Partnership working in mental health services; and an interim review of the Care Home Liaison Team

1 Introduction

In December 2012, York Health Overview and Scrutiny Committee provided its support for the reconfiguration of Leeds and York Partnership NHS Foundation Trust (LYPFT) beds for older people; and the development of a dedicated Care Home Liaison Team.

Members of the Committee asked for a subsequent update on partnership working in mental health services; an interim review of the Care Home Liaison Team; and an update on the placement of service users who had been in Mill Lodge prior to its closure. This report has been prepared for these purposes.

2 Partnership working

The Trust works with many different partners at strategic and operational levels; and is proud of its strong reputation in partnership working.

City of York Council (CYC) and North Yorkshire County Council (NYCC) are now both represented at the Trust's senior management team meeting for York services, which meets monthly. We have recently reviewed the Terms of Reference for this group and as a result representatives from Mind advocacy and Cloverleaf advocacy will be invited to join the group on a quarterly basis, to share information, feedback any issues or concerns and share best practice.

CYC and NYCC are also active participants in the Trust's community service redesign project; and have been involved in the development of the new service model and in supporting its implementation. Stakeholder letters and briefings about the redesign have been produced bimonthly since April and widely circulated. Public events such as Knowledge Cafes have been well attended; we have collated all feedback and produced a full response, which was summarised on a banner at our Annual Members' Day. One comment from a Knowledge Café said:

> "The changes you have made in a year are impressive and it shows you are acting on feedback from the community."

We have printed postcards and posters to encourage service users and other stakeholders to become involved in our redesign work and will be having open door informal events in York in November, from which we hope to establish a local service user network.

In addition to this, the Vale of York Clinical Commissioning Group (VoY CCG) holds a regular Service Improvement Group meeting, where any proposed service development is discussed. Membership includes the Trust, CYC, and NYCC.

The Trust and the two local authorities are keen to develop partnership agreements to set out how we will work together. We have worked together to develop a draft Section 75 (partnership) agreement and will shortly form a shadow Partnership Board to oversee the implementation of the agreement in York.

Trust representatives routinely attend the York mental health forum, membership of which includes third and statutory sectors, to provide updates on the work of the Trust and maintain relationships. Trust managers also have regular informal contact with voluntary sector partners to share plans and updates. Engagement leads within the Trust previously had excellent relationships with both York and North Yorkshire Link; and these strong relationships are now developing with both area Healthwatches. The engagement lead represents the Trust at the York Healthwatch assembly and attends the PPE leads meeting with colleagues from VOYCCG, York Teaching Hospital NHS Foundation Trust and York Healthwatch, to share information and broker positive relationships and partnership working.

A dedicated meeting to review delayed discharges has recently been set up, between VoY CCG, City of York Council, and LYPFT. This group will meet every four weeks; and between meetings bed lists will be sent to a central point of co-ordination each week. This will enable progress in assigning and prioritising cases for action between meetings.

A new partnership forum has developed over recent months to ensure that the operation of the new Health Based Place of Safety is effective. This includes representatives from the Police, Yorkshire Ambulance Service, York Teaching Hospital NHS Foundation Trust, Tees Esk and Wear Valley NHS Foundation Trust, CYC and NYCC; and is developing joint protocols for the operation and evaluation of the systems of working when someone is detained on a section 136.

A monthly meeting has been set up between staff at the Emergency Department at York Teaching Hospitals NHS foundation Trust and staff from our wards and home treatment teams to look at improving the experience of service users with mental health problems who present in the Emergency Department; and to reduce numbers who attend. As a result of these meetings we are developing multi agency care planning, resulting in joint care plans for service users who frequently attend the Emergency Department, or have frequent contact with the Police.

The Trust actively engages in all local health and wellbeing fora, including: the Health and Wellbeing Board; YorOK Children's Trust Board; the Mental Health and Learning Disability Partnership Board; the Urgent Care Board; and the Older People and People with Long Term Conditions Partnership Board. Our Chief Executive is the vice-chair of the Yorkshire and the Humber Local Education and Training Board (Y&H LETB), and chairs the Y&H LETB Partnership Forum. We participate in Adult and Children's Safeguarding Boards and Multi-Agency Public Protection Arrangements. We are also fully represented on the VoY Professional Engagement Forum; and are full participants in the Dementia Implementation Group and the dementia friendly communities' project.

