Inverclyde Alliance

**AGENDA ITEM NO: 12**

| | | | |
|---|---|---|---|
| **Report To:** | **Inverclyde Alliance Board** | **Date:** | **7 October 2024** |
| **Report By:** | **Kate Rocks**<br>**Chief Officer**<br>**Inverclyde Health and Social Care Partnership** | **Report No:** | |
| **Contact Officer:** | **Katrina Phillips**<br>**Head of Service** | **Contact No:** | **01475 558000** |
| **Subject:** | **NHS GGC Mental Health Strategy Refresh Public Engagement** | | |

## 1.0 PURPOSE

1.1 This is a briefing paper in conjunction with the Mental Health Strategy Refresh 2023-2028 document to detail NHS GGC Public Engagement Process.

1.2 The Mental Health Strategy Refresh 2023-2028 document has been developed in partnership with all six HSCP's within NHS Greater Glasgow and Clyde. It updates on the NHSGGC five year adult mental health strategy 2018-2023 and expands on its scope to take account of the range of services relevant to the wider complex of mental health services and the continuing impact of COVID-19 as services go about restoring and refreshing the focus on Strategy changes, initially for the next five years.

1.3 The Strategy refresh approach to implementation will include:

- No wrong door, so any appropriate referral for secondary specialist mental health care will not be sent back to Primary Care with a suggestion of an appropriate response but discussed and progressed between secondary specialist services
- More people with lived and living experience, along with families and carers, will be involved in everything for co-production
- Prevention will be better explained as addressing wellbeing
- A focus on inequalities including people with protected characteristics and those affected by the socio-economic determinants of poor health.
- Improved access for Mental Health and situational crisis
- Commitment to more established points of access & clear referral pathways
- Self-management resources for people with long term mental health issues, that are accessible and do not exclude access to services where appropriate

## 2.0 RECOMMENDATIONS

2.1 It is recommended that the Alliance Board note the contents of this report and the plan for public engagement process.

**Kate Rocks**
**Chief Officer**
**Inverclyde Health and Social Care Partnership**

## 3.0 BACKGROUND AND CONTEXT

### 3.1 Summary of the Proposed Service Changes and Improvements

3.2 What causes mental health issues is very complex. It is important to understand that just because we may not know exactly what causes someone to experience a mental health issue or distress, this doesn't mean it is any less serious than any other health issue, any less deserving of recognition and treatment or any easier from which to recover. Mental Health issues and distress can have a wide range of causes. It is likely that for many people there is a complicated mix of factors and different people may be more or less deeply affected by certain things than others. Factors that could contribute to a period of poor mental health or distress can include:

- Childhood abuse, trauma or neglect;
- Social isolation or loneliness;
- Experiencing discrimination and stigma including racism;
- Social disadvantage, poverty or debt;
- Bereavement;
- Severe or long term stress;
- Having a long term physical health problem;
- Unemployment or losing your job;
- Homelessness or poor housing;
- Being a long-term carer for someone
- Drug & alcohol misuse;
- Domestic violence, bullying or other abuse as an adult;
- Significant trauma as an adult;
- Physical causes e.g. head injury and / or neurological condition
- Neurodevelopmental vulnerabilities, especially those previously unrecognised

3.3 There are separate and specific strategies for organised health and social care service responses for each of the GGC wide mental health complex of services (Health Promotion & Prevention; Child and Adolescent Psychiatry [CAMHS]; adult mental health; older people's mental health; alcohol and drug recovery; learning disability and also Forensic mental health).

3.4 The recommendations described in this refresh will require implementation through multiple delivery work streams or other related strategies as appropriate to how they are interrelated or interdependent, such as those that contribute to the response to, or reduction of, Adverse Childhood Experiences.

### 3.5 Engagement Process

3.6 Phase 1 of public engagement took place from March to April 2024 supported by the Patient Engagement Public Involvement Team and focused mainly on widely distributed and surveys about what matters to people in local areas related to mental health and wellbeing service provision. There was a good response across the board area and from Inverclyde.

3.7 Phase 2 of the Public Engagement process is planned for August – October 2024.

**Phase two engagement activity**

**What:**

- 12-week phase from May to July 24
- Specific engagement on the in-patient beds redesign proposal
- Engagement will contribute to development of preferred option

**Who:**

- Targeted engagement: public, MH service users and carers
- Additional engagement with equalities groups and third sector partners

**How:**

- HSCP's are lead for engagement within their own area
- PEPI Team will support with planning and facilitation of public facing sessions and any sessions with third/vol sector partners
- MHN will support with facilitation of MH service user and carer sessions and any sessions with equalities groups

3.8 Inverclyde HSCP will facilitate 5 public engagement events throughout September as part of the wider GGC public engagement process. The dates below are being held and may change dependent on venue availability.

