Plymouth Community Healthcare

Older People's Mental Health Redesign Strategy

Summary:

A document which outlines plans to redesign the current service to ensure that it remains congruent with the aims of locality working, local and national commissioning drivers and the determination by Plymouth Community Healthcare to deliver high quality specialist mental health services.

It details the rationale for change, what changes will be made and how these will be delivered.

It is a document that sets the scene for mental health service delivery for the older person or those that need our specialist skills for the next 3 years and has been developed and written with collaboration and consultation at its core.

Recommendation:

It is recommended Overview and Scrutiny Committee support the OPMH redesign strategy.

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Plymouth Community Healthcare

Older Peoples Mental Health Redesign Strategy 2011-2013

1. Purpose of the paper.

This paper proposes a way forward and redesign for Older People's Mental Health Services (OPMHS) including Inpatient units, Community teams and the Memory Service which recognises the specialty and identifies the need for locality working.

Approval and engagement will be sought from the relevant fora, including Sentinel (SCCE), Plymouth City Council Overview and Scrutiny Panel and JCCN to support the reshaping and realignment of the service.

Approval has been sought to date from Plymouth Community Healthcare Provider Executive Team (PET), NHS Plymouth and Plymouth City Council Commissioners, Plymouth Joint Dementia Commissioning group and Plymouth Mental Health Local Implementation Team.

2. Background.

Older People's Mental Health Services have a long history of providing specialist mental health services for the older population of Plymouth aged 65years plus. Since 2003 these services have been provided on 2 sites, Mount Gould and Plympton Hospital and in the community. Over the course of the past 8 years these services have had to become more responsive to a number of national drivers and local joint commissioning initiatives. This has been achieved through internal service reconstruction and change as opportunities have arisen, and in 2009, using internal resources and no external investment, OPMH services were divided into 2 main care pathways:

1. Functional disorders for non cognitive impairment e.g. late onset psychosis, depression and or anxiety
2. The Memory/dementia service e.g. Alzheimer's disease and other dementias.

However the service is now in a position where it must be responsive to the demands of differing agendas e.g. Transforming Community Services (TCS),Quality Innovation Productivity and Prevention (QIPP), Plymouth Dementia Strategy, Commissioning for Quality and Innovation (CQUIN) and, as a Social Enterprise offer high quality services that are efficient and productive but keep the needs of the individual at the centre of care. Both epidemiological and

demographic changes and growth of the proportion of the elderly (65 yrs plus) and very elderly (85 yrs plus) mean that for services to be delivered accurately and in keeping with 'Safe and Well and at Home' there needs to be a whole systems approach to service improvement including the following:

- Transforming Community Services to support and encourage more care provision out of hospital and prevent and reduce hospital admissions. Inpatient bed numbers will be reduced, but patient care improved by maintaining existing staff thus increasing staff ratios and **linking** community staff more closely with the wards with a model of co-working.

- The delivery of an integrated pathway that meets the aspirations on the National and Plymouth Dementia Strategy of early diagnosis, support and treatment of dementia and the development of services to better meet changing needs. This pathway will include the Community Memory Service, Dementia community teams and the Pinewood Inpatient unit.

- The delivery of an integrated care pathway that reflects **best practice** in the care of functional illness in the elderly.

- OPMHS will continue to provide specialist services for patients with a dementia and functional illness but age will be used as a guide and **access will be defined on clinical need.** Clear access protocols will be designed and agreed by senior clinical staff in consultation with Primary Care and commissioning colleagues. Thus the **ageless agenda** will be implemented locally so that specialist services are maintained and **access broadened**.

- To **increase the quality of the Inpatient provision** and experience for the individual and their carers. Bed numbers will be reduced and staffing levels maintained thereby increasing staff time and skills for patients. Staff will be trained in dementia skills via levels 1-9 of the national learning platform.

- To meet QIPP agendas, reinvest monies into increased community provision enabling services to be sustainable to meet increasing demand.

- The Community Memory Service needs to reduce the waits for Consultant diagnostic appointment in keeping with Referral to Treatment targets.

- To increase efficiencies within the service through agreed and innovative lean and structured working as outlined in the paper.

2.1 Key targets.

There are 3 main elements to the proposal;

- Reduction in bed numbers - stop people being admitted unnecessarily and their discharge home being delayed once they are ready. Reduce number of admissions to be in line with the top quartile for comparator PCTs

- Two clear functional and dementia pathways involving inpatients and community teams working in an improved model of service delivery.