3 Care Home Liaison Team

Recruitment to the team commenced in April 2013 and the team is now fully established. It is a nurse led team comprising of one part-time manager, one band 6 clinical nurse lead, three band 5 nurses and three band 3 Health Care Assistant posts.

The team has the following aims:

- To build capacity, knowledge and expertise in care homes
- To support care home staff to care for people's mental health needs
- To reduce the need for admissions from care homes into hospitals
- To reduce referrals from care homes to Community Mental Health Teams (CMHTs)
- To improve the pathway from NHS hospital services into residential and nursing homes, helping to prevent delayed discharge.

Actions to achieve these aims include:

- Offering training opportunities for care home staff and actively engaging with stakeholders e.g. primary care, commissioners and carers with a view to developing expertise within the homes and working collaboratively to improve care

- Supporting homes in better risk management to improve the welfare and well-being of residents e.g. ensuring that adult safeguarding concerns are managed effectively within the home in accordance with best practice guidelines
- Facilitating the direct transfer of service users from home into a care home instead of admission into a mental health bed and to actively engage in any assessment process once that transfer to the home has taken place
- Supporting the discharge process from hospital.

3.1 Interim review against aims

Building capacity in care homes and supporting care home staff

To foster effective working alliances with both care home staff and GPs the team has introduced a 'liaison' approach in which individual nurses have responsibility for homes within a defined geographical area. Staff offer routine agreed visits to homes in the expectation that this regular support will help improve homes' confidence and expertise in managing mental health difficulties and may reduce the need for formal referrals to the team.

An information pack is in development, which will inform care homes how they can contact their nurse, provide team contacts and availability and provide advice on interventions to help address issues that may develop into the need to refer. Core documentation is also being developed: Care Home Liaison Team Care Plans, Target Behaviour Charts and Sleep Hygiene Charts etc, which will be used by the care homes to help structure their interventions and then accessed by the team when completing their assessments and reviews.

The team also has plans to introduce the SBAR tool. This tool consists of standardised prompt questions within four sections (Situation, Background, Assessment, Recommendations). Using the SBAR prompts staff to formulate information with the right level of detail. Its use will support homes to assess issues, review the effectiveness of their own interventions and clarify the outcomes they want from the team's involvement.

Another way in which the team can work effectively with homes is by encouraging the development of 'Dementia Champions'. If homes are supportive of this initiative it has several potential benefits: it will allow our staff to work with a limited number of individuals in the care homes who not only have an interest in this client group but can also develop expertise and good practice and may also consider if this approach can meet the needs of

the individual prior to referrals being made to secondary mental health services.

Reducing the need for admissions and reducing referrals

The team provides a service to approximately 55 homes and began accepting referrals from April 2013. The team has a clear remit to respond to all referrals submitted to the mental health service for people residing in care homes that have an elderly person's registration. Referrals include new referrals to the service but initially included significant numbers of referrals transferred over to the team from CMHT colleagues. The referrals by months are shown in Table 1.

Table 1 Referrals by month

	Apr	**May**	**Jun**	**Jul**	**Aug**	**YTD**
Referrals	6	16	25	36	30	**113**
Contacts	31	54	123	245	274	**727**

Reasons for referral have been fairly consistent: requests for assessment and intervention for behaviours that challenge, such as physical and sexual aggression, resistance to care interventions, excessive vocalisation and agitation. Other referrals are less specific but relate to requests for advice around the care and management of residents with cognitive impairment and for interventions for depression and relapse of psychosis. A minority of referrals are to undertake the medication monitoring of acetylcholinesterase inhibitors, which is resource intensive.

The team has only been fully operational since July therefore evidence of the achievement of its aims is emergent. Table 2 compares the admissions to the Elderly Assessment Unit from last year to this year using the time period when the team was established.

