Consultation Paper

4 April 2007

Older People’s Mental Health (OPMH) Service (Harrogate and Rural District) In-patient bed capacity evaluation and proposal for future service provision

Alison Laver, Modernisation Manager, Older People’s Mental Health Services

For further information please contact Dr. Laver on 01765-692677 or e-mail to a.laver@btopenworld.com

(AJL/March07/redesign)
# INDEX

<table>
<thead>
<tr>
<th>Summary</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 1: CONTEXT</td>
<td>3</td>
</tr>
<tr>
<td>1.1 OPMH Service users</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Background</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Description of the OPMH Community Units for the Elderly</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Introduction to the evaluation</td>
<td>6</td>
</tr>
<tr>
<td>1.5 Areas to be measured</td>
<td>6</td>
</tr>
<tr>
<td>SECTION 2: RESULTS and DISCUSSION of EVALUATION</td>
<td>9</td>
</tr>
<tr>
<td>2.1 Delayed transfers of Care</td>
<td>9</td>
</tr>
<tr>
<td>2.2 Bed occupancy</td>
<td>17</td>
</tr>
<tr>
<td>2.3 Readmission rates</td>
<td>22</td>
</tr>
<tr>
<td>2.4 OPMH Bed availability</td>
<td>23</td>
</tr>
<tr>
<td>2.5 Availability of OPMH beds for Respite Admissions</td>
<td>26</td>
</tr>
<tr>
<td>2.6 Staffing Levels</td>
<td>29</td>
</tr>
<tr>
<td>2.7 Staff short term sickness rates</td>
<td>30</td>
</tr>
<tr>
<td>2.8 RRICE referrals</td>
<td>32</td>
</tr>
<tr>
<td>2.9 Community Mental Health Team (CMHT) waiting lists</td>
<td>34</td>
</tr>
<tr>
<td>2.10 Capacity for Funded Nursing care reviews</td>
<td>39</td>
</tr>
<tr>
<td>2.11 Conclusion</td>
<td>39</td>
</tr>
<tr>
<td>SECTION 3: OPMH SERVICE REDESIGN PROPOSAL</td>
<td>42</td>
</tr>
<tr>
<td>3.1 Summary of redesign proposal</td>
<td>42</td>
</tr>
<tr>
<td>3.2 Increase the capacity of the Community Mental Health Team service</td>
<td>42</td>
</tr>
<tr>
<td>3.3 Re-provision of some secondary care work in an OPMH Primary Care Mental Health service (PCMHS)</td>
<td>47</td>
</tr>
<tr>
<td>3.4 Increase in-patient nursing capacity</td>
<td>52</td>
</tr>
<tr>
<td>3.5 Partner with other agencies to provide joint weekend day care</td>
<td>53</td>
</tr>
<tr>
<td>3.6 Increase the mental health liaison nurse hours</td>
<td>53</td>
</tr>
<tr>
<td>3.7 Increase capacity in psychology assistant post</td>
<td>55</td>
</tr>
<tr>
<td>3.8 Increase medical secretarial support for Old Age Consultant Psychiatrist</td>
<td>55</td>
</tr>
<tr>
<td>3.9 Enhancing collaborative working to deliver integrated care pathways</td>
<td>56</td>
</tr>
<tr>
<td>3.10 Re-provision: Outcomes Intended</td>
<td>57</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>60</td>
</tr>
</tbody>
</table>
INDEX (continued)

<table>
<thead>
<tr>
<th>LIST OF ABBREVIATIONS</th>
<th>62</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX A</td>
<td>64</td>
</tr>
<tr>
<td>Harrogate and Rural OPMH Service: Evaluation of reducing bed numbers during refurbishment of The Orchards</td>
<td></td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>69</td>
</tr>
<tr>
<td>Harrogate and Rural OPMH Service: Evaluation of reducing bed numbers during refurbishment of The Orchards Form for recording availability of beds for respite admission</td>
<td></td>
</tr>
<tr>
<td>APPENDIX C</td>
<td>70</td>
</tr>
<tr>
<td>Harrogate and Rural OPMH Service: Evaluation of Reducing bed numbers during refurbishment of The Orchards Form for recording availability of beds for transfers from General wards</td>
<td></td>
</tr>
<tr>
<td>APPENDIX D</td>
<td>71</td>
</tr>
<tr>
<td>Average daily number of available and occupied beds by sector, England, 2005-06</td>
<td></td>
</tr>
<tr>
<td>APPENDIX E</td>
<td>72</td>
</tr>
<tr>
<td>Budget for proposed redesign of Harrogate and Rural OPMH services</td>
<td></td>
</tr>
</tbody>
</table>
NORTH YORKSHIRE AND YORK PRIMARY CARE TRUST

