5 Boroughs Partnership NHS
NHS Foundation Trust

Building on Strengths

Proposal for a New Model of Care

Later Life and Memory Services

October 2011

A Better View

Contents

Executive Summary

This model outlines proposals to qualitatively change the nature and balance of service provision by 5 Boroughs Partnership NHS Foundation Trust (hereafter called 'The Trust') and its partners for people having their mental health needs met within the Later Life and Memory Service Business Stream.

A new and robust model of care is proposed, that will enable the modernisation of services which reflects the Commissioning intentions set out in the 4 Borough Alliance strategy 'Securing Better Mental Health for Older Adults (2009). This focuses on early intervention and home/community based support and treatment promoting independence and personalised care. Effective Mental Health Services will be provided on a partnership basis. The Trust strategic objectives emphasise that recovery focused Mental Health services require statutory and voluntary agencies to work together closely with service users, carers and families to ensure that services are needs-led, local, accessible and well resourced.

In accordance with National drivers, this model aims to concentrate on improving productivity and eliminating duplication whilst focusing on clinical quality (DoH 2010a). We aim to deliver, in partnership with Primary Care, Social Care, Local Authority, Statutory, Independent and Not for Profit sectors, a comprehensive, evidence based Older Adults Mental Health specialist model (DoH 2008). This will encompass core functions to deliver a high quality needs led service for people with organic and/or specific Older Adult functional needs.

The model includes a proposal to utilise a single point of access / gateway function to provide cognitive and functional screening with direct access to advanced assessment and consultation. The model also outlines a Crisis Intervention function for Older Adults requiring specialist Old Age mental health services, and will provide greater integration between inpatients and community services allowing for extending hours to services.

The model encompasses a dedicated Community Mental Health Service to deliver person-centred interventions and care on the basis of need not age, in accordance with the Department of Health four priority areas (DOH 2010b). These are an integral part of improving the care and experience of service users and carers.

Also, in line with the National Dementia Strategy objectives (DOH 2009) our multidisciplinary memory services will provide high quality services including:

- Health promotion and education within Primary Care settings
- Early detection and diagnosis of cognitive impairment
- Specialist treatment and intervention for service users and carers in partnership with local authorities and third sector organisations.
- Specialist input to minority groups e.g. Black Asian and Minority Communities, Younger people with Dementia, Learning Disabilities and Dementia.

Building on current partnership working with statutory and voluntary sector organisations will enable the provision of additional support on a range of areas including accommodation, welfare benefits, advocacy, carer assessment and support.

The model is designed to improve productivity by simplifying the assessment and treatment pathway, thereby creating the capacity to meet increased demand for the services.

1. Introduction

Using the principals and objectives contained in recent Department of Health publications, we aim to deliver a community based service supporting people to remain at home, whilst improving and maintaining the quality of life of service users and their carers.

The care pathway will clarify and standardise the care delivered to people with organic conditions and older adults with complex functional conditions whose needs are best met by specialist older people's services.

Community provision will be supported by access to specialist in-patient beds in instances when the service user cannot be safely or appropriately managed within their local communities.

The in-patient beds will form a Centre of Excellence delivering short term assessment and treatment within an excellent physical environment with care delivered by a specialist multi-professional team of staff.

This model proposes a pathway for older people's mental health services that will enable the Trust and its partner agencies to deliver a comprehensive range of integrated, evidence based services in accordance with stakeholders' wishes and appropriate to meet the challenge of rapidly increasing levels of need. Being fully committed to integrated, local community services, the model enables the delivery of enhanced community provision.

2. Scope

The model includes the delivery of service to the geographic areas of the five boroughs of Halton, St Helens, Knowsley, Wigan and Warrington and to services commissioned for the population of the area by NHS commissioning bodies.

Its primary focus is services for people with organic mental health conditions, i.e. Alzheimer's disease, Vascular dementia, Dementia with Lewy Bodies, Fronto-temporal dementia (including Pick's disease) and others, some of whom may also have a functional illness, such as depression *and* those people with a functional illness whose needs are better met by the later life and memory services.

3. Background

Under the Equality Act (DOH 2010h), age discrimination in the provision of facilities, goods, services and public function is prohibited; therefore, services must be provided on the basis of needs not age. Older people who have mental health problems have a different medical presentation compared to younger adults and services have to respond to this.

The model outlined in this strategy details specialist provision for adults with older people's needs, and is not an age specific service. The services will work collaboratively with Adults Services to ensure that provision is equable as set out in the Equality Act (2010).

In the UK, it is estimated that 700,000 people have dementia and have an estimated cost of £17 billion pounds per year. By 2037, this is set to double to 1.4 million people with an increased cost of £50 billion per year. Dementia costs approximately £8.2 billion per year in direct health and social care costs; however, much of this spend is in response to crisis in later stages of the disease. The Department of Health (DoH) launched the National Dementia Strategy in February 2009, which is a comprehensive yet ambitious 5 year plan aimed at helping people live well with dementia. The DoH estimated that the strategy would cost £1.9 billion to implement over 10 years and this would be funded largely through efficiency savings. These savings could be achieved by reducing the amount of time that people with dementia spend in hospital when they no longer have a medical need to be there, or by reducing premature entry to care homes by providing better support in the community (estimated that £1.93 billion direct cost of dementia in care homes in 2009: House of Commons, 2010). These savings could then be re-directed to other areas such as early diagnosis and interventions in people's own homes. Also, national and regional leadership would be put in place and initial seed funding of £150 million would be allocated to Primary Care Trusts (PCTs) to assist the implementation over the first two years.

However, in practice, the Department has failed to match its commitments to raise the quality and priority of dementia care with a robust approach to implementation. It has failed to align leadership, funding, incentives and information to help deliver the strategy (House of Commons, 2010). Consequently, services are reviewing their working arrangements with partner agencies and key stakeholders to strive to meet the aims of the Department's strategy despite the current fiscal pressures.

3.1 Current service configuration and environment

Evaluation of the Trust's current services for older people reveals that modernisation has been limited and varies greatly from one borough to the next. Services lack flexibility and do not fully meet the needs of service users and carers, e.g. lack of access to out of hours services. Currently, community services operate Monday – Friday, 9am – 5pm excluding Bank Holidays, and

In-patient wards are available 24/7. Whilst there has been some development in the form of designated memory services, they are, in the main, provided through a traditional model of service that is in need of modernisation to enable services to deal with the forecast substantial growth in demand.

At present, each borough has its own Organic in-patient ward: Stewart Assessment ward based at Peasley Cross St. Helens, Sephton Unit based at Leigh Infirmary, Kingsley ward based at Hollins Park Warrington, Grange ward based at the Brooker Centre in Halton, and Rydal ward based at Whiston Hospital in Knowsley; older people with functional health needs are admitted to the Adult Acute in-patient wards. However, there are occasions where it is not considered appropriate for older, frail service users to be admitted to adult wards, and they are admitted to the organic wards.

Map of location of current inpatient wards. ↗ = Site.

The map is a separate attachment to this document.

Only one of the organic wards is currently fit for purpose, having undergone major refurbishment in 2010 which has brought about ensuite single bedrooms, a sensory garden area, conservatory and quiet lounge area, along with consulting rooms.

The photographs of the refurbished unit are on a separate attachment.

The décor and signage within the ward has been chosen specifically to suit service users with dementia. Whilst the other organic wards have had some minor updating, they do not fully meet our aspirations to provide an excellent environment for patients being admitted with Dementia. A key issue for the Trust is that whilst we meet the DoH guidance on provision of single sex accommodation, we do not currently have single sex organic wards, and this adds to the difficulty in nursing people with increasingly challenging clinical presentations. However, despite these challenges the in-patient wards all meet Essence of Care (EOC) and Accreditation of Inpatient Mental Health Services (AIMS) standards and have successfully implemented the Advancing Quality Initiatives (AQIs) improving the quality of inpatient care.

In the community service provision varies: gateway and/or access services are provided in various ways:

- Assessment and Treatment Centres in two boroughs,
- Memory clinics in four boroughs,
- Day services in two boroughs,
- Older people's Community Mental Health teams (CMHTs) in four boroughs,
- 'Ageless' CMHTs in the Wigan borough,
- Hospital liaison services provided for all five boroughs.

Dedicated crisis services do not exist. Currently a crisis is managed through existing community services, during normal opening hours, but there is very little available outside routine opening times.

In addition all boroughs undertake psychiatric out-patient clinics. Services are provided from a range of sites – some of which are Trust owned, but not all, and again they are not all 'fit for purpose' i.e. lack sufficient consulting rooms, have poor décor, lack appropriate waiting areas, and are not all easily accessible.

3.2 Current staffing skill mix

On review of the current staffing skill mix it becomes clear that there is a heavy emphasis on nursing staff, whilst therapy staff and psychologists are poorly represented within the directorate.

Table 1 Breakdown of Older People's Services Community staff

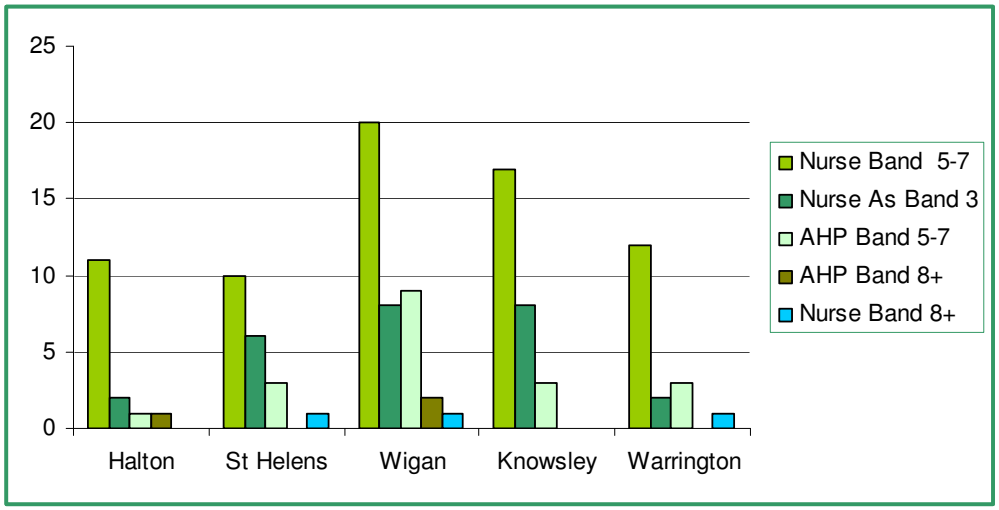


Table 1 shows that the majority of staff (Band 7 and below) working across community services are qualified nurses (N=73). This is followed by Nursing Assistants (N=26) and AHP's (N=19). There is a total of 6 practitioners (3 Nurses and 3 AHP's) working at Band 8 and above.

