LOCAL SERVICES DIVISION

ADULT MENTAL HEALTH DIRECTORATE

PROPOSAL TO ESTABLISH AND DEVELOP COMMUNITY REHABILITATION SERVICES IN MANSFIELD AND ASHFIELD AND CITY AND COUNTY SOUTH

TO ENABLE THE CLOSURE OF RESIDENTIAL BEDS AT HEATHER CLOSE IN MANSFIELD AND BROOMHILL HOUSE IN GEDLING

1 EXECUTIVE SUMMARY

This paper is the second in a series detailing the proposals for the component parts of the Adult Mental Health (AMH) Directorate's Transformation Programme for 2015/16. It builds on changes already consulted on and delivered across the city and county.

A key element of the AMH Directorate's Clinical Strategy is to "reduce inpatient bed provision through improved community services, a focus on early intervention across the diagnostic spectrum, and specialisation within community rehabilitation. This is in line with the programme of rehabilitation re-provision that has been delivered over the last 4 years.

The Clinical Strategy has been reflected in developing the Transformation Programme for 2015/16, which includes:

- The closure of inpatient rehabilitation beds at Heather Close, Mansfield in October 2015
- The establishment of a Community Rehabilitation Scheme for Mansfield and Ashfield in September 2015
- The Closure of inpatient rehabilitation beds at Broomhill House in Gedling in October 2015
- The continued development of the Community rehabilitation team already established in the City and county south
- Continued provision of Open inpatient Rehabilitation at 145 Thorneywood Mount
- Continued Provision of Locked Inpatient rehabilitation at Bracken House

This paper details proposals for how this Transformation Programme can be achieved during 2015/16.

The potential financial implication of this proposal should it be approved, would be

- ***Reinvestment in the Mansfield and Ashfield Community Rehabilitation Team of £218,807 in 2015/16 and £437,615 recurrently from 2016/2017***
- ***Potential savings of £286,452 in 2015/16, with potential recurrent savings of £286,452 from 2016/17 relating to the reduction of beds at Heather Close***

- ***All clients from the city and county south currently resident at Broomhill House with ongoing rehabilitation needs will be supported by the existing Community Rehabilitation Team, with additional investment of £80,000***
- ***Potential savings of £416,761in 2015/2016 with potential recurrent savings of £416,761 from 2016/2017relating to the reduction of beds at Broomhill House***

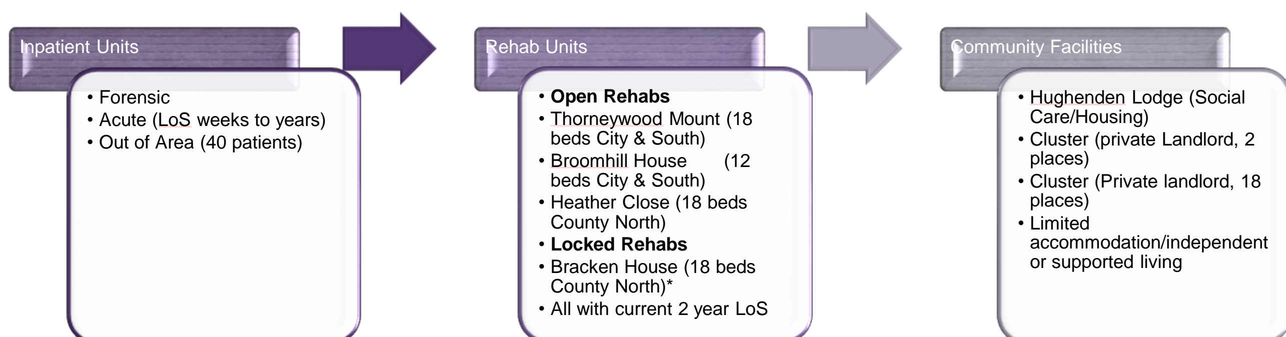
2 CONTEXT FOR SERVICE CHANGE

The key reasons for developing community rehabilitation services across Adult Mental Health Services in Mansfield and Ashfield and City and County South are:

- To implement the recommendations of the Mental Health Utilisation Review which in summary propose the redesign of service models changing focus for rehabilitation provision from in-patient to community, are a shared focus of both commissioner and provider
- To contribute to the overall development of the redesigned care pathway for community mental health services.
- To improve recovery outcomes for service users and carers who have long term and complex rehabilitation needs.
- To ensure the most effective use of available resources
- To ensure clear pathways of care across inpatient acute, rehabilitation and community services.

