

Proposal to redesign older people's mental health services and enhance provision of community care and support

Introduction:

Older people's services in York and North Yorkshire have a track record of innovation and improvement over many years. This includes the establishment of a challenging behaviour service for men (Peppermill Court) and two recent projects with The Kings Fund looking at enhancing the healing environment. Leeds and York Partnership Foundation Trust is keen to make further quality improvements and to increase the range of alternatives to hospital care wherever possible.

We would like to enhance community options for older people and their families ensuring that hospital admission only occurs when this is the best option.

This paper sets out a proposal for a dedicated nursing home team and reconfiguration of in patient beds and asks for agreement from the City of York Council Health Overview & Scrutiny Committee to proceed.

Background

The older people's service currently provides the following key elements of a comprehensive specialist service:

- In-patient beds.
- Specialist community mental health teams, including Memory Services.
- Out-patient clinics.
- In-patient respite services.
- Day hospital services.
- Continuing care provision.

The inpatient service is supported by sectorised Community Mental Health Teams (CMHTs), providing assessment and treatment in the community. CMHTs work extended hours up to 8pm. At weekends a reduced service operates, providing support to people already known to the service.

Day services are provided within the three CUE units (Mill Lodge, Worsley Court and Meadowfields).

The current day service provides therapeutic assessment, management and day care support for a significant group of people who have been in receipt of a service for several years; but who in the main require social support and interaction. Respite for carers is also provided.

We are working with North Yorkshire & York commissioners and Local Authority colleagues to review day care across the area.

The York and North Yorkshire locality does not have other community focused teams such as intermediate care or crisis services for older people. Through our transformation programme we will review capacity and demand across all services; and evaluate whether there is a need for intermediate care and crisis services for older people. In the meantime we propose developing a Nursing Home Team which will offer older people enhanced support and will reduce current and future delayed discharges.

Nursing Home Team Model and Proposal:

Estimates of the numbers of older people in residential and nursing homes with mental health problems vary: the proportion of people with dementia in care homes is estimated at between 33% and 66%; and for people with depression (mostly undiagnosed and untreated) it is estimated that the proportion in care homes is about 40% (Audit Commission, 2000). Some will be in specialist homes, but the majority are receiving care in non-specialist care homes for older people. Support from specialist secondary health services have demonstrated prevention of admissions from care homes to hospital and transfer between homes; as well as promoting better practice amongst care home staff and boosting staff confidence and morale.

We propose to improve the way that we provide this support in York and North Yorkshire services through the establishment of a nursing home team. This team will also help to improve the pathway out of NHS inpatient services into residential and nursing homes, helping to prevent delayed discharge.

Success criteria for this service will therefore include:

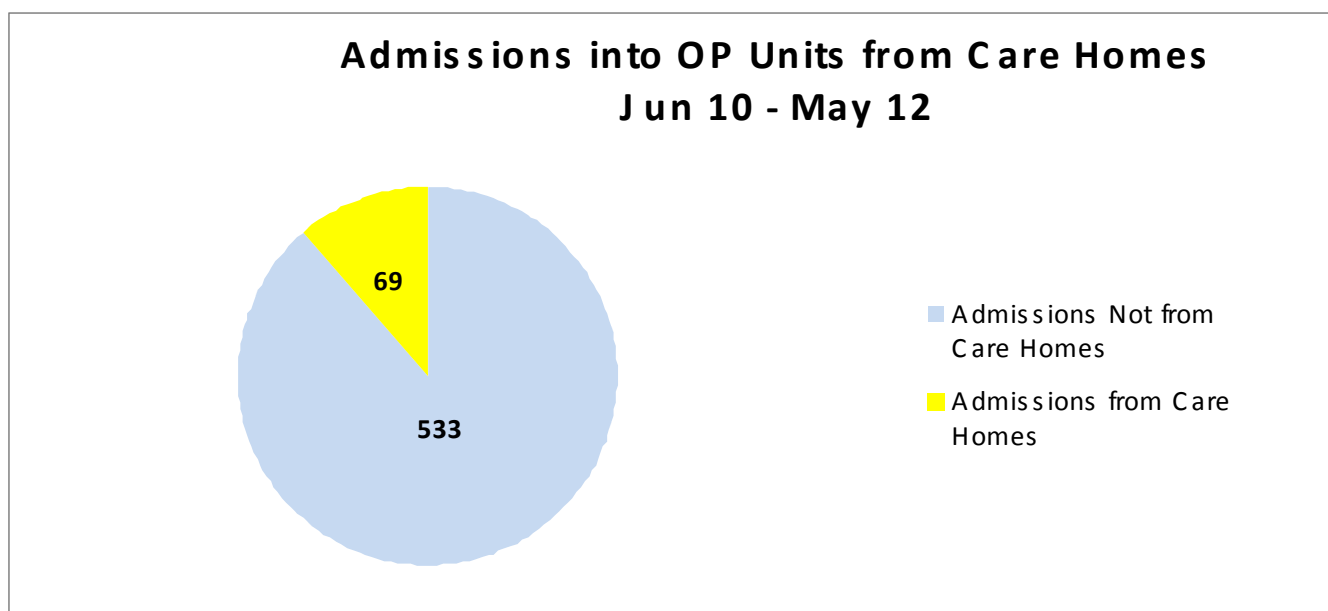
- Improved health outcomes
- Reduction in admissions from nursing homes and care homes
- Reduction in delayed transfers of care from our services
- Reduction in referrals from nursing homes and care homes to Community Mental Health Teams.