Table 2 (below) shows that the majority of staff (Band 7 and below) working across inpatient services are qualified nurses (N=73). This is followed by Nursing Assistants (N=82) and AHP's (N=0). There are no practitioners working at Band 8 and above.

In addition to these, there are 3 staff working in in-patients at a Band 2 level, fulfilling a housekeeper role.

Table 2 Breakdown of Older People's Services In-patient Staff

Table 3: breakdown of Medics and Clinical Psychologists working across both Community and Inpatient settings

There are a total of 18 Medics working across inpatient and community services. There are 2 Clinical Psychologists (8b) working in the Wigan Borough only (community).

Local Authority Staff

Our community teams are also supported by local authority staff through a variety of routes. St. Helens council second their social work staff into the CMHT whilst Warrington operates on a more "virtual team" basis. We will continue to work with our local authority colleagues and managers to ensure the best service model is delivered to meet the needs of our service users and carers now, and in the future.

3.3 Challenges: the need for change

Concerns have been raised by service users, carers, clinicians and stakeholders about the increasing demand being placed on existing resources to meet the needs of an ageing population. In recent years there has been a significant increase in older adult referrals, resulting in the present services

not being able to meet the demand in a timely way. Stakeholders have also expressed concern over the waiting times for assessment from specialist mental health services and gaining access to evidence based interventions.

Concerns have also been raised regarding the inequity between adults and older people's mental health services in being able to respond to crisis intervention and providing rapid response services.

The Healthcare Commission (in its national study of older people's mental health services) found that a contentious issue was the perception by some Trusts that services 'based on need, not age' meant that specialist services for older people were no longer required. This led to the Department of Health and the Care Service Improvement Partnership issuing clarification on 'age equality' (Minshull, 2007).

As there is a move away from purely operating from a medical model to a more person centred bio-psychosocial model of care, more attention needs to be paid towards the staffing structure across in-patient and community services. This is to ensure that high quality, evidence based assessment and care can be provided. We believe our current skill and staffing mix limits the availability we have to provide evidence based interventions.

Our proposal attempts to address these concerns, and ensure that the plans for a new service can equitably meet the needs of older people with mental health problems, through the provision of specialist services. The outline of the proposed model has been presented and discussed at a variety of venues within the LLAMS Service User and Carer Forums. (See Appendix

The National Audit Commission's report entitled 'Improving Dementia Services in England' (2007) stated that dementia is a significant and urgent challenge for health and social care. They found significant shortfalls in the NHS in the way care was provided:

- There was a lack of joint working across health and social care services,
- Spending was too late in the illness pathway,
- Too few people were diagnosed with dementia,
- People were not diagnosed with dementia early enough,
- Early interventions that were known to be cost-effective were not widely available.

These themes have been reflected in our redesign proposal. The challenge is for service providers to work collaboratively to facilitate person centred care, where the patient and their carers are able to prioritise their needs and make informed choices about their care which improves quality of life, choice and control, and freedom from discrimination.

During these times of financial constraint, there is even more reason to ensure that our services are provided in the most efficient and clinically effective way, as set out by 'The NHS Quality/Innovation, productivity and prevention challenge: an introduction for clinicians' 2010a (QUIPP).

4. National and Local Strategies and Drivers

4.1 National Policy and Guidance

There has been a growing body of policy and guidance in recent years including:

- The National Dementia Strategy (DOH 2009),
- the white paper '*Equity and Excellence: liberating the NHS*' (DOH 2010)
- the '*Revision to the Operating Framework for the NHS*' (DOH 2010)
- the Department of Health '*Quality Outcomes for people with Dementia*' (DOH 2010)
- the Equality Act (DOH 2010)
- the paper '*No health without mental health: a cross-Government mental health outcomes strategy for people of all ages* (DOH 2011)
- '*Nothing ventured, Nothing Gained: Risk Guidance for people with dementia*' (DOH 2010),
- '*The use of antipsychotic medication for people with dementia: Time for action*' (S. Banerjee 2009)
- Care Services Improvement Partnership paper '*Age Equality: what does it mean for older people's mental health services*' (CSIP 2007)

These publications have been consistent in promoting services based on need and not age, holistic person-centred services, the need for a whole-systems response, integrated mental health services involving service users and carers, supporting carers and supporting people with dementia in the community as far as possible.

The themes and recommendations implicit in these documents underpin the review of the Trust's older people's service provision, and continue to shape our service redesign.

4.2 Quality Initiatives

Innovation is a central focus for the Department of Health and the NHS, as demonstrated by the Quality Innovation Productivity Prevention (QIPP) programme. Organisational innovation and service redesign also have a major role in improving patient care, and lean methodologies are increasingly being adopted into the NHS, boosting efficiency and productivity.

Within the Older People's Business Stream there are a number of Quality Initiatives across the boroughs:

- Essence of Care (EOC) – Rating assessment and peer review has been undertaken across all teams / services / wards to identify areas of good practice. The new model supports the sharing of good practice across the Business Stream.

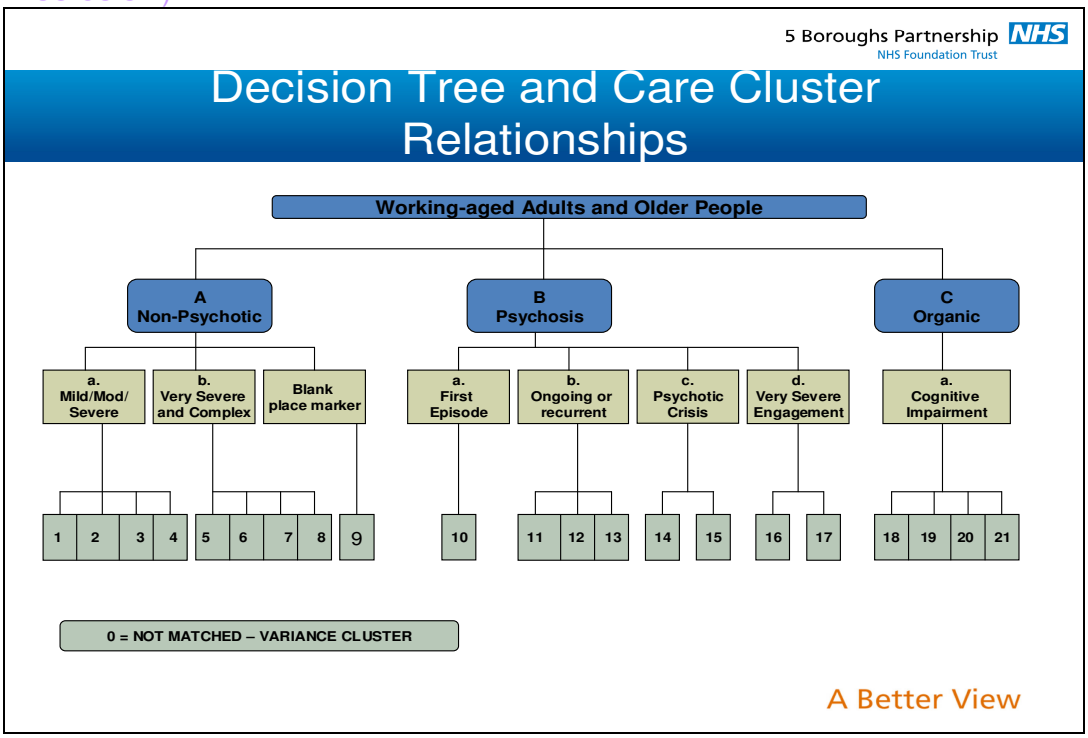
- Accreditation of Inpatient Mental health Services (AIMs) – whilst a number of our existing wards have been successful in gaining accreditation through the Royal College of Psychiatrists' accreditation programme, a number of recommendations for further improvement remain unresolved e.g. access to therapies in the in-patient setting, and single sex accommodation.
- Memory Service National Accreditation Program (MSNAP) – Three of the Trust's memory services have gained accreditation with 'Excellence'. The new model will ensure that 'gaps' identified in this process can be addressed e.g. access to neuropsychological assessment.
- Advancing Quality Initiatives (AQIs) – The Older People's business stream is implementing AQIs relating to in-patient services to improve the quality of inpatient care. Data collection regarding this commenced in December 2010.

4.3 Health of the Nation Outcome Scale (HoNOS) and Payment by Results (PbR)

Part of the Government plan is to 'modernise' the NHS by calculating the price for each transaction and then create a market (revised NHS Operating framework). This moves the contracting of services from a historical block contract basis into a more transparent process which:

- rewards efficiency
- is a fair and consistent basis for funding
- links payments to activity.

The Later Life and Memory Services Business stream has implemented HoNOS across community as well as inpatient services. HoNOS plus is being used as the basis for 'clustering' for Payment by Results (see PbR Decision Tree below).



The proposed new Model directly relates the assessment and intervention processes to the clinical presentation of patients and their resultant PbR cluster (see Figure 1 below).

