Greenfield's Option Appraisal Proposals
A Consultation Paper

Introduction

Following the Health Care Commission (HCC) Review of the Willows in October 2008 a detailed implementation plan was agreed and operationalised in regard to the main points that were identified. This demonstrated however that despite best efforts to address the key issues, it has become apparent that there are some fundamental service design and quality issues that compromise the ability of the unit to fully meet the needs of individuals with a learning disability and the complex range of needs often presented.

It has been agreed at NHS Plymouths Provider Governance Committee and Trust Board that the current service model is unsustainable and as a result, NHS Plymouth's Trust Board agreed in March 2010 that a three month consultation period would commence on the future direction of the in-patient service. NHS Plymouth's Provider Mental Health Management Team have been asked to facilitate the consultation process and will feedback the outcomes of this to Commissioners, so that an informed decision can be made about what is the best model for Plymouth's service users and carers for the future.

The aim of this paper is to inform the consultation process and put forward proposals that mental health and learning disability providers have reviewed and feel are the most viable options for the future of the service. The objective of this exercise is that NHS Plymouth and Plymouth City Council (PCC) should be in a position to deliver a quality service meeting the range of needs of the local population in an environment that promotes dignity and respect, underpinned by a service model that is flexible, adaptable, therapeutic and focuses on the long term ability of service users to live as independent and full

life as possible. This paper has been developed through discussion with senior clinicians and managers, as well as contributions from frontline clinical staff within the learning disability and mental health service.

Local Need and Case Studies

People with learning disabilities in Plymouth (current population of 1,300) have significantly higher need for health care services than the general population. The principles outlined within the service specification agreed with Commissioners in 2009/2010 articulate the need for an inpatient unit providing care and treatment to those with particularly complex needs (see appendix 4). A very small number (between 2 & 3%) of those with the most complex needs require expert/specialist inpatient assessment, treatment and crisis resolution facilities, when assisted care alternatives at home or in other health and social care settings have been exhausted. Greenfield's has provided this service to the majority of those requiring it.

Having reviewed the current service specification, it has been concluded that in essence there is a fine balance between developing a service with a clear role and criteria that is focussed enough to meet the needs of a defined group of the population without compromising quality and risk, against developing a service specification that is too restrictive and misses groups of service users who have a need that can potentially be met within the service.
It has been concluded that the inpatient unit, as it is currently configured is not resourced or able to meet the needs of the local population in the way described within the service specification. It is this issue therefore that will become the focus of this paper and process and will underpin the options that are being presented. Furthermore as part of the review process, specifications for other similar units have been reviewed. What is noticeable is that it has not been possible to identify a specification for a unit that is any more defined or detailed than the one currently available at Greenfield's. What is of note however is that other services and units provide a far broader range of therapeutic interventions and activities for service users.
The following recent referrals provide an illustrative case example of this:

1. Mr A is a 21 year old gentleman, with a severe learning disability, complicated by epilepsy (full range), communication impairment on the autism spectrum, and a history of brain trauma. Mr A is well built, ambulant gentleman, and can move quickly.
Mr A has presented with assaultative behaviour towards others over some years. Behaviour includes scratches, grabs/digging nails, bites/attempted bites to others, hair-pull, and pulling. The Challenging Behaviour Service (CBS) worked with Greenfi eld's staff and clarified the "functionality" of some behaviours i.e. Known triggers include noise, crowds, confusion, and unsolicited proximity. The resulting care plan necessitated 2:1 support whilst Mr. A. was an inpatient. Given the fact that the unit is commissioned to provide only 3 nurses per shift, this posed a significant and un-funded challenge. Medication change (epilepsy related) reduced apparent sedation, but was associated with an increase in rate of assaults on peers and staff, and a Safeguarding plan advised relocation to manage risk.
Some of Mr As behaviour seemed non-functional, (i.e. neither triggered by identifiable environmental events nor apparently reinforced by consequences, and more related to intrinsic factors). Mr A's complex needs have contributed to risks associated with his unpredictable behaviour being a challenge to manage, even with staffing enhancement, in open plan communal settings.
Mr A. has now been successfully discharged. The cost of his community placement is £169K per year. This includes a minimum of 1:1 staffing within an environment that is of low stimulation and able to accommodate his needs.