Consultation Paper for NYYPCT PCT
Provider Committee

29 March 2007

Subject: Older People’s Mental Health (OPMH) Service:
In-patient bed capacity evaluation and future service provision

Report From: Alison Laver, Modernisation Manager
Older People’s Mental Health Services

Summary
This paper presents the results of an in-patient bed capacity evaluation and recommends to the Provider Committee that the results of the in-patient bed capacity evaluation support the permanent reduction of OPMH in-patient bed capacity to 36 beds.

It recommends that 20 beds remain located on Rowan ward at Harrogate District Hospital and 16 beds are located in one of the two community units for the Elderly (CUE) at either The Orchards in Ripon or Alexander House in Knaresborough.

It recommends that following this change staff and resources be used to support service redesign within OPMH.

It recommends that public consultation is now required to seek:
- views on the reduction of OPMH in-patient bed capacity from 52 to 36 beds.
- views on the location of CUE bed provision for the future, seeking in particular the case for and against locating these beds at either The Orchards or at Alexander House.
- views of the OPMH service redesign proposal and the planned changes in service provision

SECTION 1: Context

1.1 OPMH Service users

The ‘service users’ of OPMH are people over 65 years who have organic and/or functional mental health problems and younger adults who have been diagnosed as having dementia. Organic mental health problems include a range of conditions generally called ‘dementias’. Functional mental health problems (such as depression, anxiety, prolonged grief reactions, phobias, and drug and alcohol dependency) in older people can present in a wide range of ways and are often masked by concurrent physical illnesses or social
changes. Service users of our OPMH services can broadly be divided into four categories:

1. older people with organic illnesses (dementias);
2. younger people with organic illnesses (dementias);
3. older people who have developed a functional mental illness after the age of 65 years;
4. people who have had a long-term mental illness and who have reached old age.

1.2 Background

In March 2006 the Craven, Harrogate and Rural District (CHARD) Primary Care Trust (PCT) Board approved the refurbishment of the Orchards Community Unit for the Elderly (CUE) residential unit in Ripon and the proposal to use the refurbishment as an evaluation period to assess the impact of operating the older people’s mental health (OPMH) service with 36 beds. Redeployment of staff from the CUE during the refurbishment period enabled some evaluation of the potential for improvements proposed by reconfiguration. The 28 March 2006 paper to the Board proposed that any staffing and resources released through the reduction in bed capacity would assist in service redesign within Older People’s Mental Health (OPMH) services in order to deliver a service that is fit for purpose, addresses national guidance and meets local needs. Proposals for redesign include:

- enhancing the community mental health team (CMHT), psychology, mental health nurse liaison and remaining in-patient services;
- enhancing the primary care mental health service (PCMHS) to support older people with mild to moderate mental health problems, thus shifting service provision from secondary to primary care;
- and providing a joint health and voluntary sector staffed weekend day care service in one CUE day hospital and increased 3rd sector commissioning.

The full 28 March 2006 paper “Older People’s Mental Health (OPMH) Service: Refurbishment of the Orchards Residential Unit and future service provision” described:

- service capacity and demand issues;
- national policy drivers;
- implications related to the proposed refurbishment and possible service reconfiguration;
- planned support for the individuals involved;
- financial impacts;
- human resource impacts.

1.3 Description of the OPMH Community Units for the Elderly

Alexander House Community Unit for the Elderly (CUE) is a purpose built unit situated within the community in Knaresborough. It comprises a residential unit and Alexander House Day Hospital specialising in the care of the elderly who have mental health problems. These services provide assessment and treatment for organic and functional mental illness. The
Residential unit has facilities for 16 patients (both male and female). The unit is staffed on a 24 hour basis by qualified Registered Mental Nurses (RMNs). The day hospital has 15 places per day and is open Monday to Friday (excluding Bank holidays) 08.30 to 16.30 and is staffed by RMNs. Alexander House is additionally staffed by health care assistants (HCAs) general assistants (GAs) and Occupational Therapy Technical Instructors. The CUE is also the base for two OPMH community mental health teams and the specialist service for younger people with dementia.