- **16th September 2024 – Greenock 2 sessions of 2-hour duration**
  - Wider public engagement session
  - Service User and Carer engagement session

- **23rd September 2024 – Port Glasgow - 2 sessions of 2-hour duration**
  - Wider public engagement session
  - Service User and Carer engagement session

- **23rd September 2024 – Online public engagement session**

3.9 The sessions will be supported by HSCP staff, Your Voice, CVS and NHS GGC Public Engagement Team. The sessions will be promoted through HSCP, Council and GGC social media and through Your Voice and CVS network connections

3.10 There will be further sessions and communications across the HSCP to engage and communicate the strategy refresh and seek views from HSCP staff supported by partnership representation. The dates of these sessions have still to be confirmed

## 4.0 IMPLICATIONS

4.1 Legal: none
Finance: none
Human Resources: none
Equality and Diversity: none
Alliance Partnership Plan: none

## 5.0 CONSULTATIONS

5.1 N/A.

## 6.0 LIST OF BACKGROUND PAPERS

6.1 N/A.

# Your questions on mental health inpatient beds redesign and expanding community mental health services

## Why are you reviewing the location of mental health beds now?

Patients, families and the wider public have told us they want us to focus on expanding and improving community mental health services. More mental health care can now be delivered in the community, including treatment and care traditionally offered in hospital. The benefits of offering the least restrictive care are well established, and getting people back home or into a more homely setting can help recovery from complex mental health problems. Reviewing and gradually reducing inpatient provision where appropriate, will help us fund more community mental health services going forward.

## There's a shortage of inpatient beds now so how will a future reduction in bed numbers work?

We know that beds in adult acute care can come under pressure at times, and any changes to the number of these beds will only start when practical. We also know that some people can be in hospital for a disproportionately long time, not related to their need for a bed. As community services are expanded, the demand on beds will naturally reduce. Hospital integrated discharge teams are being developed to work closely with social work services to identify the right care packages, particularly for those with complex needs, to support people in the community and reduce the risk of delayed discharge from hospital.

## Reducing inpatient mental health beds feels unsafe, how are you going to manage any risk?

Any discussion on reducing beds will always include risk assessment. Each stage will only move forward where assessment of risk indicates it is safe to do so.

Understanding and managing risk is part of the role of community teams. Individuals at greatest risk and with the greatest level of need will receive the right treatment and care for their needs, in the right setting, promoting prevention and early intervention care. We will also identify where teams themselves are under pressure, and work with them to develop solutions to issues that need to be addressed.

## Will it take longer to get a mental health inpatient bed if you need one?

Beds will still be available for those who need specialist inpatient care and where a (new or expanded) community alternative is not available or appropriate. Community Rehabilitation and

Community Mental Health Acute Care Services are specifically being developed to support people who no longer need to stay in hospital, releasing beds for those who do need inpatient care.

## What will happen to the money saved by reducing the number of inpatient beds?

As part of the reconfiguration / redesign of inpatient bed provision some money will be reinvested in wards as a response to the Health and Care (Staffing) (Scotland) Act (*). Some of the released money will also be transferred to social work services to provide support in other ways.

Some staff will prefer to stay working with inpatients and fill existing vacancies. Others will move out to jobs in the community.

*(*) The Act directs health services take account of the service type, local context, the number and needs of the patients and appropriate clinical advice to identify what staff and skills are needed to deliver safe and effective care. If not already in place, it also requires ways of identifying, assessing and escalating real-time risks to care, arising because of staffing issues.*

## How will you reassure patients, families and communities that any savings will be reinvested in community services, especially as we have experienced new services having funding withdrawn in the past?

Sometimes ‘tests of change’ / projects are withdrawn or finish and that happens because they didn’t lead to the improvements we expected, or permanent funding can’t be identified.

Inpatient beds are funded long term and the community expansions funded by those monies will not be subject to short term funding problems.

By sharing our current plan, which is that money released through reducing inpatient provision will be reinvested into new and expanded community services, and by engaging with patients, families and the wider public we hope to demonstrate that we are listening and are using feedback to help develop options for further engagement.

Our early priorities for new community services are:

1. A Community Rehabilitation Service to support people to move out of hospital and continue their rehabilitation journey while living as far as possible independently, and at home or in a homely setting in their community.

2. An expanded / enhanced Care Home Liaison service that will work with care home staff to support individuals’ needs and provide education and guidance to care home staff.

3. Expanding the Community Borderline Personality Disorder (BPD) Pathway to deliver more specialist care in the community instead of hospital and train more staff in the community in coordinated clinical care to work better with people with BPD.