2. Miss B was referred to Greenfield's following a breakdown in her supported living placement and it was felt that Miss B, who had breached her probation order, would be requested to be admitted to hospital for assessment when she appeared in court. There were concerns at the time that Miss B was hearing voices and was responding to them. She was diagnosed with negative schizophrenia. Medication changes were made which resulted in an increase in seizures. Behaviours were difficult to manage at times but there were known triggers to this - loud music, not responding, isolating herself. The discharge plan for Miss B was moving to a supported living package. A

provider was identified and introduced to Miss B to build a relationship with her whilst she stayed at Greenfield's. The provider however withdrew from the case when Miss B displayed several behavioural outbursts and it was felt that she would not be safe within a flat with only 1 member of staff. The discharge plan was reviewed and supported living was felt to be appropriate for Miss B. A flat was found and she was about to be discharged with a company that was very experienced in working with challenging behaviour, when Miss B attacked a member of Greenfield's staff. This was a week before discharge from hospital. The attack was severe and Miss B was removed to The Gables Mental Health Recovery unit as she was a serious risk to the other clients as well as staff. The severity of the attack caused the 2nd support team to withdraw their offer of supporting Miss B in the community.
The Gables, which was not experienced in Learning Disabilities, tried to work with Miss B but despite some staff training, an increase number of staff supporting her with dedicated 1:1 during the day (again unfunded). Miss B continued with her aggressive outbursts and she assaulted both staff and clients on the unit. Numerous Adult Safeguarding meetings were held and following several re-assessments, Miss B was admitted to St Andrews Hospital (as they have a Women's Learning Disability Behavioural unit) to help her manage her anger and aggression. There were no local facilities that could accommodate Miss B due to the amount of aggression she displayed and the risk she was posing to both staff and other service users. The annual cost of her out of area placement is currently £325K per year.

Having compared the Greenfield's Unit to similar facilities in other parts of the country; as well as our own local analysis, it has become very apparent that there are some obvious gaps. In particular the range of therapeutic interventions available to service users on the Unit and actual dedicated psychology time is extremely limited. It would be considered the norm for a unit the size of Greenfield's to have a dedicated half time Psychologist allocated to the core ongoing psychological treatment of service user's resident on the Unit, not to mention the wider systemic role in terms of supervision and support. As well as this, there is an obvious gap in regard to core occupational activities and interventions available to service users.

Having again compared the Unit to other similar facilities, it is suggested that a dedicated whole time Occupational Therapist would be required to address this gap.

Currently the unit is staffed to only provide a maximum of three members of nursing staff on duty both during the day and overnight. This does not enable the team to be able to engage individually with service users, particularly those with complex needs and behaviours that challenge with the benefit in reducing the need for physical interventions should service users become distressed.

With all the required skills and staff embedded within the service, it would be able to offer a full core multi disciplinary team approach to the delivery of the whole range of presenting needs of service users.

A review of the needs of recently referred service users in the context of the service specification suggests that the type of service user could be summarised as those requiring "time limited/short term (less than 12 months) specialist inpatient health care interventions for people with complex needs and whose level of risk require around the clock nursing and medical supervision".

Future Options for Greenfield's

Two potential options are presented. There remains however, an element of ambiguity as a role for any intensive support service needs to fit into the wider context and commissioning framework.

Option 1

The first option proposes that there is further investment into the service to enable it to meet the needs of those service users with a learning disability and a range of complex needs, ensuring consistency with the service specification. In keeping with the principles of valuing people (2008) it is suggested and proposed that a minimum of four nursing staff are resourced to be on duty during the day and at night.

The cost & workforce implications of resourcing the core team within the unit to this level are described in figures 1 below.

Fig 1

Roles	Band	Funded	Additional requirements	Cost	Total
Psychologist	7		0.5	£21.162	£21.162
Ward Manager	7	1		£42.524	£42.524
Clinical Team Leader	6	1		£35.444	£35.444
Deputy Ward Manager	6	1		£35.444	£35.444
OT	6		1	£35.444	£35.444
Staff Nurses	5	6	5	£28.713	£172.278
STR	4		1	£23.978	£23.978
Support Worker/STR	3	10	1	£20.538	£205.380
Secretary	2	1		£18,058	£18,058
Housekeeping	2	2		£36,117	£36,117

NB – The total cost of staff is currently £545,245. This excludes non pay costs and capital charges but includes on costs. Total additional investment required in terms of staffing is £244,687. This excludes medical support for the unit, which is currently provided from within the LD Partnership. Speech and Language Therapy and other individually required therapies are also excluded but would require individually tailored sessional input at Band 6. One session per week would have an annual cost of £3.5K.