Figure 1 Needs Led Care Framework

Need 5	(Severe – High Needs) **Risk & Complex case Management** **Interventions** – Intensive Risk and Crisis Management/Inpatient treatment (PBR Clusters Organic 21, Functional 5,6,7,8,13,15,17)
Need 4	**(**Moderate – Severe Need**) Crisis Prevention** **Intervention –** Intensive home treatment, Specialised treatment, Acute hospital liaison (PBR Clusters organic 20,21 Functional 4,5,6,7,8,12,13,15,17)
Need 3	**(**Moderate Needs**) Personalised Symptoms Management** **Intervention –** To work with families to reduce stress, Respite care, Specialist care home clinics, Medication reviews, Family, carer and staff training (PBR Clusters organic 19 Functional 3,4,11)
Need 2	(Mild - Moderate Needs) **Early intervention & Rehabilitation** **Intervention –** To aid with adjustment, Diagnose, Specialist groups, CBT, Cognitive stimulation, Anti dementia drugs, Family and carer support (PBR Clustering 18,19 Functional 2,3,4,11)
Need 1	(Mild Needs) **Self (Family) Management & Health Promotion** **Intervention –** To maintain health and well being, Primary healthcare In home practical social care packages, Day care, Voluntary networks (PBR Clustering organic 18 Functional 1,2)

Analysis of existing open episodes of care has indicated that at present the percentage split across the 5 levels of need are as follows:

Need 5	Need 4	Need 3	Need 2	Need 1
1%	28%	22%	39%	10%

Needs 1& 2 will be provided within the assessment and memory services. Capacity for future increase in demand will be created through implementation of Shared Care arrangements, as a significant proportion of those patients with level 3 needs will be transferred to Primary Care for monitoring. In addition, in-reach into care home settings providing education and advice regarding symptom management will enable those services to meet the service user's needs.

At present, Level 4 specialised treatment is provided by CMHTs and liaison. In the proposed model, the pooled community resource will additionally be able to provide intensive home treatment and crisis prevention. The expectation is that this will reduce the demand for Level 5 in-patient facilities.

4.4 Demographic Factors

The prevalence of organic and functional problems (including depression and dementia) is set to increase significantly as the population ages.

The 'Projecting Older People Population Information System' (POPPI) database identifies key characteristics within that population, projects numbers into the future, and compares future populations against

performance data. The tables below highlight the older adult population across the 5 Boroughs and the estimated prevalence of dementia and depression.

Projected population of over 65s across the 5 Boroughs:

Borough	2008	2010	2015	2020	2025	% Increase
Halton	16,800	17,400	20,300	22,700	24,700	**47%**
St Helens	29,800	30,600	34,600	36,800	39,300	**32%**
Warrington	30,400	31,800	36,400	39,700	43,200	**42%**
Knowsley	17,325	17,400	18,375	19,800	21,750	**26%**
Wigan	48,300	50,900	59,000	63,100	67,400	**39%**
Total	**142,625**	**148,100**	**168,675**	**182,100**	**196,350**	
Increase over 2008	**-**	**4%**	**18%**	**28%**	**38%**	

Projected population of over 65's with dementia across the 5 Boroughs:

Borough	2008	2010	2015	2020	2025	% Increase
Halton	1,123	1,162	1,291	1,472	1,705	**52%**
St Helens	2,007	2,080	2,309	2,613	2,936	**46%**
Warrington	2,101	2,175	2,487	2,832	3,317	**58%**
Knowsley	1,130	1,182	1,309	1,397	1,514	**34%**
Wigan	2,985	3,059	3,449	4,022	4,696	**57%**
Total	**9,346**	**9,658**	**10,845**	**12,336**	**14,168**	
Increase over 2008	**-**	**3%**	**16%**	**32%**	**52%**	

Dementia: The number of people with Dementia relates directly to the over 65 population. The incidence of Dementia increases the older people become. For the combined populations of the five boroughs the increase is forecast to be 82.6% between 2010 and 2030.

Breakdown of the local population and Depression projections for 2030:

Borough	OA Population		Depression	
	2010	2030	2010	2030
Wigan	50,500	75,800	4,364	6,471
Halton	17,300	27,600	1,485	2,374
St. Helens	30,600	43,300	2,653	3,737
Knowsley	23,100	33,300	2,011	2,874
Warrington	31,800	50,900	2,756	4,378
TOTAL	**153,300**	**230,900**	**13,269**	**19,834**

(Data source: POPPI 5.1; Department of Health, 2010)

Looking at this data by percentage change highlights the variances across the 5 Boroughs.

Projected % change from 2010 to 2030:

Borough	OA Population		Depression	
	Increase (2010-30)	Change in 2030	Increase (2010-30)	Change in 2030
Wigan	25,300	50.1%	2,107	48.3%
Halton	10,300	**59.5%**	889	**59.9%**
St. Helens	12,700	41.5%	1,084	40.8%
Knowsley	10,200	44.2%	863	42.9%
Warrington	19,100	**60.1%**	1,622	**58.8%**
TOTAL	**77,600**	**50.6 %**	**6,565**	**49.5%**

(Data source: POPPI 5.1; Department of Health, 2010

Depression: The percentage increase in depression is forecast to match the projected percentage increase in population resulting in a 49.5% increase between 2010 and 2030.

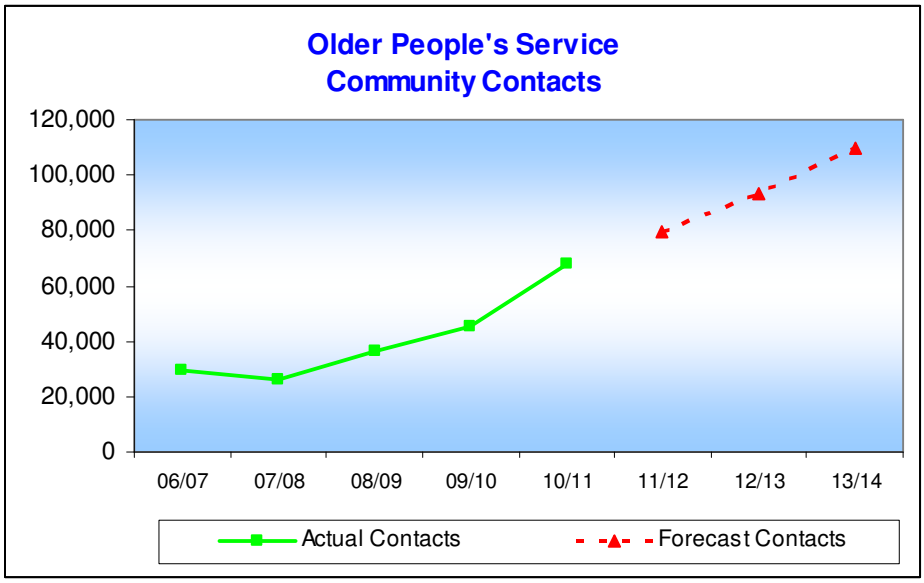
Whilst the percentage increase in Anxiety and Depression is 50% the increase in dementia outstrips this at 83%, indicating that the demographic trend predicts that as the population lives longer the predicted number of people developing dementia will increase disproportionally. Additionally, the clinical presentation will be more complex and severe as the severity of dementia increases with age: 13% of people aged over 65 have severe dementia but this increases to 23% for people over the age of 95.

4.5 Activity Trends

Analysis of activity trends over recent years, along with projections for future performance supports the development of the new strategic business model.

The number of community referrals has been steadily increasing with an average year on year increase of 17.1%. Table 1 demonstrates that between 2006/07 and 2010/11 the total community contacts rose from 29,217 to 66,556, an increase of 127.8%. Community activity is projected to rise further in coming years in line with the demographic changes highlighted previously; between 2010/11 and 2013/14 the community contacts are expected to increase by a further 60.6% to 106,913 per year. In order to meet this level of demand it is necessary to increase the community resource.

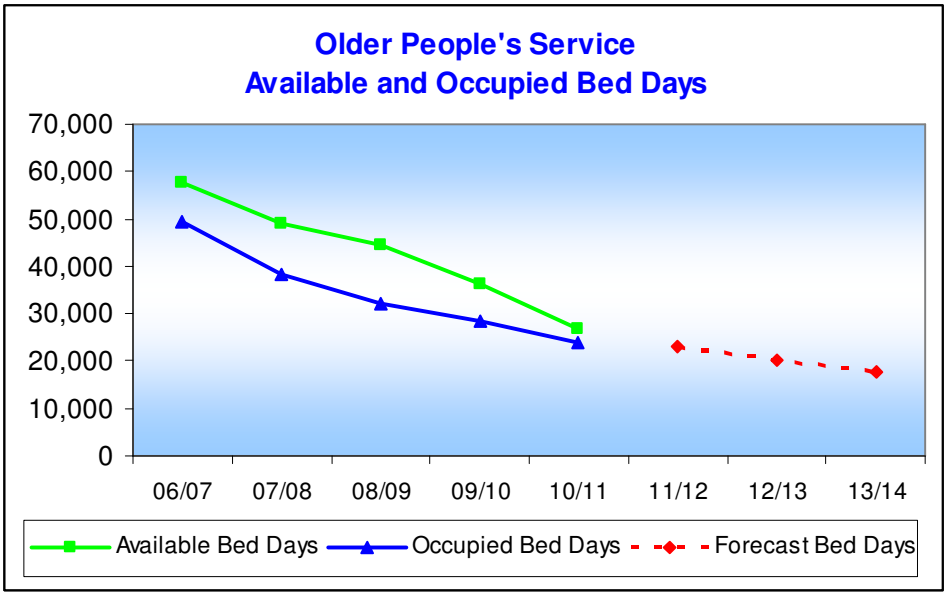
Older People's Services – community contacts



As community resources have increased to meet the 128% increase in community activity, the number of commissioned bed days has reduced as a consequence of the reduced demand of inpatient stay. Our data shows a further increase in community resources is required to meet what we believe will be the increase demand in community activity.

At the same time, evaluation of in-patient use reveals that occupied bed days for older people's services have fallen from 49,505 in 2006/7 to 23,952 (year end forecast) bed days in 2010/11, a reduction of 51.6%. During this period the number of commissioned beds has fallen by 39.8%. Between 2006/7 and 2010/11 average inpatient provision fell from 82.7 days to 51.8 days, primarily as a result of people being better supported in the community, and improved discharge arrangements. Table 2 demonstrates these findings:

Older People's Services – available and occupied bed days



The increase in community resources has been in the following areas;

- Older People Liaison Service provided in the Acute Hospitals
- Assessment, Treatment and Care Services
- Intermediate Care Service- Halton

Interventions by these teams have helped to prevent unnecessary transfers to mental health wards. The majority of service users are now admitted to the wards from their own homes.

With further enhancements to community provision by including Assessment, Care and Treatment Services with Liaison and improving skill mix by introducing Advanced Practitioners, Neuro Psychologists and Dementia Care Advisors, occupancy projections to 2013 demonstrate that further reductions in demands on beds should be achieved.