Nursing Home Team model:

The Nursing Home Team will work with all homes in the locality to support the care of people in their care with mental health needs. The team will establish regular contact with nursing homes to intervene early. Working closely with social care partners the team will ensure that service users are appropriately discharged to a residence that is able to meet their individual needs, as well as providing necessary discharge support.

The team will provide a discharge liaison service to service users discharged to nursing or residential homes from older people's mental health services. They will work alongside nursing home staff to deliver specialist mental health care. This will help to prevent admission using a step up/step down approach. The team will also provide training to nursing home staff where required and will deliver a flexible service offering support and advice over an extended working day up to 8pm.

Currently our Community Units for the Elderly inpatient services receive over 30 admissions from nursing homes per year. We expect the Nursing Home Team to reduce this by 50% within the first year.



By offering a care homes liaison service we anticipate a reduction in annual referrals to CMHTs from nursing homes of 35% in the first year.

Benefits:

There will be fewer occasions when a vulnerable older person is required to move from their home to hospital, or between homes. This will improve health outcomes for those individuals and reduce their distress and that of their carers.

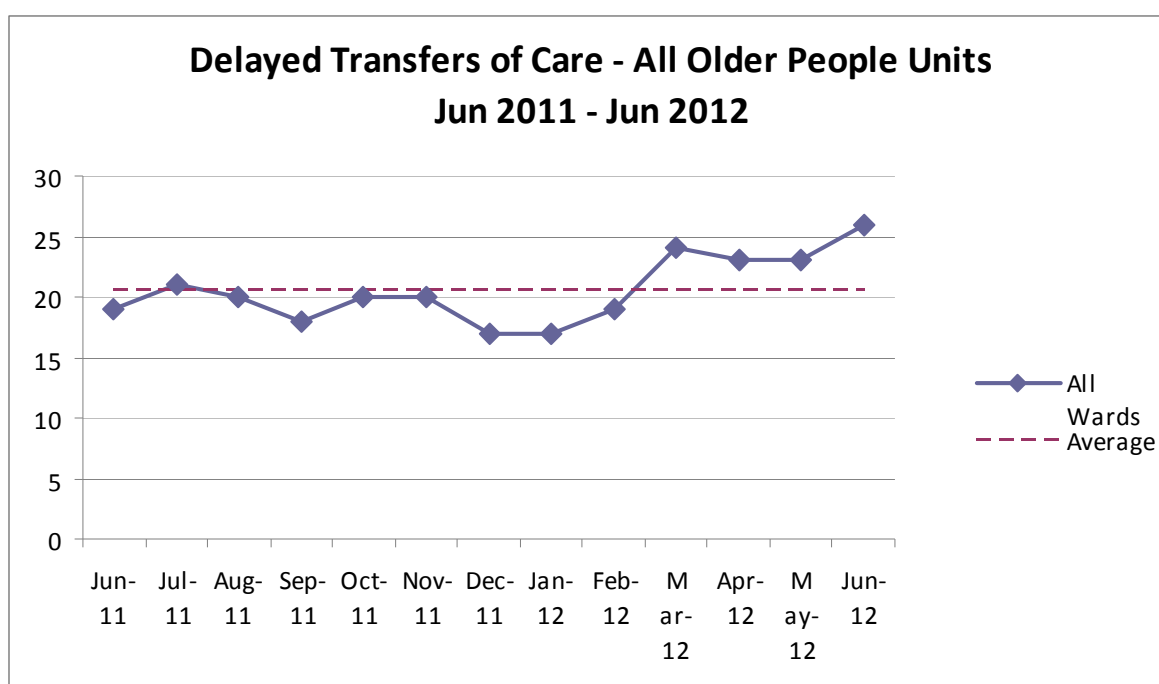
The impact of this proposal will be to release capacity within Community Mental Health Teams to further enhance the support they are able to provide.