3 CURRENT COMMUNITY SERVICES CONFIGURATION

The diagram below shows the existing service model of referral to in-patient rehabilitation for city of Nottingham and North and South Nottinghamshire and highlights the current in-patient rehab provision across Nottinghamshire:



Over the last 3-5 years a significant number of changes have been made to services as a result of health and social care strategic drivers, policy and economic requirements. Nottingham City and County areas have retained National Service Framework-created services such as Early Intervention in Psychosis, Assertive Outreach, Crisis Resolution and

Home Treatment and Community Mental Health Teams, but these are operating in different models across the county reflecting the needs of the local population and are subject to review through the community services redesign process during 2015-16.

Within the Mansfield and Ashfield CCG area, there is currently no specific community based rehabilitation service provided by the Trust. Historically there has been recognised inappropriate use of beds highlighted by the Mental Health Utilisation Review including service users who have experienced hospital as their home for many years and Service users whose needs could be better met in the community setting should an appropriate service exist .

In the Newark and Sherwood area, a similarly modelled Community Rehabilitation Service was established in August 2014. Evidence shows that there has been a significant increase in the number of people that have accessed this service (from 24 service users to 81 referrals since the 01/08/2014). The team attends the inpatient acute ward and facilitates the identification of service users who would benefit from rehabilitation, providing in reach and accompanied leave home to support early discharge. The team can visit numerous times per week if required. In the first 9 months since the close of the inpatient rehabilitation unit, on average one inpatient bed has been used by a Newark and Sherwood resident for rehabilitation. All other needs have been met by the community rehabilitation team. There have been only 2 readmissions to acute inpatient care of any service user taken on by the Newark and Sherwood Community Rehabilitation Team.

This successful model is proposed to be used as a template for Community Rehabilitation developments in Mansfield & Ashfield.

Within Nottingham City and County South CCG's area a successful community rehabilitation team has been established since December 2014. The development of this service has allowed the successful closure of rehabilitation beds at Dovecote Lane and Macmillan close rehabilitation units. The development of the Community Rehabilitation Team has offered an community rehabilitation service which has allowed the delivery of intensive rehabilitation to a far expanded client group in a community setting improving outcomes for a number of service user for whom inpatient rehabilitation was not an appropriate option.

All previous residents of Dovecote Lane and Macmillan close are appropriately placed in other supported and independent living options and some of these service users are in the process of being discharged back to primary care, a significant achievement for those who have accessed secondary care provision for much of their adult lives.

4 CURRENT SERVICE PROVISION AT HEATHER CLOSE AND BROOMHILL HOUSE

Heather Close

Heather Close is one of 2 rehabilitation units covering North Nottinghamshire. It is an 18-bedded open rehabilitation unit situated on the Mansfield Community Hospital Site, close to Mansfield Town Centre. It provides in-patient rehabilitation to service users 18 to 65 years from across Nottinghamshire.

Heather Close currently has an inpatient population of 17 clients, 12 male and 5 female. 4 service users are currently detained on a section of the mental health act, but all are improving and these will not be in place in the medium to long term.

Many of the current service users are from the Mansfield & Ashfield area; ***one of the significant benefits of this proposal for the Mansfield and Ashfield population is that a locally based Community Rehabilitation Team will be created which will provide a focused service for the population, offering them an alternative to inpatient care which is not currently available.***

Referrals to Heather close include service users stepping down from acute wards, out of area repatriation of service users, transfers from medium and low secure environments, and referrals from community and other residential services.

