proposals and recommendations and there are a number of reasons for this including:

- The report is now dated, and was due for review in January 2003
- Across the UK there are a growing number of much smaller units with evidence to show that they are sustainable and effective units
- It does not take account of the impact of Crisis Resolution and Home Treatment teams
- The need to consider population numbers, level of need and current utilisation of existing beds.

4 The impact on acute bed use of community services

There is considerable evidence available to make a strong case for a comprehensive range of well resourced community services having a significant impact on the current level of beds provided.

4.1 The impact of Crisis Resolution/ Home Treatment teams

A recent SCMH survey of eight existing Crisis Resolution/ Home Treatment teams in England showed that considerable reductions in acute admissions could be gained through the operation of comprehensive community services, including Crisis Resolution/ Home Treatment teams. The range of reductions varied from 30-50%.

4.2 Reducing very short duration admissions

The tables below show the numbers of admissions, the percentage of all admissions this represent, and the durations of all admissions.

Table 15 All admissions

	Sligo		***Donegal***	
Length of stay	N =	% of all admissions	N =	%% of all admissions
0 – 30	385	73	651	83
31 – 90	108	20	123	15
91 plus	25	5	21	3
Total	518	98 (Some data missing)	795	100

Table 16 Very short admissions

	Sligo		***Donegal***	
Days	N =	%% of all admissions	N =	% of all admissions
0 - 3	123	23	150	19
4 - 7	81	15	164	21
Total	204	39	314	39

This suggests that there is potential for community services to make a significant impact on these high levels of short duration admissions. It also supports the view that community services may have an even greater impact on the overall beds numbers than expected from Crisis Resolution/ Home Treatment teams.

5 Issues relating to Older People's services

5.1 Admissions of older people

The proportion of admissions for people over 65 is lower than expected from stakeholder perceptions.

Donegal	14.3%
Sligo/Leitrim	12.4%

This does however support initial local thinking that older people's bed numbers should be between 4 and 6 beds in each county, before factoring in the effect of community developments.

5.2 Community caseloads

SCMH calculate that the % of over 65s on Adult CPN caseloads is significantly higher:

Donegal	16%
Sligo/Leitrim	24%

5.3 Average age of CPN caseloads

The mean age of people on CPN caseloads is

Sligo/ Leitrim	53 years
Donegal	50 years
UK	40 years

In the UK most teams exclude over 65s or 70s.

In combination these figures support stakeholder views of a growing need to either develop Older People's Mental Health Services or reflect the high transition age group within adult mental health staffing ratios.

This has been a significant factor that has led to the proposals on establishing 3 fully resourced older people's teams in line with the constitution of adult CMHTs.

Consultant Psychiatrists

RCP guidelines provide a forecast for the consultant psychiatrist workforce needs of the proposed service model, and is shown in Table 17 below.

In discussion with Consultant Psychiatrists across NWHB there appear to be two perspectives on the national arrangements for calculating psychiatry posts. The differing views are based in on

- the continued use of RCP figures or
- the recommendations of the National Task Force on Medical Staffing report.

Using RCP guidelines and factoring in Clinical Director responsibilities the forecast figures for Sligo and Donegal are very close to existing capacity.

Using the National Task Force figures would require significant additional resources.

SCMH would suggest that at present the RCP figures should be used and that NWHB consider the implications of the National Task Force figures in advance of 2009, the suggested implementation date.

Table 17 ***Requirement for Consultant Psychiatrists*** *(based on RCP guidelines)*

Population		**Donegal**	**Sligo/ Leitrim**	**NWHB**
Total population (unweighted)		128,847	93,715	222,562
Adult population (unweighted)		81,174	59,603	140,777
Over 65 population		17,300	11,819	29,119
	Recommendation			
Adult mental health	Per			
	100,000			
	adult pop			
Generic	4.0			
Eating disorder	0.1			
Postnatal depression	0.1			
Intensive care	0.1			
Dual diagnosis	0.2			
Early-onset psychosis	0.1			
Assertive outreach	0.2			
Court diversion	0.1			
Crisis resolution/ home treatment	0.4			
Acute day treatment	0.0			
Neuropsychiatry	0.1			
Total	**5.4**	**4.4**	**3.2**	**7.6**
Learning disability	Per			
	130,000			
	total pop			
Adult	**1.0**	**1.0**	**0.7**	**1.7**
	Per			
	100,000			
	total pop			
Offenders with LD	**0.1**	**0.1**	**0.1**	**0.2**
Rehabilitation	Per			
	100,000			
	total pop			
Adult	0.4			
To include low secure and elderly revised up to	**0.8**	**1.0**	**0.7**	**1.8**
Substance misuse	Per			
	100,000			
	total pop			
Adult	**0.9**	**1.2**	**0.8**	**2.0**