The team will be part of the integrated community service and will play an important part in integrated care pathway provision.

Their specialist interventions and advice will help to reduce the need for medication including anti-psychotic drugs.

Care providers in other settings will gain greater understanding of mental health issues, promoting the provision of high quality care.

To resource this service improvement we will need to refocus some further resources from inpatient to community services. The case for this refocus of resources is supported by the current high level of delayed discharges within our inpatient community units; these are service users who no longer require hospital-based health care but who should be discharged to community based or residential care. An analysis of bed use in older people's services over the past year demonstrates an average of more than 20 delayed transfers of care (see table below).



Addressing delays will therefore allow us to release resource currently committed to inpatient facilities and reinvest in community based services, so reducing the need for hospital admission and supporting people to remain in their home. We anticipate that this will also reduce the number of crisis events in the community, which lead to admission to A&E departments and the acute sector.

In order to achieve this service improvement we therefore propose to reconfigure the current inpatient community units. This will allow us to vacate Mill Lodge Community Unit for the Elderly (CUE), therefore inpatient services for older people will be consolidated into the remaining units: Meadowfields, Worsley Court and Peppermill Court.

Staff will either be redeployed to the Nursing Home Team or will be moved into suitable alternative employment within existing vacancies in York and Selby; no staff will be made redundant as a result of this proposal.

It will also provide a potential opportunity to use the vacated Community Unit for the Elderly differently so improving the care environment for service users, supporting plans to address age restrictions within our services and improving the way that we provide single sex accommodation.

The proposal is fully in line with national, regional and local strategy in its aim to reduce reliance on bed-based services, improve preventative services and promote choice. It supports Department of Health objectives to:

- Give people greater control, choice and services that are built around the individual;
- Drive continuous improvement in the quality of services whilst ensuring value for money through the fair and effective use of resources; and
- Promote the commissioning, development and provision of services which allow people to live independently in the community.

Communication and Consultation

An effective communication and consultation plan is being developed to ensure the benefits of these improvements are clearly articulated. We are keen to ensure the longer term benefits of these improvements are clearly explained but that also people currently using the services are fully consulted and any anxieties or concerns they have are understood and addressed. (See Appendix 1)

We have a regular Service Improvement Group in place with membership from LYPFT, NHS North Yorkshire and York (our current health commissioners), the Vale of York Clinical Commissioning Group (our future health commissioners), City of York Council and North Yorkshire County Council. This group is aware of our proposals and will support our public engagement and consultation.

Conclusion:

This proposal sets out a new service model to significantly enhance community service provision, ensuring that service users and their families are in receipt of appropriate care and support, delivered in suitable accommodation, whilst minimising delayed transfers of care.

The expansion of community focused services provides support that service users and carers consistently request to help them remain in their home. It also supports other initiatives including the reduction of the prescribing of anti-psychotic medication to older people. It reduces our reliance on bed based services and provides a platform to make further improvements over the coming years, as demand for high quality services which promote personalisation and choice are expected by the public.

This paper seeks agreement to proceed on the basis of a one month formal consultation period during September and October. The rationale for a one month consultation period is that this is not major service change; it is a reconfiguration of existing services and no service elements will be discontinued. It will improve community services, therefore improving choice and home-based care and treatment. The reconfiguration of the inpatient services will not impact on in-patient capacity as it will be achieved by actively addressing delayed transfers of care. At the same time we will develop a new community-based Nursing Home Team, to support people receiving care in their place of residence, reducing admissions to in-patient wards and facilitating discharge. In so doing we will reduce flow into our bed base, thereby creating additional capacity.