The Orchards is a purpose built unit within the Ripon community providing 16 residential places and a 10 place Day Hospital specialising in the care of the elderly who have mental health problems. These services provide assessment and treatment for organic and functional mental illness. The Orchards residential unit is staffed on a 24 hour basis by qualified Registered Mental Nurses (RMN). The day hospital is open Monday to Friday (excluding Bank holidays) 08.30 to 16.30 and is staffed by RMNs. The Orchards is also staffed by health care assistants (HCAs) general assistants (GAs) and Occupational Therapy Technical Instructors. The Orchards provides a range of services including assessment, respite care and continuing care where appropriate. The day hospital offers flexible package of treatment for time limited periods. The unit is also a satellite base for the OPMH Rural community mental health team, which provides a comprehensive community service for older people with mental health problems.

Alexander House and the Orchards CUES offer the following service:
- provide a comprehensive assessment of the service user’s needs, including an assessment of risk, in collaboration with carers and family members where appropriate;
- staff develop, monitor and review needs based written care plans for each service user, in conjunction with CPA guidelines;
- offer tailored treatments and interventions;
- provide respite in support of vulnerable clients and carers;
- conduct regular reviews/evaluations of the effectiveness of treatments and interventions;
- maintain effective working relationships with other relevant statutory and non-statutory services which contribute to the client’s care plan;
- ensure that good systems of communication and collaborative working exist with other elements of mental health services so that continuity of care for each person who uses the service is maintained.

The CUEs provide a service for people over 65 years of age with organic and/or functional illness, requiring a period of in-patient or day hospital assessment. The CUEs also serve people with younger onset dementias where the service is the best fit for the person’s needs. This includes the following mental health problems:
- cognitive impairment (dementia)
• severe and persistent mental disorders associated with significant disability (functional mental illnesses, e.g. psychoses, affective disorders)
• any mental disorder where there is significant risk of self harm or harm to others
• complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983).
• anxiety related illnesses (clients with these illnesses would usually attend the Day Hospital only)

1.4 Introduction to the evaluation

The Orchards Residential Unit was closed for refurbishment on 10 October 2006 and refurbishment was completed in December 2006. Data was collected for a four month period from 10 October 2006 to 10 February 2007 to evaluate the impact of reducing in-patient bed capacity. The results of the evaluation of in-patient bed capacity within the Harrogate and Rural Older People’s Mental Health service are presented within this paper.

The evaluation proposal was discussed with:
• Harrogate and Rural District Strategic Planning Group for Older People’s Mental Health Services (an interagency group with representation from statutory and non-statutory providers)
• OPMH senior clinicians and managers
• a group of carers of people with dementia at a meeting organised by Alzheimer’s
• Ripon Council for Voluntary Services (CVS) staff
• Rural District Working with Local Communities Initiative (WWLCI) group
• Harrogate and Knaresborough Working with Local Communities Initiative (WWLCI) group.

There was agreement across the stakeholders, who were engaged in discussion at these meetings, that the areas identified for evaluation were reasonable measures for establishing the impact of reducing beds numbers, not just on health services but also across the wider health and social care system.

1.5 Areas to be measured

A combination of both qualitative and quantitative measures were identified for the evaluation. Bed capacity can be influenced by a wide range of variables, some of which fall outside of the control of the health service, such as funding for and availability of long-term care placements. It was considered important to acknowledge that in-patient provision is part of a complex system of services for older people with mental health problems and to attempt to
explore all those variables that stakeholders considered could influence bed capacity and community service provision.

Delayed transfers of Care (DTOC)
Evaluate any changes in delayed transfers of care and pending delays discussed at fortnightly situation report (SITREPS) meeting, record:
- Number of DTOC and % of total bed capacity
- Bed days waiting
- Category (self funding, continuing care etc.)
- Reason for wait (lack of suitable placement, waiting for place of choice, waiting for funding)

Bed occupancy
Evaluate any changes in bed occupancy.
- Record percentage (%) bed occupancy for OPMH beds at Alexander House residential unit and Rowan ward

Readmission rates:
Evaluate any changes in readmission rates, record:
- Number of readmissions to OPMH beds at Alexander House residential unit and Rowan ward

Staffing Levels:
Monitor where staffing levels have to be increased above the usual level owing to increased dependency levels amongst patients, record:
- Number and type of additional staff required.
- The reason for increased staffing levels.
- The length of duration of increased staffing level.