Heather close accepts service users who are detained under the Mental Health Act as well as those under Home Office restrictions.

Occupancy rates for Heather close for 14/15 were 84.8 %. However, this has included some service users whose needs are continuing care in nature who are about to be rehoused. The clinically appropriate relocation of service users will reduce occupancy levels even further in the coming months.

The unit is staffed on a 24 hours, 7-day per week basis by qualified nurses and healthcare assistants.

The service provides intensive rehabilitation on a strengths based model providing the following:

- Assessment and delivery of mental health care and treatment including risk assessment and management
- Education and development of daily living skills and personal functioning,
- Management of mental health symptoms and treatment
- Assessment and management of physical health
- Medication management
- Social and community engagement, employment, education

The Medical cover at Heather Close currently includes one session of Consultant time plus an extra session of Senior Psychiatric Registrar when available to the rota.

<u>Broomhill House</u>

Broomhill House is one of two Rehabilitation units serving the City and South County of Nottingham/shire. It is situated in the Borough of Gedling Nottinghamshire, it provides inpatient rehabilitation to service users 18 to 65 years old from across Nottinghamshire.

Broomhill House currently has an inpatient population of 11 service users, 6 female and 5 male. 8 service users are currently detained under the mental health act, all are improving and many of these will not be in place in the short to medium term future.

Almost all of the current service users are from the City of Nottingham or from the South of the county allowing the smooth transition of care to the already established and successful community rehabilitation team covering these areas.

Referrals to Broomhill House include service users stepping down from acute wards, out of area repatriation of service users, transfers from medium and low secure environments, and referrals from community and other residential services.

Broomhill House also offers an outreach service for previous users of the service a role which it is envisaged the Community Rehabilitation team will continue to facilitate.

Broomhill House accepts service users who are detained under the Mental Health Act as well as those under Home Office restrictions.

Occupancy rates for Broomhill House for 14/15 were 92.0%. However, this has included some service users whose needs are continuing care in nature who are about to be rehoused. The clinically appropriate relocation of service users will reduce occupancy levels even further in the coming months.

The unit is staffed on a 24 hours, 7-day per week basis by qualified nurses and healthcare assistants.

The service provides intensive rehabilitation on a strengths based model providing the following:

- Assessment and delivery of mental health care and treatment including risk assessment and management
- Education and development of daily living skills and personal functioning,
- Management of mental health symptoms and treatment
- Assessment and management of physical health
- Medication management
- Social and community engagement, employment, education
- An outreach service to service users previously resident at Broomhill house

The Medical cover at Broomhill House currently includes one session of Consultant time plus an extra session of Senior Psychiatric Registrar when available to the rota.

4.1 CURRENT FINANCIAL MODEL FOR HEATHER CLOSE

Heather Close has the following staffing structure operating on a 7 day / 24 hours staffing rota. The table shows the direct costs associated with the current service provision.

		Posts (wte)	Total cost (£)
Staffing Costs		25.56	835,000
Drugs			21,149
Other Non-Pay Costs			154,101
TOTAL		**25.56**	**1,010,520**

4.2 CURENT FINANCIAL MODEL FOR BROOMHILL HOUSE

Broomhill House has the following staffing structure operating on a 7 day / 24 hours staffing rota. The table shows the direct costs associated with the current service provision.

		Posts (wte)	Total cost (£)
Staffing Costs		21.21	689,232
Drugs			32,984
Other Non-Pay Costs			111,305
TOTAL		**21.21**	**833,522**

5 PROPOSAL TO DEVELOP COMMUNITY REHABILITATION SERVICES IN MANSFIELD AND ASHFIELD

5.1 NEW COMMUNITY REHABILITATION SERVICE MODEL FOR MANSFIELD AND ASHFIELD

It is proposed that the number of inpatient rehab beds should reduce through the closure of Heather Close inpatient rehabilitation unit – 18 beds.

It is recommended this unit is replaced by the development of community rehabilitation and recovery services across Mansfield and Ashfield, to work alongside the existing Community mental health services and the acute care pathway.