- A lean and efficient Memory Service including reduction in waiting time and caseload.

If the strategy is agreed a 12 week consultation and engagement period with patients carers and key stakeholders will follow. This will include patients/service users, carers, key stakeholders and 3rd sector colleagues e.g. Alzheimer's society. Further details are outlined later in the document.

3. Proposed changes.

The following changes to services are anticipated which fall into 2 main stages:

Stage 1: Relocation of the inpatient units onto a single site alongside community staff with an initial reduction of beds from 18 to 15 for each ward.

Stage 2: A remodelling of service provision in the community to ensure congruence with joint commissioning agendas.

These stages will be followed by:

- a medium term strategy scrutinising how locality support working and changes in the Community Memory Service have influenced the productivity of the pathway.

- a systematic review of the workforce and skill mix.

- an exploration of work in conjunction with the University of Plymouth to explore the implementation of models of service delivery.

- Long term strategy of further reduction of beds and expansion of increased support in the community.

3.1 Inpatient Services

The 2 wards on the Plympton site (Pinewood and Oakdale) will relocate to the Mount Gould site and reduce, initially, from 18 beds per ward to 15 beds per ward. Edgecumbe has been assessed as being suitable for the Pinewood patient group and Cotehele for 'functional patients'. Consultant Old Age Psychiatrists will also relocate with secretarial staff to the Mount Gould site where all OPMHS staff will then be based. This will result in more efficient team working, better medical cover and heightened productivity.

Both of these wards will be compliant with other current national agendas e.g. single sex accommodation.

The table below demonstrates the spread of admissions across the city and provide data which will help formulate OPMH staffing needs within the localities.

From 31-8-09 to 31-8-11 301 patients were admitted to OPMH inpatient beds. The breakdown of admissions by postcode across the city and areas covered by Devon Partnership NHS Trust are as follows:

Number of Admissions per Postcode

PL	1	2	3	4	5	6	7	8	9	12	13	15	19	20	21	Others
Oakdale																
1.9.09 - 31.8.10	9	4	16	5	4	16	13	4	10	2	2	3	6	8	1	9
1.9.10- 31.8.11	10	6	16	9	19	13	17	4	10	0	2	0	3	0	4	6
Pinewood																
1.9.09 - 31.8.10	11	1	16	6	20	19	25	0	18	8	0	3	1	3	4	4
1.9.10- 31.8.11	9	3	21	6	12	15	25	0	12	1	0	5	7	3	4	4

The aim of the restructure is to ensure that Inpatient acute assessment services are better **focussed** and that community teams, through co-location and working with the wards, are **responsive** to both ward and locality requirements. A link nurse role from within the ward staff team will be developed to work creatively and efficiently with community teams with the aim of preventing admissions where possible and speeding discharge. The result will be an enhanced patient and carer experience through a seamless OPMH service and a more **productive** working style with greater systemic **clarity of purpose** and **pathway** working.

Such changes are in keeping with QIPP and national strategy and will be achieved through:

- A focussed model for admissions
- Refreshment of service specifications
- Close work with the commissioning team regarding alternative suitable accommodation
- A review of staffing resource.
- Staff who will be trained appropriately and possess relevant key skills.

The proposed move of the Inpatient units will offer the following:

- an enhanced patient and carer experience and increased **quality of care.**

- **reduction of stigma** and isolation of the older person with mental health difficulties by placing services closer to mainstream provision.

- **Better access to** medical cover and **Out of Hours general medical cover.**

- **Improved access** to medical care and **nursing support** including OOH medical cover by situating the OPMH wards on the Mount Gould site. In addition the relocation creates the possibility of far greater **synergy**, co working and mutual support between medical staff and those in training. e.g. **easier development of joint clinics** with Old Age physicians for those people presenting with **complex multiple pathology.**

- Stop people being admitted unnecessarily and their discharge home being delayed once they are ready.

- Reduce number of admissions to be in line with the top quartile for comparator PCTs

- Enable people to live at home longer, reducing admissions to care homes

- Easier access for patients and carers due to Mount Gould's more central site and transport links.

- Increased access and support from medical staff to the OPMH community teams and **encourage a pathway approach** to care.

- **Transform** care into a whole system rather than team care.

- Greater support and integration of community and ward staff and promote staff rotation through the pathway to develop increasing skill set and enhance career development.

- It is anticipated that Devon Partnership will continue to access 5 beds.