Bed availability:
Evaluate whether the OPMH service have beds available for timely admissions when needed:
- Crisis admissions from the community
- Transfers from General wards

Respite admissions:
Evaluate whether the amount of respite received by service users / carers currently getting planned respite is not negatively impacted. Evaluate whether the service can meet demand for new respite admissions and for respite / assessment admissions when needed, record:
- Number of booked respite admissions cancelled and reason for cancellation.
- Number of planned regular respites where length of respite stay was reduced from usual amount of respite received.
- Number of respites that have to be changed and rebooked and the length of the delay from planned respite date to actual respite received.
Rapid Response and Intermediate care for Elderly Mentally Ill (RRICE) team:
Evaluate any increase in demand on RRICE service, record:
  • Monitor any changes in referral rates
  • Monitor capacity and waiting time issues

Rural and Harrogate and Wetherby OPMH Community Mental Health Teams (CMHT)
Evaluate any increase in demand on CMHT service. If staff are redeployed to CMHTs during refurbishment evaluate the impact of increased staff capacity on meeting the demand, record:
  • Waiting list numbers and category
  • Waiting times
  • Caseload size

In most cases this data was already being collected and baseline data was available for comparison with the four month evaluation period data. In some cases additional processes and data collection forms were developed. These were implemented from 1 September 2006 (please see Appendices A, B and C).
SECTION 2: OPMH Evaluation - Results and Discussion

Hypotheses were developed based on concerns raised by OPMH staff and wider stakeholders including carers of older people with mental health problems and colleagues from social care and voluntary organisations providing services for older people with mental health problems and / or their carers.

2.1 Delayed transfers of Care

2.1.1 Definitions
A delayed transfer of care (DTOC) occurs when a patient is ready for transfer from an acute mental health bed, but is still occupying such a bed. A patient is ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer;
- and a multidisciplinary team (MDT; usually comprising health and social care professionals) decision has been made that the patient is ready for transfer;
- and the patient is safe to discharge or transfer (package of care or appropriate placement is available).

(Definition drawn from the Community Care (delayed discharges etc) Act 2003)

Within the OPMH service a person categorised as pending is someone the MDT have identified as moving towards a target discharge date. This category has been used, in line with acute services at Harrogate District Foundation Trust, to alert commissioners and clinicians to forthcoming discharges in order to facilitate proactive discharge planning.

2.1.2 Hypotheses

Hypotheses to be evaluated:

- that a reduction in bed capacity will lead to an increase in delayed transfers of care.
- that a reduction in bed capacity will lead to an increase in the percentage of OPMH beds occupied by people who are DTOC.

Linked to this hypothesis was a concern amongst some stakeholders that the joint effort of health and social care staff to move all people who were delayed transfers of care in a short time period by October 2006 in order to close the Orchards for refurbishment would place a pressure on independent long-term care bed capacity and budgets for placements resulting in a subsequent challenge to place future people who became delayed transfers of care. Concern was also expressed that the significant improvements in reducing DTOC over the past three years might be compromised by a decrease in bed capacity. In August 2003, when the local Delivery Plan (LDP) bid was developed for the Rapid Response and Intermediate Care for Elderly Mentally Ill (RRICE) service, delayed transfers of care (DTOC) within OPMH stood at
26 which was 50% of the 52 bed capacity. Following LDP funding for the new RRICE service targets were set to reduce DTOC as follows:

- Year 1: 01/04/04 - 31/03/05: reduce delayed transfers of care by 25% (6.5 delays)
- Year 2: 01/04/05 - 31/03/06: reduce delayed transfers of care by 35% (9.1 delays)
- Year 3: 01/04/06 - 31/03/07: reduced delayed transfer care by 50% (13 delays)

Three years later in August 2006 the DTOC were 6 which was a reduction of 20 delays = 76.9% reduction.