Following the recommendations of the Mental Health Utilisation Review, which focuses on moving from inpatient provision to community provision for rehabilitation, different models for Community Rehabilitation have been developed according to local need, but all retain the same key characteristics:

- To enable service users to live meaningful lives they wish to by introducing access to roles, relationships, facilities and opportunities for all.
- To enhance the existing Community services pathways.
- Create new pathways of care for in-patient mental health recovery and rehabilitation services as part of a local pathway of health and social care mental health services for people with long term mental illness and complex needs living in Mansfield and Ashfield.
- Provide a flexibility which improves the Service User and carer experience by offering earlier medical and nursing interventions in the community to people when they require it, for the period of time that is needed. This would reduce admissions and length of stay and outpatient clinic numbers.
- To provide full Multi-Disciplinary Teams overview and intervention including OT and Psychology provision
- Develop and implement care pathways in line with PbR mental health clusters.
- Develop specific interventions in line with PbR cluster pathways such as nurse prescribing clinics and nurse led recovery clinics.
- Develop services to deliver interventions including family interventions in line with NICE guidelines
- Improve staff satisfaction levels by focusing on what they should be providing, so improving the quality of the interventions.

- Create a sustainable service within the resources available that links clearly with key partners including social care.
- To improve recovery outcomes for service users and carers
- To ensure the most effective use of available resources; accounting for the Trust needing to deliver services with a year on year tariff deflator of 1.8%, re-provision in the community is how this would inevitably be achieved.

5.2 OPERATIONAL MODEL

The community rehabilitation team (CRT) would aim to provide a comprehensive, multi-disciplinary flexible recovery focused and client-centred service for people and their families experiencing serious and enduring mental health problems that require a period of rehabilitation.

The multi-disciplinary team would deliver intensive time-limited rehabilitation support for people with severe and enduring mental health problems in a community setting. All staff would have a shared responsibility for the care of all service users and service users would be viewed as active participants in the implementation of their care package.

The proposed new service has been designed to be closely aligned to the existing Community mental health services, including the already established community rehabilitation teams in other geographical areas. The aim is for the new Community Rehabilitation Team service to work predominantly with those in clusters 12-13. It will also be providing focused in-reach to all acute inpatients whatever their cluster. The Community Rehabilitation Team will also become involved with those in cluster 10 and 14 working alongside the Crisis Resolution Home Treatment and Early Intervention Teams to maintain these service users at times of increased need in the least restrictive environment possible thus minimising risks of acute admission. In order for this team to effectively achieve these objectives, we suggest that the CRT should stand as a separate service to the other community mental health teams with management and operational structures that focus strongly on promoting and supporting recovery in this wide-ranging group.

5.3 CRITERIA FOR ENTRY AND EXIT

- The service would be for people who fit the criteria for intensive community rehabilitation which will mainly be people in the psychotic care clusters 12 & 13 as per the care pathways. Though all service users identified with complex rehabilitation need will be considered. This Mirrors the successful model in the Newark and Sherwood area
- Expected duration of treatment/intervention would be a maximum of 2 years with the aim to try to move people through the system within 12-18 months.
- Community rehabilitation would be considered as an alternative to an inpatient rehabilitation admission.
- Exit from the service following a successful period of rehabilitation moving towards discharge to primary care or if assessed as requiring social care support discharged to social care or into other community mental health services

5.4 REFERRAL PROCESS

Referrals would be taken from;

- The other community mental health teams
- Inpatient acute admission wards.
- Inpatient rehabilitation units

5.5 DISCHARGE PROCESS

Discharge planning would start from entry into the community team through the development of an agreed plan with the service user.

Discharges from the CRT could be to:

- Other appropriate community mental health teams, if a longer period of intervention with secondary mental health services is required
- Social care
- Primary Care/GP
- Specialist inpatient services if the service user has a higher level of need.