The aim of this investment would enable a reduction in the use of out of area placements and the ability to manage service users closer to their home thus promoting continued ties with family and carers and the avoidance of breakdown of placements.

Furthermore, 8 beds could be used to develop a Peninsula specialist inpatient unit. A bid to the Strategic Health Authority (SHA) for pump priming investment could be considered in order to mitigate short term financial risks for NHS Plymouth.

Referral to the service

To ensure the success of this option it is essential that there is a "robust" process of referral to the service. This should include a full multi-disciplinary team discussion prior to any admission to ensure that:

1. The admission is necessary and appropriate options to meet the person's needs are considered as an alternative to an in-patient admission
2. That there are clear reasons for the admission with an expected outcome and an initial formulation of interventions and necessary treatments are agreed.
3. A Care Co-ordinator is allocated
4. Clear accountabilities for discharge planning are agreed

Changes would be required within the LD community team to ensure this process can be followed and are able to fully support the decision making process and any community based interventions that may be recommended. Due to the wide range of needs of people that may require admission to Greenfield's, it is important that the environment is configured to ensure that all service users and staff are safe. The environment needs to be flexible to allow for individualised care when required - this will result in management of people with different needs to be supported in the same unit and not require placements away from Plymouth.

Option 2

Option two is the providers preferred option and works on the premise that the current Greenfield's Unit is decommissioned as it is currently provided. The resource would be used to develop the skills and expertise to provide a peripatetic community support team ("Community Treatment/Support Service") or service, to enable service users to remain in their current environments or placements with intensive treatment and support. The detail in terms of roles, skills and numbers would need further consideration. The service however would be envisaged to work flexibly in terms of hours of operation (based on service user and carer needs) over 7 days and be funded from within the current allocated resource at Greenfield's. The service could either be a stand alone team, or be embedded within existing teams and services, in keeping with the principles of Greenlight. Alternatives to hospital admission would be considered as part of an enhanced community package of care e.g. intensive home support, respite care, review of medication etc….. Other resources currently available within the community, such as residential

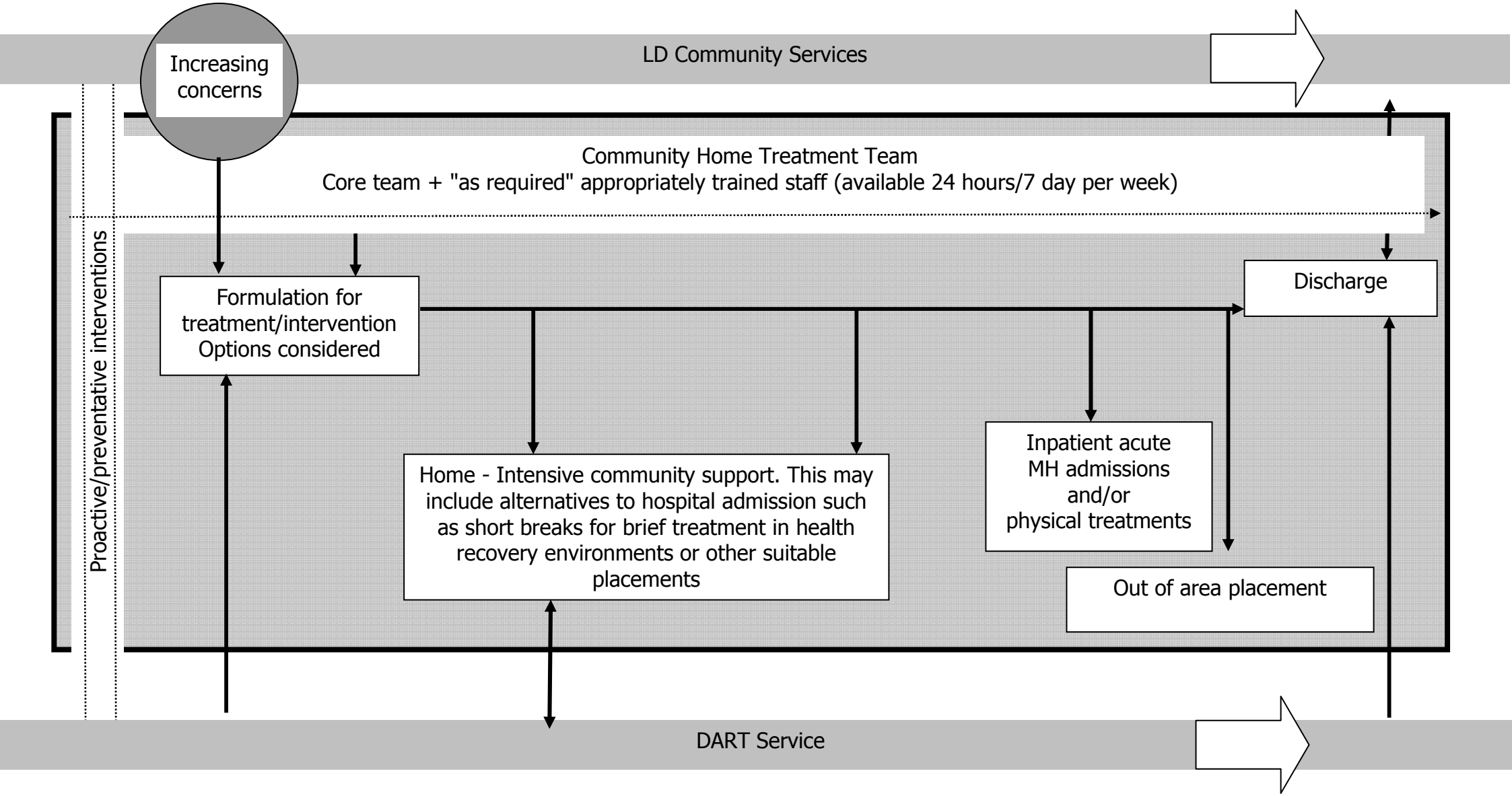
services, supported living placements and local authority short break (respite) services could be included in the range of alternatives to admission. Where community treatment, support and accommodation options have been exhausted due to level of need, there would need to be appropriate environments available to support service users who are detained under the Mental Health Act. Those with a severe learning disability would require suitable specialist or self-contained accommodation utilising the Mental Capacity Act and Best Interests framework to arrange their care, treatment and support.