### 2.1.3 Number of DTOC

**Figure 1** provides a graph which shows the number of delayed transfers of care, the number of pending delays and the total number of cases reviewed at situation report (SITREP) meetings for a baseline period of four months prior to the closure of the Orchards for refurbishment and the four month evaluation period. Data was reported fortnightly. As can be seen from Figure 1, during the four month baseline period DTOC ranged from 4 – 12, pending cases from 9 – 19 with total SITREPS ranging 19 – 26 this compares to the four month evaluation period when DTOC ranged from 2 – 10, pending cases from 5 – 17 and total SITREPS ranging 15 – 20 cases.

The graph in Figure 1 appears to show the impact of the concerted, joint effort by health and social care staff to move all people who were delayed transfers of care by October 2006 in order to close the Orchards for refurbishment and the lowest number of DTOC (n = 2) were observed shortly after the closure of the Orchards. Since early December numbers of delays have been held within a close range of between 7 – 10 cases. The graph shows an increase in pending delay cases during July 2006. Staff report this was related to a review of those people who had occupied beds at the Orchards on a longer term basis. Following reassessment and it was agreed their needs could be met elsewhere so they were placed on the pending list whilst the relevant assessments and discussion with the service user, family and social care colleagues took place regarding placement and funding options. During November we see the number of people who are pending delay reducing as people were transferred to the DTOC list. Since December 2006 the number of pending delays have been held within a close range of between 5 – 10 cases. Staff report that a positive impact from the project has been an increased joint working between health and social care colleagues and an increased focus on early discharge planning and proactive work with people who are identified as pending delays.
Situation reports

Figure 1
In terms of targets associated with a reduction in DTOC, during the evaluation period DTOC ranged between 2 – 10, compared with the 26 DTOC recorded in August 2003 this represents a 92.3 – 61.1% reduction in DTOC. Even at the higher end of this range (10 DTOC) the OPMH service have comfortably met our target of reducing delays by 50% for the 06/07 period despite the reduction of bed capacity in October 2006.

One variable that needs to be mentioned is changes to the numbers of registered beds (including provision for nursing, residential and challenging behaviour placements) which has occurred during the baseline period. Registered beds in the area stood at approximately 224 in June 2006 and had increased to 315 in October 2006. The availability of newly registered beds was very timely and assisted placement of DTOC during this period and is reflected by the low number of DTOC seen during October and early November. We were able to place people who were delayed in OPMH beds, funding coming from several sources including Continuing Health Care, Third Party Top Ups and as a result of some fees being negotiated between providers and Adult and Community Services. Delays then increase slightly in November and December once the initial increased capacity had been filled and the system returned to issues related to throughput and funding.

The future issue will be how this expanded market is managed as NYCC have standard rates they can pay and these often fall short of what the care homes charge. Some homes currently have vacancies and they will need to have a strategy to manage this. The reason that DTOC continue despite some vacancies within the long-term care market relates to funding issues and people who are self-funding waiting for a bed to become available at their placement of choice.

2.1.4 DTOC as percentage of total bed capacity

Bed capacity began to be reduced from 16 June 2006 (when capacity was reduced from 52 to 49 beds) in preparation for reducing bed capacity in order to close the Orchards for refurbishment. Delayed transfers of care on 1 June 2006, when the capacity was still 52, was 11 DTOC. This represented 21% (11 / 52) of the total bed capacity. During the four month baseline period as the beds were gradually reduced from 52 to 36 the DTOC ranged from 4 – 12. The average DTOC over this 15 week period was 8.2 delays. As the bed capacity was steadily reducing during this period it is only possible to provide a range for the percentage capacity taken up by DTOC during this time. This range was between 16.7% (8.2/49) to 22.7% (8.2/36). During the evaluation period, once the capacity had been reduced to 36 beds, DTOC ranged from 2 – 10. The average DTOC over this 15 week period was 6.9 delays which represents 19.2% (6.9/36) of the reduced OPMH bed capacity. This falls within the middle of the baseline ranges.

2.1.5 Conclusion: The hypothesis that a reduction in bed capacity would lead to an increase in the percentage of available OPMH beds occupied by people who are DTOC was NOT supported.
2.1.6 Delayed Transfers of care (DTOC) Numbers and Bed days lost

Forty-eight people were delayed in OPMH beds over the whole eight month period. Of this 48, 18 people who were categorised as delayed transfers of care during the baseline continued to have their transfer delayed for at least some of the evaluation period. Bed days lost is defined as the number of days following the point when a patient is categorised as a delayed transfer of care when a bed is not available for a new assessment or respite admission because the person who is assessed as fit for discharge has their transfer of care delayed.