5.6 FOCUS OF CARE/INTERVENTIONS

The care pathway for Community Rehabilitation would focus on service users being active participants in their care, involved in developing a recovery focused plan of care aiming towards discharge from the service.

Service users would be supported to engage in recovery-focused interventions:

- practical assessment of activities of daily living and tenancy support needs,
- family education and interventions,
- psycho-social education and training
- symptom management and treatment
- medication education and management
- developing wellness recovery plans with peer support workers
- community engagement
- Assessment of occupational functioning, for employment, education or volunteering opportunities.

5.7 REMIT OF SERVICE

The proposed service would provide in-reach to inpatient acute admission wards for early identification of service users appropriate for a community rehabilitation pathway to support effective and timely discharge and pathways through inpatient services.

The service would provide in-reach to the inpatient rehabilitation units in Nottinghamshire, including locked rehabilitation to ensure discharge packages are proactive and a continuity of therapeutic relationship is provided, promoting timely discharge and transition through services.

Service users would have, if required, an OT assessment identifying social functioning, availability and opportunity for occupational, education, employment and or volunteering opportunities as an integral part of service delivery.

The Mansfield and Ashfield CRT would act as the direct interface with social care and housing, building relationships with partner organisations and developing local packages of care. Service users would be referred for social care self-directed support assessment, to identify additional social care support needs, such as tenancy support in advance of discharge.

The service would offer an alternative to an inpatient rehabilitation admission via a community rehabilitation package with the emphasis on maintaining people in the community as a first priority.

The service would liaise appropriately with those clients in Out of Area placements to support effective and appropriate return to Nottinghamshire services as and when appropriate as part of their care pathway.

5.8 STAFFING MODEL FOR THE PROPOSED MANSFIELD AND ASHFIELD COMMUNITY REHABILITATION TEAM

The proposed Staffing Model for the Mansfield and Ashfield Community Rehabilitation Team is based on a Monday to Friday service, operating from 9am until 6pm with no enhancements:

	Posts (wte)	Total Cost (£)
Total - Pay (Clinical)	10.4	£364,588
Total - Non Pay		£48,027
Total - Drugs Expenditure		£25,000
TOTAL	10.80	£437,615

The following table shows the staffing profile for the new service in comparison to the staffing for Heather Close. Of particular importance is the move to create a more multi-disciplinary approach to community rehabilitation involving psychology and occupational therapy.

	Existing – Heather Close	Proposed – Mansfield & Ashfield CRT
Medical Staffing	0.2	0.2
Clinical Psychologist	0	0.40
Occupational Therapy	0.7	1.00
Team Leader	1.00	1.00
Nursing (qualified)	10.86	5.00
Healthcare Assistants	14.0	3.00
TOTAL	**25.56**	**10.40**

5.9 RATIONALE FOR THIS SERVICE CHANGE

There are a number of important drivers that form a part of the rationale for this proposed service change

5.9.1 ACTIVITY MODELLING:

The implication on activity for the CRT would be as follows:

Service	Current Activity	Proposed Activity
Heather Close inpatient rehabilitation	6570 occupied bed days	0
Mansfield and Ashfield Community mental health services	26,576	26,576
Mansfield and Ashfield Community Rehabilitation Team	0	7728

There are currently 144 Mansfield and Ashfield patients in Clusters 12 and 13 who are recorded on the RIO system:

- 9 of these are current inpatients
- 28 in medical outpatients and
- 109 are being managed by Community mental health services.

The AMH referrals report has identified an overall increase in referrals to community teams in the Mansfield and Ashfield area in the last 6 months of 5%. Both the early intervention in psychosis (106%) and the assertive outreach team (120%) are currently exceeding caseload targets. Several new supported living options have recently opened or are due to open in the Mansfield and Ashfield area in the near future, all of which will potentially increase referral rates into the secondary care mental health services.