Table 2 Admissions to EAU

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Total**
Year 12/13	6	10	9	6	8	**39**
Year 13/14	7	10	5	7	9	**38**

There is no discernible difference in admission rates. However admissions for 2013 are to a service that has a reduced total bed state for older people; with no increase in admissions to EAU. Table 3 shows the number of service user

transfers from EAU to the CUEs during the time period. This indicates that in 2013 more service users were discharged back to the community than transferred to another NHS unit.

Table 3 Transfers from EAU to CUEs

	2012	**2013**
April	0	1
May	3	1
June	1	0
July	0	1
August	3	0
Total	**7**	**3**

Although EAU does cater for people with dementia its primary focus is on people with a functional illness. People with dementia are also directly admitted to the CUEs. Table 5 therefore shows admissions to the Community Units for the Elderly during this time period.

Table 5 Admissions to the CUEs

		Apr	**May**	**Jun**	**Jul**	**Aug**	**Total**
Meadowfields	2012/13	2	3	2	3	4	**14**
	2013/14	7	1	5	4	3	**20**
Mill Lodge	2012/13	4	3	2	2	1	**12**
	2013/14						**-**
Peppermill Court	2012/13	1	1	2	0	2	**6**
	2013/14	0	1	2	2	2	**7**
Worsley Court	2012/13	6	4	1	4	5	**20**
	2013/14	2	4	1	6	2	**15**
Total	**2012/13**	**13**	**11**	**7**	**9**	**12**	**52**
	2013/14	**9**	**6**	**8**	**12**	**7**	**42**

It can be seen that there is a net reduction in the numbers of admission (19%). This is against the background of a continued increase in the ageing population.

Delayed discharges

The team aims to work with the wards to facilitate the prompt return of people to their care homes and thus reduce delayed discharges. The majority of delayed discharges are because of service users awaiting nursing home

placement or availability therefore the impact of the team on delayed discharges will be limited. However, initial results are encouraging. Table 6 shows the delayed discharges from the EAU and CUEs during the relevant time period.

Table 6 Delayed discharges

		Apr	May	Jun	Jul	Aug	Total
EAU	2012/13	1	1	0	2	3	7
	2013/14	4	4	1	1	1	11
Meadowfields	2012/13	9	9	8	9	8	43
	2013/14	2	5	6	8	6	27
Mill Lodge	2012/13	4	5	7	5	3	24
	2013/14						-
Peppermill							7
Court	2012/13	1	2	3	1	0	
	2013/14	0	0	0	1	0	1
Worsley Court	2012/13	3	3	2	3	0	11
	2013/14	3	6	6	5	5	25

From April to August 2012 there were 92 delayed discharges and in 2013 this has reduced to 64; a reduction of 30%.

4 Placement of Mill Lodge service users

The Health Overview and Scrutiny Committee expressed concern about how the needs of Mill Lodge service users would be met.

When Mill Lodge closed there were 5 remaining service users placed there. One service user was transferred to a care home in East Riding with the involvement and agreement of the family. The remaining 4 service users all required further NHS care and treatment: 3 were transferred to Meadowfields and 1 was transferred to Worsley Court. The three who were transferred to Meadowfields continue to need NHS hospital care and remain in Meadowfields. The service user who was transferred to Worsley Court is now awaiting a placement in a care home. All five settled into their new units and there have been no concerns raised from their families.

5 Conclusion

The team's manager reports that all staff have proved to be well motivated, supportive of each other as a group and committed to develop their expertise. There are early indications that the team members are beginning to achieve their aims. We are confident that further progress will be made once the capacity building and support networks with care homes have been completed.

LYPFT is undergoing a service redesign of its community services in York and Selby and the team will be an integral component of the re-configured services thus ensuring it retains its early involvement in referrals from care homes.

A more comprehensive evaluation will be completed at 12 months and we will ensure that this also captures qualitative feedback from carers and care homes. We believe this will demonstrate the team's continued and increased impact on reducing the number of occasions when a vulnerable older person is required to move from their home to hospital, or between homes.