Scrutiny of admissions in the last year shows an increase in the number of detained patients – from 21% in April 2010 to 48% in February 2011 (Appendix iv). With good, effective community services in place, only those people who cannot be assessed in the community setting need to be admitted to the Trust's wards. Enhancing community services would also therefore enable some of those patients not detained, to have their assessment needs met in their usual place of residence rather than the hospital.

The redesign includes in-patient beds for older people with non-organic presentations. Review of the primary diagnosis of patients admitted (Appendix v) highlights that in 2010/11, 74.7% of admissions were for people with a diagnosis of Alzheimers (N=150), Organic/Dementia (N=140) and 'other' (N=41) presentations which were not functional. 25.3% of admissions were for *non*-organic presentations. This distribution is consistent with the proposed redesign of two single sex wards for organic presentations, and a single ward for older adults with functional conditions, whose needs cannot be met within the Adult Acute setting.

5. Performance Trends

Analysis of performance trends over recent years, along with projections for future performance supports the development of the new strategic model.

The number of community referrals has been steadily increasing with an average year on year increase of 17.1% (Appendix i). Between 2006/07 and 2010/11 the total community contacts rose from 29,217 to 66,556, an increase of 127.8%. Community activity is projected to rise further in coming years in line with the demographic changes highlighted previously; between 2010/11 and 2013/14 the community contacts are expected to increase by a further 60.6% to 106,913 per year. Clearly this level of increase can not be

accommodated within existing services configured as they are, hence the need to realign resource into community settings, thereby strengthening them and equipping them to meet the challenge of increased demand.

At the same time, evaluation of in-patient use (Appendix ii) reveals that occupied bed days for older people's services have fallen from 49,505 in 2006/7 to 23,952 (year end forecast) bed days in 2010/11, a reduction of 51.6%. During this period the number of commissioned beds has fallen by 29.7%, but clearly there is scope to reduce the number of in-patient beds provided by the Trust, and reinvest the savings into community services. Additionally, the Average length of stay has reduced from 82.7 days in 2006/7 to 51.8 in 2010/11 as people are being supported to remain in the community more, and discharge arrangements from in-patients are being facilitated more quickly. Both of these trends put increasing pressure on community services.

Reviewing the source of admissions (Appendix iii) highlights that the number of admissions from General Acute hospital has reduced over the past 5 years, from 210 to 74. This reflects the introduction of Mental Health Liaison services provided in all acute hospitals within the 5 Boroughs footprint. This helps to prevent unnecessary transfers to Mental Health in-patient units. The majority of patients are admitted to mental health wards from home.

Another trend which supports the redesign proposal is the fall in number of delayed discharges. In 2008/9 the number of bed days lost due to delayed discharge was 3515, attributable to 543 patients. In 2010/11 this has fallen to a total of just 774 lost bed days, attributable to just 133 patients. Enhanced community services and integrated working with local authority services will help reduce the delays further.

6. Proposed New Model

The proposed new model reflects the Trust's Strategic Development Objectives, these being to have; Effective and Efficient Organisations, Service Innovations and Business Development, Financial Viability, Governance and Organisational Development.

In line with national drivers to meet increasing demands, absorb increasing costs, concentrate on improving productivity and eliminate waste whilst at the same time focusing on clinical quality (QIPP 2010), there is a need to review pathways into and within the Trust's Older People's services.

This model sets out a new pathway of specialist mental health care that is built on the commissioning intentions of the Alliance strategy 'Securing Better Mental Health for Older Adults' (2009). It is designed to facilitate the development of a comprehensive dedicated Later Life and Memory Service. It will provide a high quality service, focusing on three key dimensions of quality; clinical effectiveness, safety and service users/carers experience (Dazi 2008) by implementing a new streamlined pathway (Appendix vi).

The model establishes a fully integrated Later Life and Memory service which provides three key functions of referral / access, assessment and intervention. This will be achieved by 'pooling' existing older people's community resources within each Borough. This will ensure that the main service provision remains local to its community, providing services that are accessible and meet the needs of its population.

To ensure the successful implementation of the model, the following components are essential:

Integration of Services: the needs of the service user can be met via the new care pathway by linking primary care, hospital care and community care, based on local agreements with a range of providers. Following the core assessment, needs are identified and the appropriate provider will deliver the interventions.

Shared Care arrangements: An agreement is required between the Consultant and the GP regarding transfer of patient under the shared care protocol from secondary to primary care.

Patients will be considered suitable for transfer for GP prescribing when:

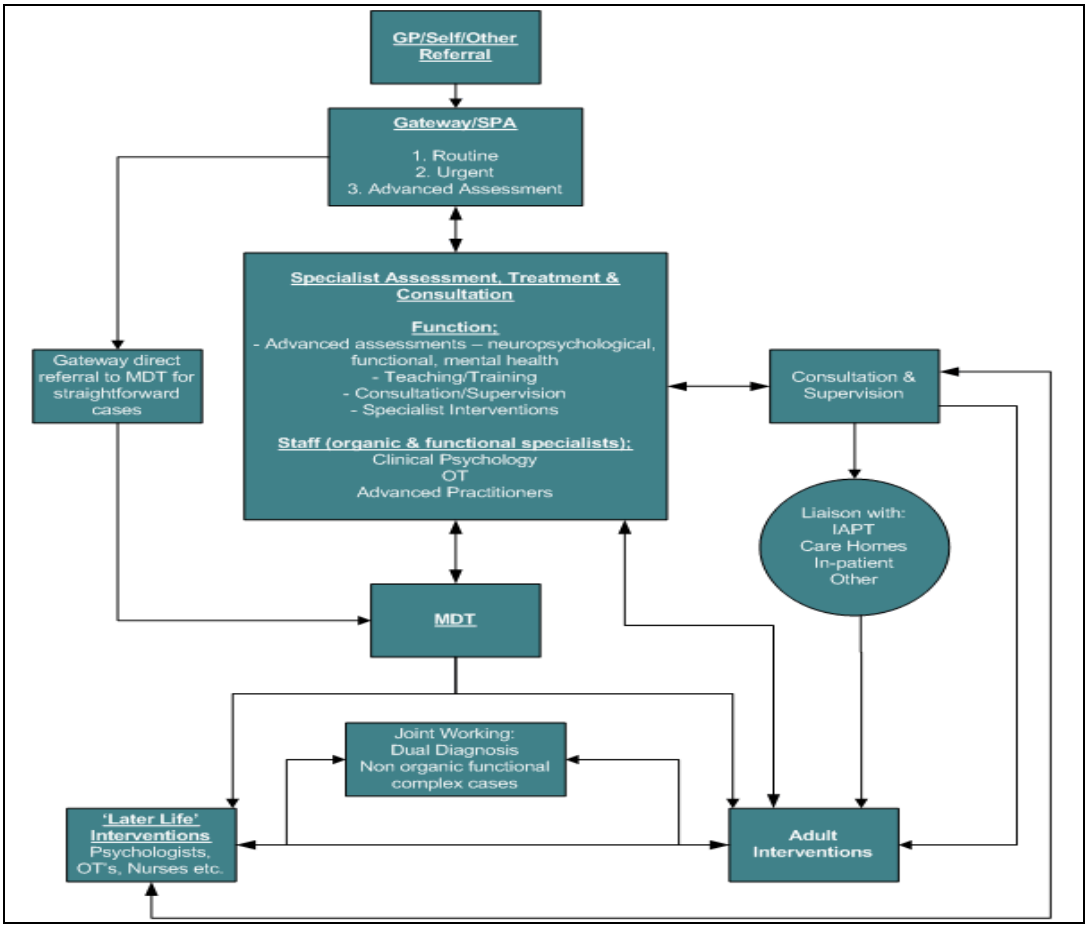
- The patient's condition is stable
- The side effects from medication are manageable
- Drug concordance is established

Training for Partner providers: For the community pathway to be successful, partner providers e.g. care homes need to have staff trained and skilled in the management of people with Dementia. This can be facilitated through attendance at Trust training events, as well as through in-reach from specialist secondary care teams.

Dementia Advisors: Need to be available in each borough, and work in collaboration with later life and memory services.

Acute Physical Care: Access to physical health care providers via robust SLA agreements. This may include links with acute Trust medics as well as other integrated primary care health professionals e.g. Speech and language Therapist, Physiotherapist, Dietician.

Later Life & Memory Services Care Pathway:



6.1 Community Provision

Existing community mental health teams, memory services, assessment and treatment services, and Liaison services in each borough will integrate and by efficient implementation of the new care pathway an 'enhanced community team' will be formed. These teams will be multidisciplinary in nature, and will be able to provide an advanced assessment along with appropriate evidence based interventions and specialist consultation. Essentially, the service user will have their needs assessed and care/intervention provided within one 'umbrella' team, thus reducing the need for multiple assessments, whilst streamlining the pathway to treatment.

6.2 Access and Crisis Management

It is proposed that through integrated working with existing Gateway or Access and Crisis Resolution services, access and crisis intervention functions for older people with a functional illness will be introduced, these services operating extended hours, in line with GP practices. The management of crisis situations for people with Organic presentations out of

hours will be enhanced by the staff from the organic in-patient units providing advice and support directly to service users, or via local authority, or third sector, out of hours, and 5 Boroughs Crisis teams where staff will have the flexibility to work across into the community. Implementation of this model thereby meets the request from stakeholders to provide older people out of hour's services.

Referrals will be screened the same day (Monday – Friday, excluding bank holidays); service users with an organic presentation will enter the older people's service pathway. The use of the Camberwell Assessment of Need for the Elderly (CANE) for screening purposes, will help to identify those service users presenting with a functional illness whose needs would best be met by older people's services rather than adult mental health services. 'Urgent' referrals will receive a face to face assessment on the same day. Routine referrals accepted to the service will be seen within 10 working days.

We recognise that pressure may be placed on community services in delivering the services outlined above within the suggested timeframes, but the introduction of new technology to aid community working will also bring efficiencies in service delivery. The Trust will invest in technology following robust trials to ensure that service improvement and efficiency is assured. Future activity rates are projected and shown in Appendix (i).