Two key commissioning documents, The Joint Commissioning Panel for MH-guidance for rehabilitation services, 2013 and Royal College of Psychiatrists –complex psychosis services, the role of community mental health rehabilitation teams, 2012 suggest the need for a community rehabilitation service that is distinct from a more general Adult Mental Health service. The latter interestingly identifies the group of service users who are often held in outpatients as they engage with services and are not presenting with immediate risks but have high levels of need which negatively impacts on their lives. It suggests that this group would benefit from active rehabilitation to improve recovery and quality of life.
Therefore, with the staffing levels for care coordinators identified in this paper for the Mansfield and Ashfield CRT, this would support the management of caseloads for clusters 12 and 13. The caseload levels would be similar to those put in place at the closure of Macmillan Close (i.e. approx. 15 per care coordinator).

5.9.2 GEOGRAPHICAL MAKE-UP OF THE CURRENT INPATIENT POPULATION

The geographical make-up of the service users who are currently inpatients at Heather Close is shown in the following table

Original Locality	Number of service users
Newark & Sherwood	1
Mansfield & Ashfield	9
Bassetlaw	4
Notts City	2
Nottinghamshire County South	1

This relates to the original home location of the patient. Once they have registered with a local GP, some of these patients will now show on RIO as being from Mansfield and Ashfield as opposed to their original place of residence.

5.9.3 POTENTIAL FUTURE ACCOMMODATION/PLACEMENT FOR THE EXISTING INPATIENT POPULATION AT HEATHER CLOSE

An analysis has been undertaken of current plans for the future accommodation or placement of current residents at Heather Close in relation to the potential closure in October 2015. This shows that;

- 5 have supported living placements identified and dates set for discharge in or prior to September 2015
- 3 will require supported living placements, all have had completed community care assessments and Health and social care colleagues are actively involved in allocated placements. All have discharge dates set for September 2015
- 5 of the current residents have tenancies to return to/ or will return to live with relatives. All no longer have inpatient rehabilitation needs and their needs will be met by the newly established CRT in Mansfield and Ashfield
- 2 Will require continuing care packages, both have had community care assessments and have been clearly identified as no longer having ongoing rehabilitation needs. Placements are being sought and discharge dates have been set for September
- 2 of the current residents may require further open rehabilitation which will be facilitated by Adult mental health should this be the case. 1 of these cases relates to complex social needs and an ongoing court of protection application which may delay onward referral. The 2nd may be able to be supported in the community but this is dependent on the success of the current inpatient rehabilitation prior to October 2015

5.9.4 EXPERIENCES IN BASSETLAW

In 2012 a similar Community Rehabilitation Team was established in Bassetlaw. Covering a similar population, in an arguably more challenging area, the success of the CRT in Bassetlaw has produced a template that we are looking to replicated in Newark and Sherwood and are Looking to replicate in Mansfield and Ashfield.

Feedback from one service user and her family is that they have benefited by being able to vent their feelings and not feel a burden to the team. Anxiety management, relaxation techniques and behavioural family interventions were identified as most useful and the

family could not have managed without the team. This service user stated that prior to the team's involvement her husband felt overwhelmed and close to suicide but is now able to cope. Another service user has stated that it has been helpful to have regular visits at home at convenient times. He feels the team has been flexible in meeting his needs, involved in the care plan and listened to. He says help with practical tasks of daily life and help to contact friends has been the most supportive element.

The provision of a similar service model in the Mansfield and Ashfield area alongside existing community mental health services will offer a real positive alternative to service users and carers when delivering intensive rehabilitation.

5.9.5 PROVISION OF IN-REACH TO MILLBROOK

One of the difficulties faced by current community mental health teams is providing consistent in reach to the inpatient acute wards thus facilitating timely discharge. Under the revised model, this responsibility would be passed to the CRT, who would visit the inpatient wards at Millbrook each day, and be the primary point of coordination for those service users who are on the inpatient wards and open to secondary mental health teams. This will free up the Community teams resource, and thus provide significant benefit across the entirety of the care pathway. Close liaison will be established with RRLP and CRHT, and work undertaken to reduce acute inpatient admissions by facilitating packages of home treatment wherever possible. This will include close liaison with primary care, GP's, and Social care colleagues.

