Review of Guernsey Mental Health Services 07.12.2018
Summary of key findings 01.10.2021

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Introduction

The review found that Guernsey has good mental health services, which in many ways are as good as or better than those in most countries in the world. The services are well resourced, providing a wide range of clinical interventions to meet the needs of the population. There are very low waiting times, a sufficient number of in-patient beds and a focus on the physical health and wellbeing of patients. The service adopts the Recovery Approach, which staff understand well and use effectively.

The Oberlands building is spacious and welcoming for patients and visitors, with a service-user run café in the reception area. It provides a pleasant working environment for staff and has the advantage of accommodating all of the specialist mental health teams in a single building. This has the potential of facilitating communication and co-ordination between teams, often the biggest problem that services experience.

There is less bureaucracy than in services in the UK, and resources are not diverted to commissioning groups and regulatory bodies, but are used to provide a good level of clinical and support staff. Health and social care are managed together, avoiding the organisational boundaries in English services.

The findings of the review are that a major reorganisation of services is unnecessary, as the service can build on the strengths of the existing structure. The functions of the teams are good, but there is a need to reduce fragmentation. A number of small changes could improve the service and the perception of the service significantly.

The report proposes:

- A robust management and professional leadership structure to strengthen the identity of the service and improve external communication
- A single community team to streamline pathways and reduce duplication
- A wider range of interventions in the adult in-patient ward
- Minimal changes to improve services in CAMHS and for people with eating disorders and substance use problems
- The introduction of personal health budgets and peer support workers in line with best practice in modern mental health services
- A new approach to quality improvement, engaging staff and service users
- A link with a UK mental health trust to provide mutual benefits
- A creative recruitment and retention strategy with regular campaigns and rotation posts
- Stronger partnerships with the third sector, community and service user groups and a co-production approach to service improvement

Areas for development

Management and Leadership

Management is surprisingly light for the size of the service. The Service Manager is covering two posts as the service manager for both adults and older adults. She currently has at least 20 staff reporting directly to her, which is not sustainable. There is a need for more dedicated managers, who are skilled in management and committed to the role.

Professional leadership is variable, with clear leadership for psychology, administration, nursing and medical staff, but not for occupational therapy or social work.

Recommendations

- The Service Manager becomes a substantive post for adults and older adults with fewer people to line manage, which gives capacity for additional responsibilities:
  - overall responsibility for finance, staffing, quality and performance
  - line management of three operational managers and lead professionals
  - uniting the staff, giving them a sense of identity as part of a single mental health service for people of all ages
  - regular events for all staff to network and share good practice, to strengthen the identity of a single mental health service
  - liaison with senior management in the HSC and part of senior HSC meetings
  - external face of service, leading on partnerships, service improvements and implementing new initiatives
  - Lead Nurse for the service

- The Clinical Director post does not need to change, except that some of the current management responsibilities go to the Service Manager. Responsibilities include:
  - working closely with the Service Managerwith joint accountability
  - lead responsibility for care quality, working closely with professional leads
  - lead psychiatrist with oversight of the outpatient service and on call rotas

- Three dedicated Operational Manager posts are created with no direct clinical work.

- Operational Manager (community)
  - manage a single community team, integrating the current teams to streamline processes, take out duplication and address gaps
  - oversee a single assessment process
  - ensure staff continue to work with their patients when admitted to the wards
  - work closely with the manager of the Primary Care Mental Health Team, ensuring there are no gaps in provision of psychological therapies
  - develop staff and recognise their skills, while ensuring the team as a whole meets the needs of all patients

This would be a new post, mainly funded from one senior practitioner post. The remaining senior practitioners would not carry management responsibilities, giving more capacity for clinical work.

- Operational Manager (in-patients)
  - oversee all in-patient services and those placed in inpatient units off island
  - provide strong management and clinical leadership to the wards, with additional support to the ward managers
  - integrate the work of the Recovery and Wellbeing Service (RAWS) with the wards
  - improve staff retention by ensuring supervision, support and more opportunities for learning and development

- Operational Manager (CAMHS)
  - overall responsibility for CAMHS: the community team and inpatients
  - ensure an equitable distribution of the workload with no gaps in provision
  - work closely with senior managers in other services, such as children's social services and adult mental health
  - review the skill mix of the teams with a view to creating STaR worker posts

- A clear professional leadership structure, in which all staff are aware of who their professional lead is and the distinction between this and their line manager.