The *Mansell Report* (1993 and revision 2007) sets out a number of key factors for success for services (known as a 'Developers Model') that support people with complex and challenging needs, they include competent commissioning, organisations and management, well supported and trained workforce, appropriate occupation and engagement and crucially suitable environments in which to provide treatment, support and care.

Most individuals would be supported at home, however, in some instances there would be additional costs associated with this model such as the spot purchasing of potential residential or supported beds as a short term placement for individuals in crisis. The cost of these placements could fall to Plymouth City Council or NHS continuing health care requirements.

Evidence within mental health would suggest that there is potential for efficiencies however its application with learning disability service users is unclear locally at this point in time.

Fig 2 below describes the referral pathway.


LD Community Services
Increasing concerns
Community Home Treatment Team
Core team + "as required" appropriately trained staff (available 24 hours/7 day per week)
Proactive/preventative interventions
Formulation for treatment/intervention Options considered
Discharge
Home - Intensive community support. This may include alternatives to hospital admission such as short breaks for brief treatment in health recovery environments or other suitable placements
Inpatient acute MH admissions and/or physical treatments
Out of area placement
DART Service

Notes:

The dark grey shaded box represents the role of the "Home Treatment Team" - this overlaps with existing community teams and the DART service that all have a focus on early intervention and prevention - this work would be enhanced by the development of the Home Treatment Team.

The circle represents a point in time that concerns are expressed about the continuing deterioration in health which triggers a team discussion - facilitated by the Home Treatment team - and includes people supporting the person and community based staff currently involved. From this point onwards the Home Treatment Team takes responsibility for the person working closely with others as required, e.g. social care specific therapies etc.

Whilst the Home Treatment Team will provide 24 hour/7day a week treatment (when required) the environments that this happens in will depend upon the person's needs and circumstances - a number of options are shown in the diagram. (These resources are necessary to ensure the success of this model). DART, therapy and other services have an on-going involvement as agreed through MDT discussion.

When the person is stable the Home Treatment Team would discharge the person but community services - including DART - may continue to be involved.

Conclusion

As the service is currently configured, it is not sustainable and/or able to meet the requirements of the service specification, particularly given the level of complexity of service users that present and the model and resource currently available to the Greenfield's Unit. It is therefore concluded that there must be fundamental change with regard on how the service is delivered to meet the needs of the local population.

This paper has described what is felt to be the most viable options locally and we offer the proposals to key stake holders for consideration and discussion in regard to the future development of the learning disability service in Plymouth.