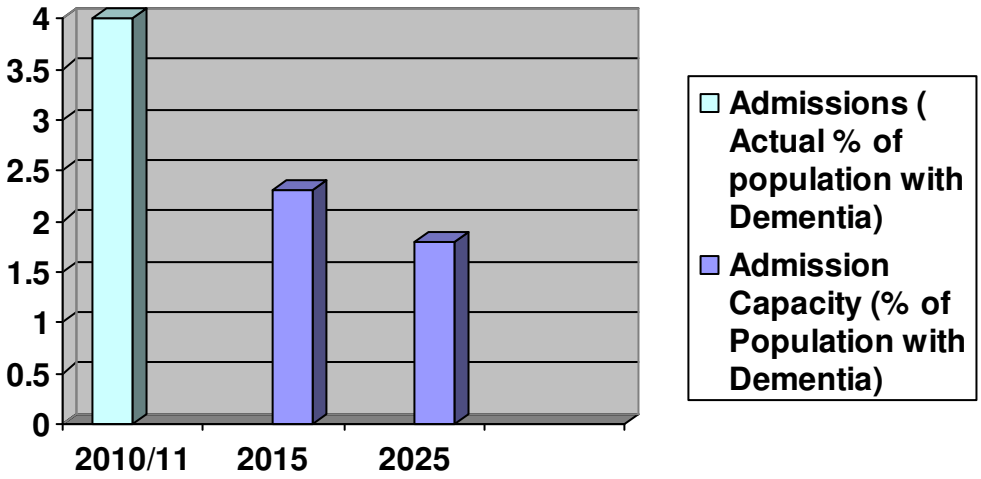
6.3 In-patient Wards

It is evident from the performance data that there is an inverse correlation between the demand for community services and the demand for in-patient beds. Evidence from 'Dementia: The NICE-SCIE Guideline on supporting people with dementia and their carer's mental health and social care' (National Collaborating Centre for Mental Health, 2007) states that people should be assessed and treated in their own home/environment as much as possible. If there are skilled community teams (including outreach services, crisis resolution and home treatment teams), less than 1% of people with dementia should require treatment in an inpatient unit. Applying this percentage to the POPPI data (Department of Health, 2010), and using an average length of stay of 52 days (in 2010-11 it was 51.8 days within the Trust) the demand for in-patient beds can be calculated.

Projected population of over 65's with dementia across the 5 Boroughs:

Borough	2015	1% X 52 bed days	No. Beds Req.	2020	1% X 52 bed days	No. Beds Req.	2025	1% X 52 bed days	No. Beds Req.
Halton	1,291	676	2	1,472	780	3	1,705	884	3
St Helens	2,309	1196	4	2,613	1352	4	2,936	1560	5
Warrington	2,487	1300	4	2,832	1456	4	3,317	1716	5
Knowsley	1,309	676	2	1,397	728	2	1,514	780	3
Wigan	3,449	1820	5	4,022	2080	6	4,696	2444	7
Total	**10,845**	**5668**	**17**	**12,336**	**6396**	**19**	**14,168**	**7384**	**23**

In 2010/11 the Organic bed usage in the Trust was 20,434 bed days, from a population with dementia of 9658, equating to 4%. Implementation of the new pathway enhances the community interventions, and therefore the % population with dementia requiring admission is expected to decrease. Whilst it is acknowledged that achieving a 1% target for admissions may take some time to achieve, the new model has the capacity to accommodate gradual progress towards this.



The projections suggest a reducing demand for beds which mean it will potentially not be cost effective to continue to provide inpatient facilities in each Borough.

The new model offers the opportunity to consolidate older people's in-patient provision onto one site, providing a male organic ward (18 beds), a female organic ward (18 beds) and a mixed sex functional ward for people whose needs cannot be met within the Adult acute setting (12 beds). Whilst it is recognised that Women have a longer life expectancy, and therefore could have a higher demand for in-patient beds, recent trends in bed occupancy has shown that current usage is 44% male to 56% female in terms of number of admissions over a 6 month period. However, the rate of turnover is higher for females, which accounts for the higher percentage. Male patients tend to have more challenging clinical presentations which result in a longer length of stay.

The design of the centre of excellence will allow for flexibility in the use of the beds so that fluctuations in occupancy rates by gender and diagnosis can be accommodated.

Other options considered are outlined below.

1. Maintain current provision of service: Due to greater use of community resources and support, the demand for in-patient care has reduced. Therefore it would be inefficient to continue with the existing service configuration.

2. Two site Option for inpatient care: This would still create inefficiencies in service delivery, because the proposed model involves the implementation of Single Sex accommodation for people with challenging organic presentations. Additionally, it is the intention to provide a functional ward for older people with complex conditions, but there is not the demand to warrant provision on two sites.

6.4 A Single Site

Having the in-patient facilities on one site will allow for current 'gaps' in service provision such as Occupational Therapy, Dietetics, Speech and Language Therapy, Physiotherapy to be addressed, along with access to psychological assessment and intervention whilst service users are in this setting. This approach enables older people's in-patient services to be delivered within a 'Centre of Excellence' for acute mental health care.

The model of care aims to deliver separate male and female dementia wards and a smaller functional old age ward that will manage men and women within the same ward but with completely separate facilities. The ambition is to deliver care from purpose re-designed wards all with single room en-suite shower and toilet facilities. The wards will also provide assisted bathrooms, family visiting facilities, and access to a sensory garden as well as therapeutic activity areas. The overall aim will be to provide a 'homely' environment, with décor and signage specifically chosen to meet the needs of people with organic conditions.

The skill mix will be more integrated and accessible with greater integration of specialists' services.

Experience in the NHS of having specialist services has demonstrated consolidation can be effective in centres such as The Walton Centre NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, and The Christie NHS Foundation Trust.

Evidence tells us that wards for our targeted group should be closely aligned with a "hot" acute site to enable timely access to a full range of diagnostic tests and to allow for improved provision and access to specialist physical health care, which is so often an associated factor in older people's clinical presentations (NICE-SCIE, 2007). The Royal College of Psychiatrists' report 'In-patient care for older people within mental health services' (April 2011) reaffirms that mental health beds for older people, ideally should be based on the same site as a general hospital.

Our Resource and Recovery Centre situated on the Whiston Hospital site is the only site where the Trust has direct access to an A&E department and on site emergency support. Frequently older people are admitted to acute wards for medical or physical related conditions. This change of environment adds to their distress and disorientation. We believe that developing positive working

relations with the key staff in the acute hospital will avoid unnecessary admissions to their wards and minimise distress to a service user.

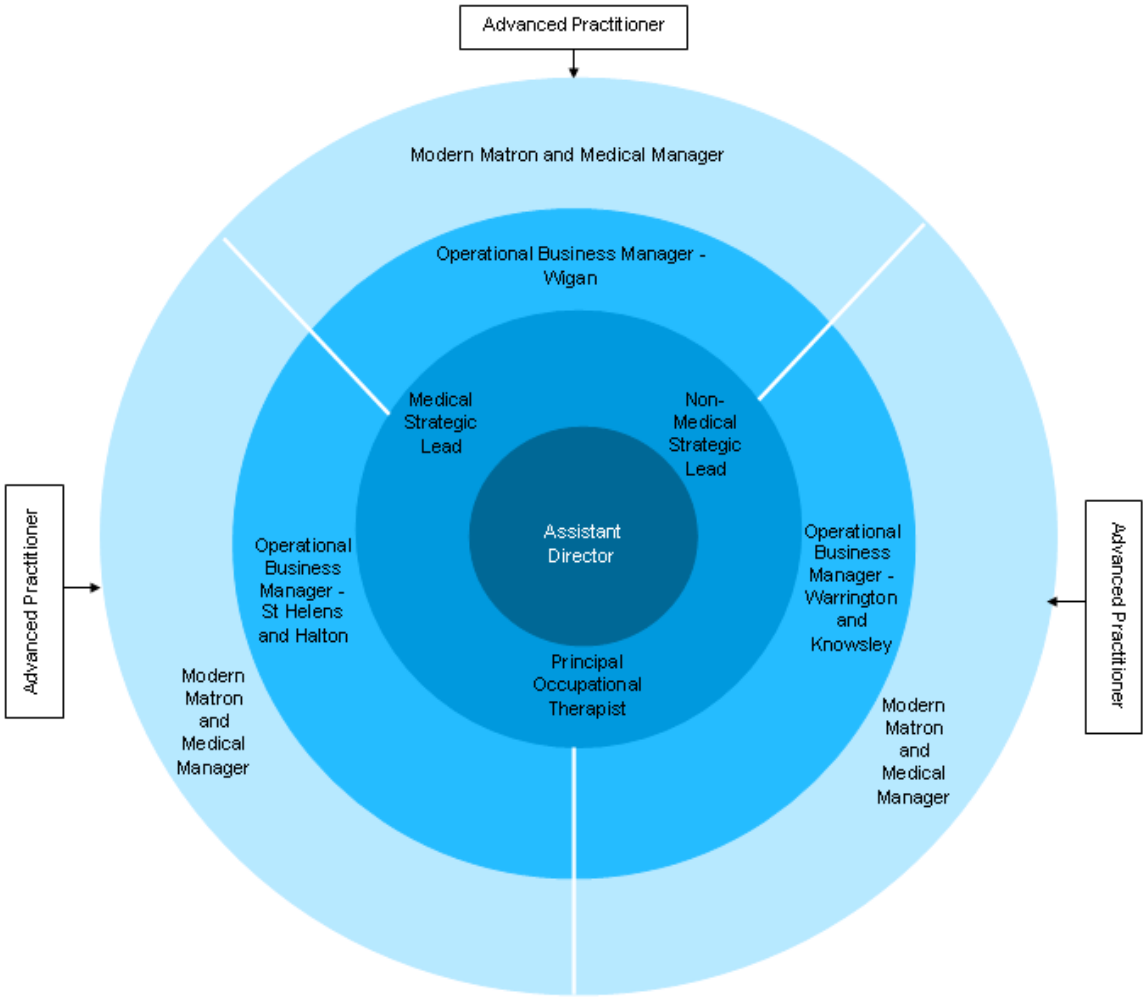
Alternative solutions for the provision of suitable accommodation for a Centre of Excellence for the Trust would involve the construction of a new building on sites that are not adjacent to an acute hospital, and which have therefore been discounted.