- A lead mental health OT role is created for a senior OT with dedicated time to lead on OT professional development and professional standards.

- A lead mental health social worker role is created for a senior social worker with dedicated time to lead on social work professional development and professional standards, providing advice and guidance to ASWs on Mental Health Law.

Community teams

Work within the teams is often excellent, but teams do not always link in with the wider service. The teams are not fully multi-disciplinary, and are usually made up of nurses and one other professional group. The number of small teams causes some duplication, such as internal referrals and multiple assessments.

There are gaps in the service, where the needs of patients do not fit the brief of any team, including people with long term problems, such as personality disorder. The gap is usually filled by the outpatient service without the benefit of a multi-disciplinary approach.

There will be increasing demands on the older adults CMHT, as a continual reduction in the number of working age adults and a continual increase in the number of over 85 year olds is projected. More services will be required for the over 85 year olds, as dementia prevalence rates and disability ratios increase exponentially with age.

Recommendations

- The community teams are brought together under one manager to create a single community team with specific functions, each led by a senior practitioner reporting to the manager.

- The manager leads a small senior group of senior practitioners, responsible for ensuring that the team provides an equitable service to all patients. Staff in the team retain specialist areas of interest, but the senior group ensures there are no gaps in service.

- The community team incorporates the current older adults CMHT and provides a service for all adults from 18. There is a senior practitioner and staff from all disciplines specialising in dementia and other organic conditions. As demand for these services grows, the manager redistributes resources accordingly.

Inpatient services

The wards are well resourced with sufficient beds which gives the potential for intensive clinical work. Tautenay provides an excellent service for older people, with a skilled multi-disciplinary team. Crevichon provides for patients at highest risk and with the greatest needs, yet has limited provision of therapies and psychological consultation compared to the community teams. A wider range of therapies should be available to inpatients. RAWS is an excellent and well-resourced team, but does not provide a service for people who are acutely unwell or with the greatest needs on the ward.

There is a low threshold for admission with some patients admitted inappropriately because of social circumstances. Also sometimes patients stay too long on the ward because of poor discharge planning.

Recommendations

- Care co-ordinators and key-workers from the community team increase the intensity of their work with patients who are admitted, to provide continuity for the patient, with psychological and social interventions as required.

- RAWS is closely aligned to the wards and the balance of work shifts to providing more for acute patients. RAWS OTs contribute to the assessment and discharge planning for all inpatients. STaR workers provide activities and OTs provide therapy on the ward in groups or individually.

- There is a Speciality Doctor in the Crevichon team to review patients daily, drive discharge planning and provide a link between the team and the consultants.

CAMHS

CAMHS is well resourced and provides a good service. Transitions to adult services are well managed, in line with the policy.

There is no dedicated manager for the service. There is a Team Leader who manages nursing staff and the Lead Psychologist manages psychology staff. Senior clinicians take on some management tasks, but do not have management authority.

There is a wide range of specialist skills in the team, but a reluctance to take on generic work, and problems remain unresolved without a manager to allocate work and give direction.

Recommendations

- An Operational Manager post for CAMHS is created, reporting to the Service Manager. This can be funded from the Team Leader post.

- The senior clinicians do not carry management responsibilities, giving more capacity for clinical work.

- A review of the skill mix with consideration given to STaR workers, to take on some of the generic work, which resolves current problems and is cost effective.

Eating Disorders

The level of need does not warrant a dedicated service, but an effective virtual team with a pathway. There is a consultant psychiatrist responsible for CAMHS and this works well, but no consultant with responsibility for adults. An external consultant comes for a day every two months, gives advice and supervision, but cannot take on clinical responsibility.

A nurse in the psychological therapies team carries out all the eating disorder assessments, and takes the patients on her caseload. The philosophy is to provide episodes of care then discharge, which is good practice and the nurse has good outcomes.

Recommendations

- The integrated community team ensures there is a multi-disciplinary approach to eating disorders.

- The Operational Manager ensures that training is provided so that staff are confident in working with eating disorder patients.

- The service identifies a consultant psychiatrist with clinical responsibility for eating disorders, with training and support as required.