3.2 Dementia Pathway

The Dementia pathway will be comprised of the Dementia Community Team (Locality Support Working and High Intensity Support) and the Community Memory Service (CMS).

3.2.1 *Dementia Community Team.*
(Previously known as Complex Care Team/High Intensity team)

The current community team will be co working and located with the wards and will have 2 strands of work:

- a focus on an acute care model of highly skilled and intense, time limited intervention designed to avoid admission and speed earlier discharge.

- support of the localities by **named** link Dementia Community team members who have dementia knowledge and expertise who will support and liaise with locality health hubs (Locality Support Working) and who will work across localities as required. The team will **support** moves towards an integrated Rapid Response Service to ensure that all OPMH clients have access to the service. This will be achieved through the appointment of a Band 6 OPMH Nurse who will provide active liaison, support and care between OPMH and RITA/Reablement.

3.2.2 Locality Support Working (LSW) - <u>functional **and** memory pathway</u>

In both pathways there will be **named** link staff that will be the first point of contact with the locality and will work with the localities under the 3R's rubric:
Respect
Reciprocity
Responsibility.

Respect: LSW will bring to the localities specialist knowledge of how mental health presents in old age and will work with locality team members in contributing to high quality holistic assessments and recommendations. There will be the expectation of the development of strong and trusting relationships to be built up both within the locality team and with relevant residential and nursing establishments in that locality. LSW will **support** and **contribute** where cognition and behaviour are relevant factors on the Continuing health Care (CHC) Decision Support Tool (DST).

Reciprocity: ensuring that older people with functional and memory problems have the **same access** to the same physical health support available in the locality.

Where it is evident that more specialist assessment or intervention is required the Locality Support link worker will screen and seek more active intervention from the more specialist/high intensity element of the pathways.

Responsibility: LSW will support specialist mental health care through timely and seamless onward referral to access high intensity/highly specialist mental health resources e.g. Memory Service, neuropsychological assessment, management of behaviour where placement or maintenance of residence is at risk and facilitate return to locality support.

It is anticipated that that there will be an allocated worker from each of the pathways in the locality who will be expected to cover for each other in periods of absence

The aim of LSW is to ensure that throughout an episode of care the person and their supporters receive the 'right care, by the right person at the right time' and to keep the person "Safe and Well and at Home" wherever this is appropriate. The care required and the people providing it will change throughout an episode but

the person receiving that care will always feel confident that they are in safe and supportive system that puts their needs first.

All individuals will continue to be assessed for CHC Funding and Section 17 Aftercare .Closely integrated work with Joint Commissioning of services will continue to ensure that services available enhance options for care.

With the support and agreement of commissioners It is anticipated that a proportion of any savings made in the restructure through QIPP will be invested in the overall OPMH pathway and particularly the Dementia Care team working at high intensity who will have a brief to support those people with a dementia combined with high and challenging needs to enable them to remain in a place with which they are familiar. The team will draw on the 'Newcastle Model' of management of Behavioural and Psychiatric Symptoms of Dementia (BPSD) where appropriate.

Through the development of new and innovative community resources it is anticipated that beds will be used only by those who present as having complex need (Cluster 20+) and those under the Mental Health Act.

The management of the Community Dementia team/wards will emerge as the service transforms into the new structure.

3.2.3 Community Memory Service.

Referrals to the Community memory Service have increased

Apr 2004 – 2005	28
Apr 2005 – 2006	144
Apr 2006 – 2007	183
Apr 2007 – 2008	187
Apr 2008 – 2009	381
Apr 2009 – 2010	508
Apr 2010 – 2011	560

Current referral rate is 60 per month.

The level of referrals to the service has risen year on year and the demographic trend suggest that this will continue.

The level of referrals and the number of potential New Patient (NP) appointments for consultant diagnostic clinic (12 per week) mean that there is always a shortfall and there is currently a waiting list that has meant the service has been unable meet waiting time targets.

To address the waiting times a number of initiatives and actions are proposed:

- The Community Memory Service will move towards a **time limited** period of assessment, diagnosis, treatment and post diagnostic support and **6 month Follow Up appointment** prior to discharge back to primary care. There will

be guaranteed easy return to the CMS/High Intensity Support from the Dementia Community Team if circumstances or presentation change. Difficulties encountered by patients and carers would be assessed by staff locality support working from the Dementia Community team and the person reintegrated into active mental health care at a level appropriate to care need. This will reduce the current caseload by approximately 33%.