The Trust acknowledges that some carers / relatives may find it difficult to travel to the proposed Whiston site, should the service user need an in-patient admission. The Trust is committed to provide travel from current existing in-patient sites to the new Centre of Excellence, should this be required.

6.5 Leadership

To ensure effective leadership and management the new model proposes that each borough has a dedicated integrated clinical leadership team that is fit for purpose to provide key functions. In July 2010 a new leadership structure (Figure. 2) was introduced into older people's services.

Figure 2 Leadership Model (as of July 2010)



The redesign of service provision sets out to deliver the essence of Government strategy, improving awareness of dementia, facilitating early diagnosis and high quality treatment at what ever stage of the illness and in what ever setting (DOH 2009).

7. Evidence-Based Clinical Care

Within the new model, greater emphasis is placed on the provision of *evidence-based* clinical care, in accordance with National Institute of Clinical Excellence (NICE) guidance for both organic and functional presentations.

This includes the reduction in the use of Anti-psychotic medication for older people (DoH 2009) as well as access to the provision of anti-dementia medications at earlier stages of the illness development. Alongside pharmaceutical treatments, evidence based psychosocial interventions will be available for older people with organic and/or functional difficulties.

7.1 Functional Mental Health

Functional problems include: depression, anxiety, schizophrenia, alcohol and drug abuse, suicide, self-harm and neglect. The evidence suggests that older people can benefit from a wide range of psychological therapy to reduce mental health problems, increase quality of life, increase the effective management of long term conditions (including diabetes and heart disease), decrease the rates of suicide and increase independence in the community (Positive Practice Guide, 2009). Psychological therapy can also help to address wider health and social care costs by reducing GP appointments and having less reliance on the prescription of anti-depressants, reducing contact with A&E departments, and reducing admission to mental health in-patient services.

The Spending Review states that by 2015, every patient in the country should be able to get timely access to evidence-based psychological therapies and that money needs to be invested to up-skill staff in therapeutic interventions including: Counselling, Interpersonal Therapy (IPT), Brief Dynamic Therapy and Couple Therapy (Ministers Speech, 2010). At present, the over 65 population accessing IAPT (Improving Access to Psychological Therapies) is approximately 4%, and is significantly less than this in some Boroughs within the Trust footprint. This figure should be around 12%, in line with the demographic and clinical prevalence data. The new model will support service users to access IAPT services and provide training/support to the practitioners working within these services to ensure they are equipped to meet the needs of an older adult population.

The research evidence for the provision of psychological therapies for older people with a functional mental health problem highlights that:

- Psychotherapy for emotional disorders in later life seems comparable in efficacy to medication. (Pinquart et al., 2006)
- Structured multi-component interventions may reduce and delay institutionalisation (Laidlaw, 2008)
- Recent developments in later life anxiety shows evidence for highly specialised CBT for people with cognitive impairment (Mohlman et al., 2008)
- Interpersonal Therapy (IPT) has been modified for older adults with cognitive impairment (IPT-ci). These modifications are expanding its clinical usefulness for increasing sub-group of depressed older adults with cognitive impairment (Mild Cognitive Impairment - 'MCI'; early dementia) who are not usually suitable candidates for psychological therapy (Miller et al., 2005).

7.2 Dementia

Mild Cognitive Impairment (MCI) is a relatively recent concept and is characterised by memory impairment that cannot be explained by normal ageing or by dementia. Research suggests that approximately 40% of people over the age of 65 have age-associated memory loss, with 10% of this population group presenting with an MCI. It is estimated that within one year, 10-15% of people with an MCI will develop dementia, with this rising to 50 % within 5 years.

Memory services should assess this patient group and those identified with an MCI should be followed up by this specialist service in order to monitor cognitive decline (NICE-SCIE, 2007).

The research evidence for interventions for people with MCI indicates that:

- A diagnosis of MCI is an opportunity to identify the patient at increased risk of developing dementia and to initiate treatment that can delay further decline (Pace & Graham, 2008)

- Neuropsychological assessment is helpful in diagnosing MCI and allows for distinctions between the different types of MCI including: anmestic; non-amnestic; single and multiple domain (Rosenburg et al. 2006).

- Individuals with MCI can benefit from a multi-component cognitive rehabilitation programme with regards to Activities of Daily Living, mood and performance (Kurz et al, 2009).

Cognitive rehabilitation is a relatively new approach for improving the well-being and quality of life for people with dementia. Psychosocial interventions can also be provided along with medications and it is possible that these approaches will complement one another in order to maximize the benefits for the person with dementia.

Cognitive rehabilitation enables people with cognitive impairments or deficits to achieve an optimum level of functioning by reducing the disability caused by damage to the brain. Cognitive rehabilitation is used in conditions that result in cognitive deficits such as Alzheimer's disease. Cognitive rehabilitation was initially developed for individuals for non-progressive brain injury; however, it is increasingly being used for progressive conditions as well. Cognitive rehabilitation approaches include restoration of function, compensatory techniques, and environmental modification. These techniques are incorporated with approaches that are directed towards the person's emotional response to their limitations. It is important to target those areas where cognitive deficits affect everyday life. Specific techniques are used to address those areas while the person's emotional responses are addressed (Clare, 2008).

The research evidence for interventions that support people with cognitive impairment suggests:

- Early intervention for memory difficulties in mild cognitive impairment, using cognitive rehabilitation in compensatory strategies, can assist in minimizing everyday memory failures as evaluated by performance on prospective memory tasks and knowledge of memory strategies. (Kinsella et al, 2009)

- Facilitating remaining episodic memory functioning. Where the aim is to build on the remaining episodic memory ability to encourage learning of important new information, or re-learning of previously-known information, a number of guiding principles can be followed. These include providing support at both encoding and retrieval (Bäckman 1992), ensuring effortful processing (Bird and Luszcz 1993), reducing errors during the learning process (Clare, Wilson, Breen, and Hodges 1999; Clare et al. 2000), and encouraging encoding through multiple sensory modalities (Karlsson et al., 1989). Specific methods include spaced retrieval (Camp 1989), cueing (Clare and Wilson 2004; Clare, Wilson, Carter, Roth, and Hodges 2002), simple mnemonics (Clare, Wilson, Breen & Hodges (1999), encouraging semantic processing of material (Bird and Luszcz 1991, 1993) and the use of subject-performed tasks as an aid to encoding (Bird and Kinsella 1996).

- Supporting procedural memory. Where the aim is to improve or restore the ability to carry out selected activities of daily living, action-based learning can be used (Hutton, Sheppard, Rusted, and Ratner 1996). Prompting methods can be used to encourage and support performance of an activity. A schedule of prompts can be devised on the basis of a detailed task analysis; prompts may be verbal or physical. Once performance is well-established, prompts can be faded out. Approaches of this kind can be useful when introducing new external memory aids.

- Supporting semantic knowledge. Approaches used with people who have semantic dementia include repeated rehearsal combined with contextual information (Reilly, Martin, and Grossman 2005; Snowden and Neary

2002), and demonstration of object use (Bozeat, Patterson, and Hodges 2004).

Despite existing knowledge around mental health problems in older people, one of the main obstacles continues to be the lack of appropriate assessment, diagnosis and management of care. Implementation of the new model will seek to address this through the establishment of strong clinical leadership and the training of staff to deliver evidence-based therapies.

Different therapies are useful during different stages of Dementia, as summarised below:

All types and severities of dementia which have co-morbid agitation:

- Aromatherapy
- Multi-sensory stimulation
- Music/Dance therapy
- Animal-assisted therapy
- Massage

People with dementia who have depression and/or anxiety:

- Cognitive Behaviour Therapy (CBT)
- Reminiscence therapy
- Multi-sensory stimulation
- Animal assisted therapy
- Exercise
- Evidence is emerging for other psychotherapeutic interventions including interpersonal therapy and psychodynamic psychotherapy

Psychological interventions in the early stages of dementia: (therapy aimed at enhancing adjustment and mood)

- CBT (modified)
- Life review
- Cognitive rehabilitation approaches

Psychological interventions in the moderate/later stages of dementia: (therapy aimed at increasing well-being and quality of life – usually provided for in residential/nursing homes)

- Cognitive Stimulation Therapy
- Reminiscence Therapy
- Music, dance, arts and craft therapies
- Behavioural management approaches to be pursued before prescribing psychotropic medications

Psychological interventions for late stages of dementia: (therapy aimed at increasing well-being and quality of life – usually provided for in residential/nursing homes)

- Multi-sensory stimulation
- Music therapy
- Animal-assisted therapy
- Hand massage
- Aromatherapy

(NICE-SCIE Guideline, 2007)

7.3 Support for Carers

Evidence suggests that a well supported and resourced carer is a major factor in the long term well being of the person they are caring for. Through close working with other partner agencies (e.g. Alzheimers Society, Carer Support Services) the new model supports Professionals to carry out a carer's assessment and seek to identify psychological distress and the psychosocial impact of the dementia on the carer. This will be an ongoing process and may include a period after the person with dementia has entered residential care.

Carers will have access to a variety of psychosocial interventions including:

- education on dementia (individual or group based)
- access to peer support groups
- support via the telephone or the internet
- supportive counselling
- psychotherapy
- rapid support in crisis
- faith based spiritual assistance

(NICE-SCIE Guideline, 2007)

7.4 Quality of Life in Dementia

Health related quality of life questionnaires that examine the patient's perceptions of their global quality of life (not the number of symptoms they have), has been shown to be extremely important for older people. This is due to the fact that the complex nature of their health status can result in symptom alleviation in one domain but deterioration in another. For example, with regards to cognition, an increase in cognitive impairment does not necessarily result in a decrease in quality of life. (Selai & Trimble, 1999).

There are two popular and evidence based quality of life measures that are used with dementia; Quality of Life-Alzheimer's Disease (QOL-AD; Logsdon et al 2002) and the Dementia Quality of Life (DEMQOL; Smith et al, 2005). The QOL-AD is a brief 13 item measure designed to obtain a rating of an individual's quality of life from both the patient and caregivers perspective. The measure has been developed for use with people with dementia and covers a range of areas including cognition, finances, physical health and

mood. The DEMQOL is a 28 item and 31 item measure and is used to gain a subjective account of quality of life from both the patient (DEMQOL 28 item) and from the caregiver's (DEMQOL-PROXY 31 item) perspective.
The DEMQOL and the DEMQOL-PROXY both provide a reliable way of measuring health related quality of life in dementia. The DEMQOL can be used with mild to moderate dementia whilst the DEMQOL-PROXY is showing promise with severe dementia.