Continued over page

		Donegal	Sligo/ Leitrim	NWHB
Liaison	Per			
	100,000			
	total pop			
	0.4	**0.5**	**0.4**	**0.9**
Older Age	Per			
	10,000			
	Over 65 pop			
	1.0	**1.7**	**1.2**	**2.9**
TOTAL		**9.9**	**7.2**	**17.1**

Appendix 4 Workforce P… t… C…
Quality Fou… p…

LEADERSHIP

Assistant Chief Officer

- Regional Manager
- Workforce Planning and Modernisation leads from Implementation Team.
- Local Implementation Teams linked to Clinical Networks

PEOPLE MANAGEMENT

- Identify and celebrate local good practice
- Engage key reps from each LIT

POLICY & STRATEGY

- Mental Health Policy
- Occupational Standards
- Knowledge & Skills Framework

on need

- Board workforce knowledge
- "Changing Workforce Programme"

PROCESS

- Who provides what service?
- Map existing workforce via Information Project
- Use of Clinical Pathway to shape future workforce management
- Conduct gap analysis of:
  - numbers
  - skill mix
  - learning required
- Produce step–wise development Plan 2004-08
- Write a *Local Workforce Action Plan.*
- Commission learning & Training:
  - Pre-registration
  - Post-Graduate
  - CPD
- Develop evaluation framework for the Plan

PROFESSIONAL SATISFACTION

- Greater clarity on roles and responsibilities
- Increased retention
- Continuing Professional Development
- Opportunities to mainstream best practice

PATIENT & PUBLIC SATISFACTION

- Increased partner engagement
- Greater continuity

IMPACT ON SOCIETY

- Improved support for vulnerable people
- Reduced 'burn out' of scarce staff

ORGANISATIONAL RESULTS

- Increased size of workforce
- Better skill mix
- Working across professional and organisational boundaries
- Better integrated workforce
- Patient & policy relevant workforce
- Meet standards
- Active learning plans for all
- 3 year planning cycle with clear delivery plan

ENABLERS

Objectives

RESULTS

Appendix 5 Continuing Professional Development for the Mental Health Workforce: Supporting Policy Implementation and Delivery

Mental health Promotion	Crisis Resolution and Home Treatment	Rehabilitation and Assertive outreach	Early Intervention in Psychosis	Primary Care
Raise staff awareness of local needs assessment for mental health and a 'Public Mental Health' perspective.	To understand the principles of Crisis Resolution and to include cultural, gender and anti-racist training.	To understand the principles of Rehabilitation and Assertive Outreach and to include cultural, gender and anti-racist training.	To understand the principles of Early Intervention services and to include cultural, gender and anti-racist training.	General awareness training for mental health and specific competencies is required including working safely, support to identify role boundaries, education about cultural issues, and information about local services are as important as specific skills training.
Raise staff awareness of how individuals, families, organisations and communities think and feel.	To acquire the skills to deliver the key components of the Crisis Resolution Home Treatment.	To acquire the skills to deliver the key components of Rehabilitation and Assertive Outreach	To acquire the skills to deliver the key components Early Intervention in Psychosis service	Development of brief effective interventions such as cognitive behavioural therapy and psycho-social interventions, using an inter-professional focus.
Raise staff awareness of the factors that influence how individuals, families, organisations and communities think and feel, including risk assessment and positive action.	Team building, colleague support and working within a team framework.	Suicide awareness and prevention techniques.	Suicide awareness and prevention techniques.	Need to improve access to counselling

Raise staff awareness of the impact that this has on overall (physical) health and well-being.	Medication: storage, administration, legal issues concordance training and side effect awareness.	Medication: storage, administration, legal issues concordance training and side effect awareness.	Medication: storage, administration, legal issues concordance training and side effect management, prescribing to under 16 year olds.	CPD should be delivered to whole teams rather than individuals in primary care. An accredited curriculum needs to be developed.
Develop workforce capacity to establish an evidence-based mental health promotion strategy that covers individuals, in a range of settings and 'at risk' vulnerable groups.	Values and use of the Mental Health Act and alternatives to hospital treatment.	Use of the Mental Health Act and alternatives to hospital treatment.	Use of the Mental Health Act and alternatives to hospital treatment.	There are opportunities to scope new roles for Community Mental Health teams in relation to primary care. Primary Care Mental Health Staff will need to be engaged within primary care teams if they are to work across primary, specialist and social care for mental health.
Develop workforce capacity to work across professional and sector boundaries to promote good mental health.	Benefits to service users and family/carers of home treatment approach.	Benefits to service users and family/carers of an assertive outreach approach. Engaging and interacting with other services. Suicide awareness and prevention techniques.	Benefits to service users and family/carers of this service. Understanding of Children's Legislation Suicide awareness and prevention techniques	