- The short term solution of extra paid consultant time (2 weeks AL) funded through short term funding from OPMH underspend as reviewed at the end of August to reduce waiting times.

- Tighter service specification with the Commissioning team to meet the requirements of the Department of Health National Commissioning Pack for Dementia.

- Increased use of shared care agreements after titration of ACI medication as agreed with GPs and medicines management team once stability of medication and appropriate support is in place.

- Involvement and feedback form GPs regarding their expectations of a Memory Service and ongoing care. GP engagement and education/training sessions begin on 14-9-11 with 4 subsequent 'Master Classes' arranged with the support of Primary Care Commissioning.

- Did Not Attend and/or cancellation of 2 offered appointments leading to discharge to be rigorously applied.

- Longer term solutions of 2 extra medical clinic sessions will be sought from reinvestment of CQUIN monies once the waiting lists have reduced.

The overall impact of the changes across the memory pathway is to ensure that, in the arc of a long illness during which many people and professions are likely to be involved, the patient and their carers are treated and supported by pathway teams with shared values and an ethos of 'individual first'. The aim of the pathway teams will be to ensure that the frailest and the most vulnerable in the community experience health care of the highest calibre wherever they are in the progression of their illness.

The Dementia pathway will give us the opportunity to provide seamless care for people with memory problems, a diagnosed dementia and those requiring admission to admission through to End Of Life. This will not be appropriate for all people referred and some will be discharged from the pathway to primary care with the option of easy return to the pathway if required.

The dementia pathway will follow the person from initial referral through to CHC providing the appropriate level of care with primary care colleagues at each stage of the illness.

3.3 Functional Pathway

The Functional pathway will be comprised of the Functional Community Team (Locality Support Working and High Intensity Support).

It is anticipated that the Functional team will remain within OPMH management and will mirror the memory/organic pathway through developing **strong outward looking links with the locality health team hubs**. The OPMH functional specialists would be expected to support people clustering at 3+ across the mental health spectrum and work creatively with ward and medical staff to **minimise admissions** and proactively and energetically **support early and active discharge** and on occasions may call upon the wider AMH resources e.g. Home Treatment and Psychological Therapies. The team will form one pathway with the ward and develop a strong LSW model.

The workforce plan will be reviewed to ensure that the skill mix is optimal for the provision of care.

This plan has the wholehearted multidisciplinary support of the service and is viewed as a 'win-win' scenario.

3.4 Staff training and support

The expertise and skills of the OPMH memory pathway staff group will be supported by the expectation of **all** staff members participating in an appropriate Dementia Learning Platform provided by Learning4health. This activity will be a part of subsequent Personal Development Plans and be addressed in line management.

Staff team members in the functional team will be encouraged to explore and access appropriate sites and training with relevant managers and training department. It is suggested that the team will also access agreed dementia training to ensure skills are interchangeable within the team.

4. Commissioning context

There are a variety of investments taking place across health and social care in Plymouth to improve community services for Older People with a mental health condition and support implementation of the Plymouth Dementia Strategy. The development of these services will increase people's ability to stay independent at home for longer and reduce their need to access specialist services. Whilst some of this investment is time-limited it will enable evaluation of which interventions are successful and enable an increased focus on community provision.

NHS Plymouth invested £359,000 in 2010/11 and £4.25 million in 2011/12 in social care services to support health and reablement services. This level of investment is expected to continue into 2012/13. Of this NHS Plymouth has specified the expectation that this resource and redesign will ensure rapid response and reablement services meet the needs of older people with a mental health diagnosis through the development of a liaison post between RITA/Reablement and OPMH. Key outcomes will include a reduction in admissions to acute and psychiatric beds and care homes. Reablement services will increase in capacity and be accessible to people with dementia. Key

outcomes will include reducing hospital admissions to Derriford, preventing deterioration and delaying dependency. The remainder of the resource will be utilised to improve Information advice and advocacy, Practical Support at Home and using technology to support people.

The Strategic Health Authority has made available £20,000 for enhancing early intervention and diagnosis for people with dementia, with particular focus on engaging GPs. This aims to increase the proportion of people who receive an early diagnosis and are able to access successful interventions to enable them to remain independent for longer. Training is being delivered with the support of Primary Care Governance with no extra investment.

NHS Plymouth has invested an additional £123,000 in 2011/12 into services to carers alongside Plymouth City Council's existing commitment. Some of these services are generic to carers of people with a variety of diagnoses and some specific to people with dementia. Examples include developing Alzheimer's Society contract to provide befriending services and enhance their links to the memory service.