7.5 Integrated teams - skill mix and knowledge

The demand for patient-led services has led to careful thought on the skill mix of teams. The NHS workforce should involve: 1) team working across professional organisations and boundaries, 2) flexible working to make the best of the range of staff knowledge and skills, 3) streamlining the workforce planning and development (based on patient not professional need), 4) maximising the contribution of all staff and implementing New Ways of Working for Consultant Psychiatrists, 5) modernising education and training to ensure staff are equipped with the right skills and 6) expanding the workforce to meet demands (Practice Management Network, 2011).
The LLAMS business stream has developed a training programme in conjunction with the Trust Education Centre. Modules are now available covering core key skills / knowledge including: safeguarding, mental capacity act, Deprivation of Liberty, management of challenging behaviour, and physical health care.

Non-medical staff

There needs to be a clear distinction between clinical leadership and organisational management. Organisational management ensures there are sound policies, procedures and systems for managing staffing matters, finances and information systems. Clinical leadership is focused on strategic vision and driving service improvement and effective team working to provide excellence in patient/client care (Department of Health, 2007). In order for this to happen, senior clinical roles for non-medical staff need to be established. These roles can provide clinical leadership within teams, advanced skills in working with service-users, formal and informal education and supervision of others. They are also essential for meeting legal requirements, for example, under the Mental Health Act and can assist in the recruitment and retention of clinical expertise in the workforce.

Medical staff

The document "New Ways of Working for Psychiatrists" (Department of Health, 2005) values and encourages the use of the advanced skills and competencies of other members of the mental health multidisciplinary team, which in turn, would "free up" the time of the Consultant Psychiatrist so that they can focus on the more complex cases. The document encourages distributed responsibility, effective input and focused leadership from Consultant Psychiatrists. This new Model of Care for our LLAMS is consistent with New Ways of Working. It has an emphasis on a person-centred bio-

psycho-social approach in which the broad training and experience of the Consultant Psychiatrist is fully utilised to enhance the experience of service users and carers.

7.6 Key enablers

Creating time for clinicians is a piece of work currently being developed through discussions with staff, service users and carers. The aim being to obtain representative views on how this could be achieved. The evaluation of the focus groups will determine a way forward. Mobile technology is currently being piloted in some of our clinical areas. We are piloting the use of digital pens, computer tablets and assistive dictation. The evaluation of the pilot will determine what has been successful to enable us to roll out these tools to other areas in the Trust.

7.7 Research

The 5 Boroughs Partnership Foundation Trust has a dedicated research facility with a satellite site based in the Memory Assessment service in Knowsley. Recent research projects have focused on depression, schizophrenia, dementia and Mild Cognitive Impairment (MCI). The MCI trial explores the use of a vaccine to delay the onset of Alzheimers disease. It uses detailed psychometric assessment and neuroimaging to facilitate early diagnosis and treatment. Other projects are exploring the use of psychosocial treatments including music therapy, cognitive stimulation and simulated presence therapy. Future work will explore the use of vitamins as preventative therapies for dementia.

The research team is embedded within the Later Life business stream giving service users the opportunity to participate in cutting edge treatments. It also allows best clinical research practice to be cascaded straight into the heart of our services at the earliest instance.
The Trust is a regional lead in mental health research and has published widely on improving mental health outcomes in later life. This includes showing the effectiveness of Community Memory services in delaying nursing home placement and the reduction of carer distress.
The Trust is also about to publish NICE promoted research on the effectiveness of dementia drugs in severe Alzheimers disease and has recently published guidance on the management of schizophrenia in later life.

8. Estates and Facilities

8.1 Estates

The Trust currently provides services, both in patient and community, across 31 sites within its footprint. Our model of care is committed to providing community services locally. The Care Pathway helps to determine where

service users should receive their assessment and treatment. There are many instances where this will typically be in the service users home, others will require access to a local “out-patient clinic” environment.

8.2 Community estates

As mentioned earlier it is anticipated that service users will receive assessment care and treatment in their own homes if appropriate. If access to out-patient clinics is required or access to group interventions for service users or carers is appropriate then these will be provided locally.

Out-patient facilities will be warm and welcoming and will be fully equipped to carry out assessment, diagnostics and interventions.

8.3 In-Patient Estate

The model of care aims to deliver separate male and female dementia wards and a smaller functional old age ward that will manage men and women within the same ward but with completely separate facilities. The ambition is to deliver care from purpose re-designed wards all with single room en-suite facilities.

Evidence tells us that wards for our targeted group should be closely aligned with a “hot” acute site to enable timely access to the range of diagnostic tests and physical interventions required.

9. Summary of Benefits

There is no doubt that the growth in our older people’s population presents one of the biggest challenges of the coming decades and we can only meet it by working in partnership with a wide range of local and national organisations. Most importantly we must see those who are ageing and their families as partners. Their active engagement is essential if we are to ensure that longer lives are happy, healthy and meaningful lives.

We are committed to working in partnership with key stakeholders and commissioning colleagues, to ensure that service gaps are appropriately addressed. This will enable the delivery of our vision to provide high quality, accessible, community services to support service users in their own homes and communities for as long as possible to promote quality of life. In addition, when in-patient assessment is required, the new model will ensure it is provided in fit for purpose accommodation, delivering the full range of specialist assessment and treatments.

In summary, this new model ‘Building on Strengths’ aims to deliver:

- Extended Opening Hours
- Timely response to assessment

- Rapid Response to urgent referrals, same day face to face
- Single care assessment process
- Improved clinical outcomes
- Improved quality of care
- Reduced psychological distress
- Improved Access to Psychological therapies
- Shorter length of stay in in-patient settings
- Reduced readmission rates
- Coordinated service delivery individual to need and performance
- Needs led services
- Increased interface between services
- Strong leadership presence
- Cost effectiveness
- Improved carer/service user experience
- Improved quality of care in general hospitals
- Reduced use of anti psychotic medication
- Increase in independent living
- Improved outcomes for service users in care homes

10. Mapping the Change

The trust has mapped out the current position to future state which is up to 2014. The following have been developed to support the development of the model -

- A workforce plan to establish what impact the change will have on the existing workforce
- A financial model which includes the impact of estate development within the proposed model
- A service delivery plan to demonstrate all the stages from development, to engagement, consultation and implementation of the model. It describes the milestones, timescales and identified leads
- A training needs analysis to ensure that all staff have the skills and knowledge required to enable them to deliver quality clinical care within the new model
- A consultation and communication plan has been developed.

There is a nominated Business Transformational lead working with the senior managers and a Business Transformation Steering Group established to oversee the projects progress. The Steering Group is overseen by the Trust Operational Management Board.

11. Cost Improvement and Efficiency

Monitor and the Department of Health have published their planning guidance for Foundation Trusts for the foreseeable future. The guidance identifies that each Trust is required to make a 4% cost improvement each year for the next few years.

In 2011/12 and in future it is the PCTs through the national tariff will reduce contracts with Trusts by 4% to reflect this, this money will therefore sit in PCT (or successor bodies') budgets. Trusts will be given uplifts to reflect inflation but this is to offset automatic price increases like pay awards and inflation.

This means that in real terms, year on year the Trust will be 4% worse off and if it doesn't make savings will fall into deficit.

So in order to stand still financially the Trust has to put in plans to improve efficiency and reduce costs by this 4% each year (20% over five years)

The Trust's plans and strategic intent is to make this happen whilst maintaining the level and quality of the services provided to patients and contracted for by commissioners.

Appendices
Appendix (i) Older Peoples Business Stream – Community and Out-patients data

					Forecast Information			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Number of Referrals Received	6,154	5,902	8,841	8,870	11,401			
Number of Total Contacts	**29,217**	**26,389**	**36,187**	**45,486**	**66,556**	**77,948**	**91,289**	**106,913**
Total DNA's	313	1,130	1,201	1,821	2,121			
% DNA's	1.1%	4.1%	3.2%	3.8%	3.1%			
Number of Discharges	3,220	4,918	6,220	7,564	8,132			

% Increase Year on Year Total Contacts		-10.7%	27.1%	20.4%	31.7%			
Average Increase Year on Year					17.1%			

Appendix (ii) Older Peoples Business Stream - In-patients

						Forecast Information			
	2006/07	2007/08	2008/09	2009/10	April 10 to Feb 11	2010/11	2011/12	2012/13	2013/14
Average LOS	82.7	75.7	72.6	71.5	51.8	51.8			
Available Beds	57,763	48,922	44,511	36,075	24,604	26,841			
Occupied Beds	49,505	38,173	31,961	28,283	21,956	23,952			
% Occupancy	85.7%	78.0%	71.8%	78.4%	89.2%	89.2%			
Total Commissioned Beds			118	131	83	83			

Whilst the Trust remains commissioned for 83 beds, it is currently utilising only 69 beds:
Stewart = 12
Grange = 12
Rydal = 6
Kingsley = 16
Sephton = 23
TOTAL = 69

Appendix (iii) Number of Admissions by Admission Source

Borough of Ward	Admission Source	2006/07	2007/08	2008/09	2009/10	April 10 to Feb 11	2010/11
5 Boroughs Partnership NHS Foundation Trust Summary	Local Authority Pt 3 Residential Accommodation	6	12	16	6	3	
	NHS prov - High Security	8					
	NHS provider - WD for general pts or YPD or A&E	210	194	166	103	74	
	NHS provider - WD for Mat or Neonates	2					
	NHS provider - WD for MI or LD	10	1	9	13	13	
	NHS run care home	17	7	4	6	3	
	Non-NHS Hospice (not LA)	1	1				
	Non-NHS Hospital				1		
	Non-NHS Residential Care Home (not LA)	25	15	14	16	19	
	Not Specified				1		
	Penal, Court or Police Stn	2	4	1	1	1	
	Temporary Residence	5	7	9	11	3	
	Usual place of Residence	404	344	354	348	290	
	Total	690	585	573	506	406	