4. Further developing unscheduled (unplanned or emergency) care;

- Linking the Mental Health Assessment Units set up during Covid as an alternative to busy emergency departments when physical health care is not needed with new Community Mental Health Acute Care services (CMHACS) providing intense support in the community for people as a safe alternative to hospital admission or prolonged inpatient care.
- Offering services that help people with mental distress (and not mental illness), providing non-clinical support where clinical care wouldn't really help. These include the NHS24 111 Mental Health Hub and locally commissioned services such as the Glasgow City Compassionate Distress Response Service (run by GAMH) and similar across the six HSCPs.

5. Expanding Dementia Post Diagnostic Support (PDS) providing a year's post diagnostic support for everyone diagnosed with dementia helping people;

- Understand their illness and manage their symptoms.
- Be supported to keep up community connections and make new ones.
- Have the chance to meet other people with dementia and their partners and families.
- Plan for future decision-making.
- Plan for their future support.

## Will each Health and Social Care Partnership area get an equal share of the reinvestment so that they are able to provide equal access to services?

We'll take a board-wide approach to ensure we're looking at the whole system, and all Health and Social Care Partnerships (HSCPs) have agreed that by end point of the strategy, money released for reinvestment will be shared across services delivering care in all six HSCSPs. Whilst HSCPs may deliver services in different ways with different teams, they will all work to the same principles of promoting continuity and equity of care for people who need to use mental health services.

## Will there be longer waiting times for community mental health services if more people are using them?

No. The combination of new and expanded community services and more effective and efficient ways of working should mitigate against longer waiting lists.

## Have you thought about the impact any changes might have on patients, families and on already stretched third sector providers?

We know that people with mental health issues may have fewer family members and friends that they are in regular contact with, and maintaining these connections can help recovery. Issues like transport are likely to be a concern and we'll take this and other issues into account when developing options and making decisions on where services are in the future, however it's possible some services may still be moved due to other factors. If that happens, we will work closely with our partner organisations, including the local authorities and e.g. Strathclyde Partnership for Transport, to address issues.

A key aim of the strategy is to support a shift in resources between psychiatric inpatient care and community mental health care. In 2023/24 893 third sector organisations across NHSGGC (NHS Greater Glasgow and Clyde) were awarded 3.3m via the Communities Mental Health and Wellbeing Fund to develop grass roots community activity that supports a culture of mental wellbeing and prevention in local communities. Amounts ranged from a few hundred pounds to just under £30,000 with a significant majority of projects designed to tackle social isolation and loneliness.

The Community Mental Health and Wellbeing Fund is time limited, and other sources will need to be identified for expanded and recurring funding for public mental health, wellbeing promotion and early intervention, to continue to effectively prevent or reduce the need for psychiatric service responses in secondary mental health care.

## What about the impact on other services, such as GP's (General Practice), Accident and Emergency departments and the Mental Health Assessment Units?

The impact of reducing the number of beds will be addressed in several ways:

1. Additional services such as the Community Rehabilitation Team
2. Expanded services such as Borderline Personality Pathway and Care Home Liaison
3. More effective working releasing capacity across existing services, including;

- More virtual patient management (telephone, video) – saving unnecessary time and travel commitments.
- Patient initiated (led) follow up – providing alternatives to unnecessary appointments
- Shared assessments – reducing duplication and people answering the same questions, multiple times.
- MHAU, CMHACS and Community Mental Health Teams working in partnership to help people requiring more intensive treatment and support.

GPs are already aware they can refer people to Mental Health Assessment Units instead of emergency departments and are kept up to date with any changes to unscheduled care by clinical leaders.

## What are the timescales for these major changes?

We anticipate this will start Spring / Summer 2025 through to Autumn 2028. We will review progress, outcomes and impact regular stages to ensure that it is safe to continue.

## How are you involving people who use services, and the public in these proposals?

We routinely gather feedback from people who use our services and are working closely with

community and third sector partners such as the Mental Health Network to ensure that the wider public, mental health service users and carers have an opportunity to be involved as these proposals develop. People with lived experience will be represented and involved throughout the review, planning and redesign phases.

## Where can I find out more information about these proposals?

You can read more about the Mental Health Strategy 2023-28, the proposal to review inpatient provision and expand community mental health services, and any upcoming public engagement opportunities by visiting the NHS Greater Glasgow and Clyde website here: Mental Health Services Engagement - NHSGGC

## Summary of abbreviations used in this document

| | |
|---|---|
| **NHSGGC** | NHS Greater Glasgow and Clyde |
| **HSCP** | Health and Social Care Partnership |
| **CMHACS** | Community Mental Health Acute Care Services |
| **MHAU** | Mental Health Assessment Unit |
| **CMHT** | Community Mental Health Team |
| **BPD** | Borderline Personality Disorder |
| **PDS** | Post Diagnostic Support (Dementia) |