Substance use

The Community Drug and Alcohol Team is well resourced and multi-disciplinary, including nurses, social workers, a systemic practitioner, STaR workers and a consultant psychiatrist. The team carries a large caseload and finds it difficult to discharge people, because primary care does not manage people on high doses of medication.

There are some interface issues between teams, when people with substance use problems have mental health issues and it is unclear who should lead on their treatment.

There is a high level of alcohol use on the island and the Emergency Department wants more support from mental health services.

Recommendations

- The interface issues can be resolved if the Community Drug and Alcohol Team is part of the integrated community team.

- A specialist worker in substance use in mental health [dual diagnosis] is created, providing substance use training to mental health professionals and consultation on complex issues.

- There is closer liaison with the Emergency Department to help both services to understand the other's perspective and clarify what each can and cannot do.

Model of intervention

There is a high number of psychiatrists for the size of the population, which is required to cover the on-call rota and to service the large outpatient clinics. It is difficult to discharge many people to primary care, where they might disengage because of the cost, and GPs are reluctant to manage certain treatments.

The service responds to individual needs in line with the Recovery Approach, but there is no systematic personalisation approach and no self-directed support, personal health or social care budgets.

There is a high incidence of people with a diagnosis of personality disorder, but there is no agreed care pathway for them.

Recommendations

- There could be more opportunity to discharge people to primary care, by working more closely with GPs. For example, each practice could have a named professional in the service, to supplement the linked consultant psychiatrist, which may encourage them to accept more patients.

- The Operational Manager (community) and lead professionals develop a pathway for people diagnosed with personality disorder, including therapies and discharge planning, linking people into support in the community and third sector.

- The introduction of personal health and social care budgets could reduce dependency on services. There are examples of moving towards this approach with gym memberships and payments to support personal recovery goals.

- Managers consider converting some STaR worker posts to peer support workers, possibly in collaboration with MIND or service user groups to improve partnership working.

Care Quality

The review did not examine the quality of care in the service, but found a wide range of therapeutic approaches from experienced and skilled clinicians. Staff welcome the lack of bureaucracy in the assessment and care planning process.

Recommendations

- The service benchmarks with services in the UK to demonstrate quality of care to provide assurance within the organisation and improve the public perception of services.

- The service considers accreditation, such as Accreditation of In-patient Mental Health Services [AIMS], led by the Royal College of Psychiatry.

- The service introduces a Quality Improvement [QI] approach to increase staff and team engagement and service user involvement in service improvement.

- A link or partnership with a UK mental health trust could provide mutual benefits, such as peer reviews, learning from good practice or incidents, staff learning and development, secondments and student placements. This could also improve recruitment and retention of staff.

Recruitment and retention

Findings

Recruitment of qualified professionals is challenging because there is no professional training on island and it is difficult to attract professionals from overseas. Some staff reported long delays in the recruitment process.

Professionals from the UK and beyond tend not to stay for more than two years, even though there are generous recruitment and retention incentives in place. It is always likely that staff from other countries will stay in Guernsey for a limited period of time. Recruitment and retention incentives and pay-scales will have some impact but not change the pattern significantly.

Recommendations

- Regular creative and focused recruitment campaigns to attract people for two years, with the option of staying permanently.

- Rotation posts to enable newly qualified staff to gain a wide range of experience and a link with a university to enhance this with accredited learning.

- Managers work closely with the HR partner, ensuring no delays in the recruitment process.

Strategy and Partnerships

The Mental Health & Wellbeing Plan for Guernsey 2017-2020 is the current strategy. It proposes a new model for mental health and wellbeing, with a focus on independence, resilience and a mix of support from community, third sector and statutory sectors. The service needs to be central to driving the strategy as part of a Mental Health and Wellbeing steering group.

Recommendations

- The service develops clear criteria in line with the strategy for mental health and wellbeing, and maintains boundaries. Public health and other partners should reinforce this approach and help people to access support appropriately and reduce dependence on statutory services.

- The service develops a constructive approach to partnership working with statutory and non-statutory organisations, including the hospital Emergency Department, learning disability services, the police, voluntary sector, service user and carer groups.

- The service adopts a co-production approach to service improvement, engaging with service user representatives, who have a say in how services are developed within existing resources.