Appendix (iv) Mental Health Act (Sections) Report

Financial Year 2010/11
APRIL 2010 - FEBRUARY 2011

TOTAL Occupied Beds

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	566	563	547	560	462	446	563	514	370	389	428	0	**5,408**
Grange Ward	353	367	359	371	332	331	371	349	319	343	334	0	**3,829**
Stewart Assessment Centre	494	537	561	565	560	558	500	477	466	472	414	0	**5,604**
Sephton Unit	637	669	601	581	575	581	549	633	670	676	640	0	**6,812**
Rydal Unit	0	0	0	0	0	0	0	0	0	140	163	0	**303**
Total on a Section	**2,050**	**2,136**	**2,068**	**2,077**	**1,929**	**1,916**	**1,983**	**1,973**	**1,825**	**2,020**	**1,979**	**0**	**21,956**

Occupied Beds of SECTIONED patients

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	97	74	87	10	45	40	42	78	127	133	145	0	**878**
Grange Ward	173	175	171	151	111	116	88	125	151	190	181	0	**1,632**
Stewart Assessment Centre	66	113	118	122	30	48	85	178	212	120	214	0	**1,306**
Sephton Unit	101	111	155	151	161	162	105	153	176	297	401	0	**1,973**
Rydal Unit	0	0	0	0	0	0	0	0	0	25	7	0	**32**
Total on a Section	437	**473**	**531**	**434**	**347**	**366**	**320**	**534**	**666**	**765**	**948**	**0**	**5,821**

Percentage Occupancy of SECTIONED patients

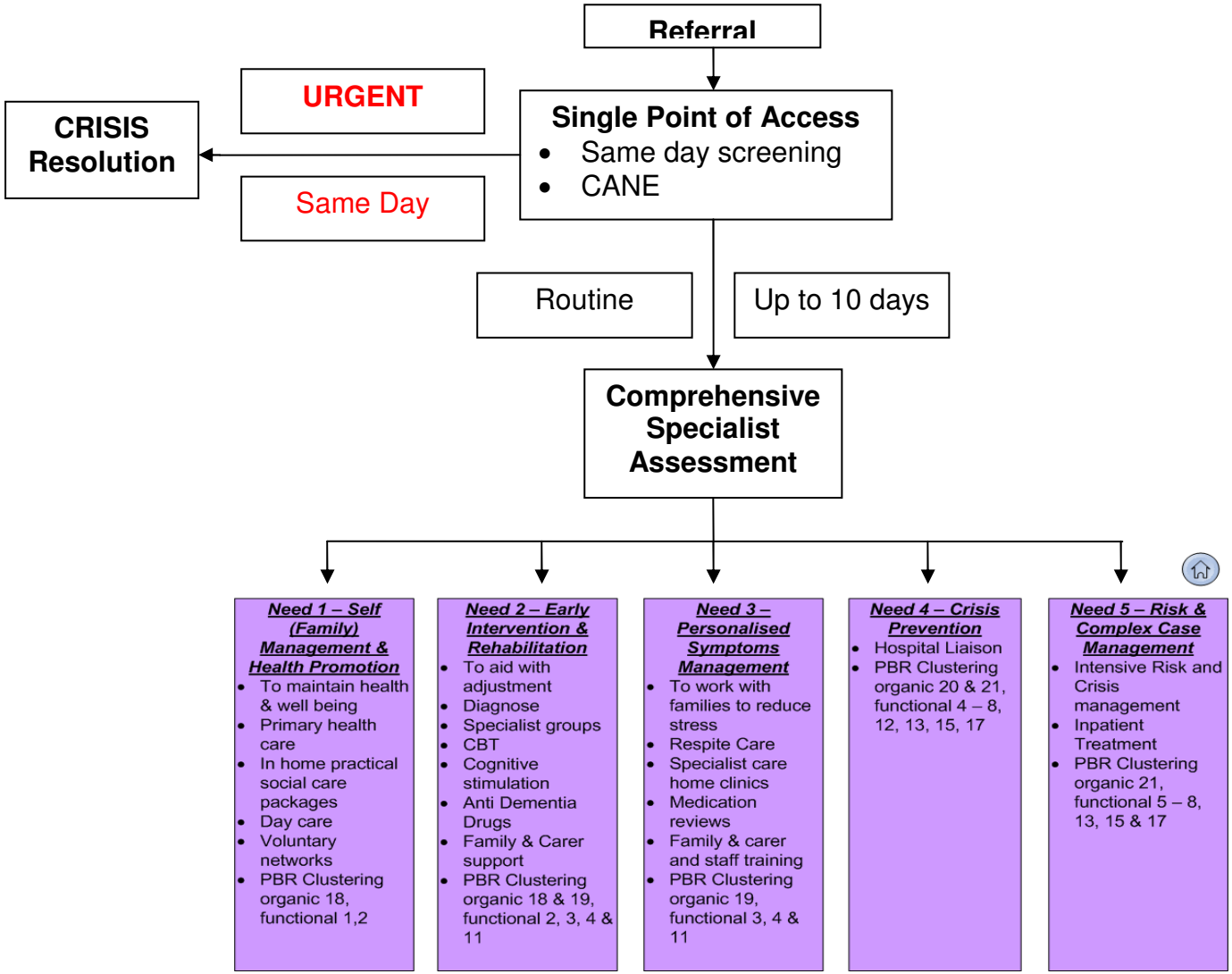
PCT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	17%	13%	16%	2%	10%	9%	7%	15%	34%	34%	34%		**16%**
Grange Ward	49%	48%	48%	41%	33%	35%	24%	36%	47%	55%	54%		**43%**
Stewart Assessment Centre	13%	21%	21%	22%	5%	9%	17%	37%	45%	25%	52%		**23%**
Sephton Unit	16%	17%	26%	26%	28%	28%	19%	24%	26%	44%	63%		**29%**
Rydal Unit	-	-	-	-	-	-	-	-	-	18%	4%		**11%**
% on a Section	21%	22%	26%	21%	18%	19%	16%	27%	36%	38%	48%		**27%**

Appendix (v) Diagnosis Data

All Patients admitted in year with Primary Diagnosis as below

Primary Diagnosis	2006/07	2007/08	2008/09	2009/10	2010/11
Alzheimers	120	95	111	167	150
Anorexia nervosa				1	
Antiparkinsonism drugs					1
Disorders of adult personality and behaviour	2		1	1	1
Huntington's disease					1
Mental and Behavioural Disorders	8	12	10	12	4
Mood Disorders	155	105	92	95	58
Need for continuous supervision	1				
Neurotic, stress related	41	28	39	25	6
Organic/Dementia	206	154	227	184	140
Other	65	70	51	40	41
Parkinson's disease	6	5	14	9	5
Schizophrenia	42	50	35	27	24
Unknown	80	81			
(blank)					
Observation	2	8	3		12
Grand Total	**728**	**608**	**583**	**561**	**443**

Appendix (vi) New Streamlined Pathway



(Appendix vii) New Community Pathway – Pilot Project

Rationale

In order to demonstrate the effectiveness and efficiencies that can be achieved by implementing the new community pathway for LLAMS, we intend to Pilot the new way of working in one Borough.

Methodology

The project will run from January 2012 for an initial period of 6 months. At this stage a review will take place which examines the changing patterns of service usage i.e. Response rate to referrals, bed occupancy, Length of Stay, Demand for 'Extended Hours services', impact of shared care arrangements and benefits of integrated working with local authority and non-statutory agencies.

After this review, consideration will be given to expanding the Pilot across another Borough for a further 6 months. At 12 months, a full review will take place to examine the evidence and inform full implementation of the new Model.

Option Appraisal to determine site for Pilot

In order to determine the best site to run the pilot, the following criteria matrix was used, highlighting key components of the LLAMS proposed new pathway:

	HALTON	St.HELENS	WARRINGTON	KNOWSLEY	WIGAN & LEIGH
Single point of Access			✔	✔	✔
Memory Service Including:	✔	✔	✔	✔	✔
Specialist nurse	✔	✔	✔	✔	✔
Psychology					✔
Social worker		✔			✔
OT	✔		✔	✔	✔
Counsellor					✔
Dementia Advisors			✔	✔	✔
Admiral Nurse service				✔	
OPCMHT	✔	✔	✔	✔	✔
Liaison service	✔	✔	✔	✔	✔
Care Home inreach (advanced practitioner)	✔		✔		✔
Shared Care		✓			✔
Extended Hours					
Crisis / Home Treatment					

Based on the above criteria, Wigan & Leigh meet the majority of the requirements of the new model.

Gap Analysis

None of the existing services currently provide extended hours or Crisis and Home Treatment services. We do not want to introduce another pathway into services which could become confused with the adult crisis and home treatment service and therefore a clear criteria and system will be developed to avoid this from occurring.

Recommendation

It is recommended that the Pilot is run in the Wigan & Leigh Borough, and that to facilitate implementing the extended hours and Crisis service functions additional funding is made available for additional staffing:

Band 6 Specialist Nurse Practioner	1 wte
Band 5 Nurse Practitioner	1 wte
Band 3 Health Care Support Worker	1 wte

This will allow the service to operate between the hours of 9am – 9pm Monday to Friday, and 9am – 1pm Saturdays.
Some preparation work will be required to take place between the Trust and the Emergency Duty Team to avoid duplication and ensure effective communication takes place during the pilot.

Outside these hours, crisis response will be provided by existing services within the Local Authority Emergency Duty Team and Acute Trust A&E.

(Appendix viii)

LLAMS Service User and Carer Forum

Dates 2011	Venue
Tuesday 8th February	United Reform Church St Helens, Ormskirk Street, St Helens, WA10 1BQ
Tuesday19th April	Legends Bar Leigh Sports Village Leigh Stadium Sale Way Leigh WN7 4JY
Monday 13th June	Huyton Suite Knowsley Civic Way, Liverpool, Merseyside L36 9GD
Tuesday 9th August	The Foundry Halton 65 Lugsdale Rd Widnes, Cheshire WA8 6DA
Tuesday 18th October	Winwick Leisure Centre, Myddleton Lane, Winwick, Warrington, WA2 8LQ
Tuesday 13th December	St Helens, World of Glass

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