5.10 COMPARISON OF FINANCIAL MODELS (HEATHER CLOSE V CRT)

The comparison of the direct costs between the two

	Heather Close		CRT	
	£	**wte**	**£**	**wte**
Staffing Costs	£835,000	25.56	£364,588	10.40
Drugs Expenditure	21,419		£25,000	
Provisions Expenditure	91,138			
Other Non-Pay Costs	62,963		£48,027	
Total Direct Costs	**£1,010,520**	**25.56**	**£437,615**	**10.40**

The level of reinvestment required to achieve the proposed CRT model would be £437,615(full year effect).

6 PROPOSALS FOR SUPPORT OF SERVICE USERS CURRENTLY RESIDENT AT BROOMHILL HOUSE

6.1 CURRENT COMMUNITY REHABILITATION TEAM PROVISION AND COMMUNITY SERVICES REVIEW

The City of Nottingham and Nottinghamshire County South have a successfully developed community rehabilitation which was developed in December 2013 as an integral part of Adult Mental Health Services Rehabilitation Strategy focusing on increasing the provision of intensive rehabilitation in the community setting.

The development of this team allowed the successful reduction of inpatient rehabilitation beds at the Macmillan close and Dovecote Lane sites.

The Community Rehabilitation team for City and county South now has a caseload of 134 clients, all from Clusters 12 and 13, and is providing intensive and complex rehabilitation packages to this groups of service users whom historically often limited engagement with rehabilitation services leading to them being unable to optimize their recovery and often to admissions to inpatient care.

Alongside the successful development of the community rehabilitation team, Adult Mental health services are undertaking a wide review of Community mental health provision and are keen to focus on responsiveness, evidence based treatment and care clear and simplified pathways for service users carers and referrers, value for money and services that will stand the test of time.

Adult mental health feel confident that the current residents at Broomhill House can be effectively supported by appropriate existing community mental health services, particularly the Community Rehabilitation team, with a small re-investment of 2 additional staff members.

6.2 STAFFING MODEL FOR THE EXISTING CITY AND COUNTY SOUTH COMMUNITY REHABILITATION TEAM

The table below shows the multidisciplinary staffing provision for the existing Community rehabilitation team serving the population of Nottingham city and Nottinghamshire County South. It is proposed that a further £80,000 is invested into this team.

	Current City and County South CRT	Proposed Additions
Medical Staffing	0.2	0.2
Occupational Therapy	2.00	2.00
Team Leader	1.00	1.00
Nursing (qualified)	8.60	10.60
Healthcare Assistants	9.43	9.43
TOTAL	21.03	22.03

6.3 RATIONALE FOR SERVICE CHANGE

There are a number of important drivers that form a part of the rationale for this proposed service change.

6.3.1 ACTIVITY MODELLING

The implication on activity (measured in contacts) for the CRT and Other Community teams would be as follows:

Service	Current Activity	Proposed Activity
Broomhill House inpatient rehabilitation	4029	0

Broomhill Outreach	4223	0
Community Rehabilitation Team	8724	TBD
City Community services	77174	TDB
County South Community Services	37938	TBD

Changes to activity for existing community teams relating to the reduction in inpatient beds at Broomhill House will be determined as part of the community services review and negotiated with relevant CCG's.

There are currently 1112 City and County South patients in Clusters 12 and 13 who are recorded on the RIO system, 9 of the current residents of Broomhill House are in these clusters and would be appropriately placed with the community rehabilitation team.

Two key commissioning documents, The Joint Commissioning Panel for MH-guidance for rehabilitation services, 2013 and Royal College of Psychiatrists –complex psychosis services, the role of community mental health rehabilitation teams 2012 suggest the need for a community rehab service that is distinct from a more general Adult Mental Health service. The latter interestingly identifies the group of service users who are often held in outpatients as they engage with services and are not presenting with immediate risks but have high levels of need which negatively impacts on their lives. It suggests that this group would benefit from active rehabilitation to improve recovery and quality of life.