Plymouth City Council in partnership with NHS Plymouth has obtained additional investment to lead the development of the Dementia Quality Mark for care homes. This project is intended to increase the quality of care for people with dementia in care homes.

Plymouth City Council has invested in a workforce strategy and training for staff across the city to increase awareness and the quality of care provided. Domiciliary Care agencies are undertaking training with Jackie Pool Associates to develop their knowledge to work with people with dementia.

NHS Plymouth will continue to explore the potential to pilot the dementia advisor role working with the memory service.

For consideration.

a) The bed reductions are predicated upon the reduction of inappropriate admissions and delayed discharges.

b) It is anticipated that Devon Partnership will continue to purchase 5 of the overall complement of 30 beds.

c) There is a need for a specialist OPMH service for both pathways in order to deliver the quality and skilled care.

d) Development of services needs to be informed and driven by **accurate epidemiology** of dementia and other psychiatric illnesses in the frail elderly, notably the Data Bank used by the commissioners. There will need to be an ongoing consideration of the care provided and analysis of resources available. Current Royal College of Psychiatry guidelines suggest 4 Old Age substantive consultant posts for the Plymouth population (not including an Old Age Liaison Psychiatrist).

Work is under way with Public Health to strengthen the data used for forward planning.

e) Both pathways will work actively with Adult Social Care to offer a quality service and will support, wherever appropriate the personalisation agenda.

5. Public involvement and consultation

- There will be a formal period of consultation with service users and carers, IP units and community teams after agreement in principle from the Sentinel Clinical Commissioning Group. There will be discussions with staff about how the needs of patients and carers are best met and will include open meetings with patients, their carers and staff at appropriate times and will include the offer of meetings at weekends and evenings.

- Plymouth Community Healthcare's Joint Committee for Consultation and Negotiation have been involved with the process to date and their views will continue to be sought through appropriate staff consultation. The proposed changes have the overwhelming support of clinical staff.

- With the eventual relinquishing of OPMH wards on the Plympton site administrative, secretarial and hotel services staff will transfer to the Mount Gould site through the current redeployment policy as agreed with Human resources.

- Edgecumbe ward patients and staff will be part of an in-house consultation regarding the move of ward. Initial, exploratory discussions with staff have raised no significant issues and there is a willingness and enthusiasm on their part for the potential move. Estates have been involved and view the move as helpful within the Mount Gould site.

- A longer term review of overall staffing is part of the Plympton Steering Group.

- The service will seek the support of the University of Plymouth research team to evaluate the changes in keeping with national best practice OPMH community and inpatient models

- The Southwest Dementia Partnership (SWDP) is undertaking a peer review of Memory Services/diagnostic pathways which is likely to comment on the wider access to services after diagnosis. We view this as a helpful addition in ensuring that services are delivered to the appropriate standard.

5.1 Proposed time scales for consultation:

External consultation.
The paper has been seen by:

Plymouth Community Healthcare Provider Executive Team	15-9-11
NHS Plymouth and Plymouth City Council Commissioners (QIPP Transformation meeting)	20-9-11

Plymouth Joint Dementia Commissioning Group	26-9-11
NHS Plymouth and Plymouth City Council Commissioners	26-9-11
Plymouth Community Healthcare Board	27-9-11

and will be discussed by:

Plymouth Community Healthcare Joint Trade Union Forum (JTUF)	7-11-11
Plymouth Community Healthcare Joint Committee for Consultation and Negotiation (JCCN)	16-11-11
Cllr Monahan to visit Community Memory Service	4-11-11
Sentinel Clinical Commissioning Executive	9-11-11
Health and Social Care Overview and Scrutiny Panel	9-11-11

5.2 Proposed action plan time scales: see attached sheet for details

- **Internal consultation**. Consultation period of 12 weeks with patients carers and staff will start following agreement by OSR and SCCE. This will include weekend and evening sessions to ensure the widest constituency of engagement and involvement. Consultation dates for patients, carers, and staff are attached. The consultation will include Edgcumbe Ward. (Appendix 1)
- Bed numbers reduced and wards moved by 31-3-12 or following consultation period whichever is soonest.
- Edgecumbe ward to move to Greenfields December/January.
- Memory Service waits to be reducing by 31.1.12 in preparation for SWDP Peer Review in December'11/January 2012, MSNAP review in February 2012 and cleared by 31-3-11.
- Action plan and time scales are attached.

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