The development of the Community rehabilitation has had a demonstrable positive impact on the above identified client group.

6.3.2 GEOGRAPHICAL MAKE-UP OF THE CURRENT INPATIENT POPULATION

The geographical make-up of the service users who are currently inpatients at Broomhill House is shown in the following table;

Original Locality	Number of service users
Newark & Sherwood	1
Mansfield & Ashfield	0
Bassetlaw	0
Notts City	4
Nottinghamshire County South	6

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6.3.3 POTENTIAL FUTURE ACCOMMODATION/PLACEMENT FOR THE EXISTING INPATIENT POPULATION AT BROOMHILL HOUSE

An analysis has been undertaken of current plans for the future accommodation or placement of current residents at Broomhill House in relation to the potential closure in October 2015. This shows that:

- 1 is being transferred to acute inpatient care
- 6 will return to own homes with community intervention from health and social care prior to proposed closure date
- 1 will require a supported living placement which will be facilitated prior to proposed closure date

- 3 may require transfer to other inpatient open rehabilitation settings which can be facilitated by the Adult Mental Health Directorate.

6.4 COMPARISON OF FINANCIAL MODELS

The reduction of inpatient beds at Broomhill House does not require significant further investment in the CRT in existence as it is proposed that services for the current residents will be provided by the existing teams with a small additional investment as indicated;

	Heather Close	
	£	**wte**
Staffing Costs	£769,232	23.21
Drugs Expenditure	32,984	
Provisions Expenditure	68,547	
Other Non-Pay Costs	42,758	
Total Direct Costs	**£913,521**	**23.21**

7 OUTCOMES AND BENEFITS

Key outcomes arising from this proposal are as follows:

Service User Benefits:

- The provision of support and care in the person's own home where appropriate as opposed to a more restrictive hospital environment
- Increase in ability to provide intensive intervention at home in a more responsive way to meet service user need.
- Increase family and carer support through the provision of family interventions including behavioural family interventions, psycho-education and information about treatments and services.
- Provision of further NICE based therapeutic interventions
- Access to an extended range of professional and support staff
- A more responsive and preventative approach to care.
- More positive experience for service users and carers of secondary mental health care.

Organisational Outcomes:

- This service redesign is an important component of the implementation of the Adult Mental Health Directorate Clinical Strategy.
- The establishment of a Community Rehabilitation Team for Mansfield and Ashfield providing equitable service provision across all geographies.

Performance & quality outcomes that would be measured include:

- Positive Service user feedback and satisfaction with services
- Positive Carer/family feedback and satisfaction with services
- Positive Service user recovery outcomes measures:
- All services users to have a recovery focused care plan, crisis and contingency plans in place
- Provision of relapse prevention support and plans
- Reduced length of stay in inpatient rehabilitation units
- Reduced re-admissions to inpatient rehabilitation

- Reduced re-admission to acute care
- Length of stay in community rehabilitation to be maximum 2 years (potential to decrease over years)
- Number of service users supported through the CRT who would have had an admission if service not available.

8 NEXT STEPS & RECOMMENDATION

8.1 NEXT STEPS

The next actions which are suggested as a consequence of this paper are:

- Engagement with staff, service users, carers and the public with regard to outlined plans for a 6 week period.
- There has been previous discussion with commissioners about the potential to establish a Crisis House facility in the North of the county along similar lines to that recently opened serving city and county south (possibly with a third sector provider). We believe this would provide an excellent support mechanism on the closure of Heather Close, providing the opportunity for locally based respite, without requiring inpatient admission. We would welcome further discussions on this topic.

8.2 RECOMMENDATIONS

The Committee is asked to support the Trust to engage and consult on the following plans for a 6 week period:

- The closure of inpatient rehabilitation beds at Heather Close, Mansfield and Broomhill House Gedling from October 2015.
- The establishment of a Community Rehabilitation Team in Mansfield and Ashfield from October 2015 and additional investment to the City Community Rehabilitation Team.

Adult Mental Health Directorate May 2015.