Baseline period
(NB. Dates are slightly different to some other aspects of this report owing to the dates of SITREP meetings when reports on the number of DTOC are recorded). Total DTOCs from 29/05/06 to 1/10/06 = 33 people
In the baseline period the longest wait (i.e. bed days waiting) was 785 and the patient was transferred in mid June.

Evaluation period
Total DTOCs from 1/10/06 to 4/02/07 = 33 people
In the evaluation period the longest wait was 510 days and the patient was transferred mid October.

Comparison of average bed days lost
These two people with the 785 and 510 bed days waiting had experienced particularly long delays and there was concern that this might skew the results. Therefore an analysis of average bed days lost related to DTOC was calculated including these patients, and then calculated again without these two patients in the sample, results are shown in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Average bed days lost for whole sample</th>
<th>Average bed days lost when two longest waits are removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline 29/05/06 to 1/10/06</td>
<td>72.15</td>
<td>51.48 days</td>
</tr>
<tr>
<td>Evaluation period 1/10/06 to 4/02/07</td>
<td>40</td>
<td>26.74</td>
</tr>
<tr>
<td>Percentage change</td>
<td>32.15</td>
<td>24.74</td>
</tr>
<tr>
<td></td>
<td>44.6%↓</td>
<td>48%↓</td>
</tr>
</tbody>
</table>

As can be seen in table 1, the average bed days lost reduced significantly during the evaluation period.
2.1.7 Situation Report (SITREP) Category data

DToC Category (self funding, continuing care etc.) and reason for wait (lack of suitable placement, waiting for place of choice, waiting for funding) were monitored and explored. The individual data for all people classified as DToC in the baseline and evaluation has been reviewed. Results are shown below in Table 2.

Table 2: SITREP category reports comparison of data from baseline and evaluation periods

<table>
<thead>
<tr>
<th>SITREP Coding</th>
<th>Baseline Total number of days delayed</th>
<th>Evaluation Total number of days delayed</th>
<th>change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category A - Completion of assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ab – Both (waiting for completion of health and social care assessment)</td>
<td>35</td>
<td>42</td>
<td>7↑ (20%↑)</td>
</tr>
<tr>
<td>Ah - Health</td>
<td>139</td>
<td>139</td>
<td>0</td>
</tr>
<tr>
<td>As – Social Services</td>
<td>222</td>
<td>182</td>
<td>40↓ (18%↓)</td>
</tr>
<tr>
<td><strong>Category D – Care Home Placement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diib – Both</td>
<td>799</td>
<td>0</td>
<td>799↓ (100%↓)</td>
</tr>
<tr>
<td>Diis – Social Services</td>
<td>239</td>
<td>0</td>
<td>239↓ (100%↓)</td>
</tr>
<tr>
<td><strong>G – Patient or family choice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gh - Health</td>
<td>1,436</td>
<td>955</td>
<td>481↓ (33.5%↓)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2891</td>
<td>1339</td>
<td>1552↓ (53.7%↓)</td>
</tr>
</tbody>
</table>

2.1.8 Conclusion: the hypothesis that a reduction in bed capacity will lead to an increase in delayed transfers of care was NOT supported by the data.
**2.1.9 Length of stay:**
Length of stay data is linked to delayed transfers of care and is recorded within provider services on an ongoing basis. There was concern amongst stakeholders that with a reduced bed capacity people might be discharged quicker than previously and that this might result in increased readmissions (see section 2.3).

**Hypothesis to be evaluated:**
- That a decrease in bed capacity would result in shorter lengths of stay owing to pressure on bed capacity

Figure 2 presents the average length of stay figures for Rowan ward, Alexander House and the Orchards for the four month baseline and the four month evaluation period. The Orchards figures dropped during October as people were transferred or discharged, a number of people who were discharged from the Orchards in September 2006 had been admitted for quite long periods and this accounts for the high length of stay recorded for that month. Obviously once the Orchard’s beds had been closed for refurbishment of the unit the length of stay at that residential unit dropped to zero.

Alexander House provides both an assessment and rehabilitation service and a booked and emergency respite service. The respite provision means that patients stay for short periods of time (usually one to two weeks); this is why the Alexander House average length of stay is traditionally lower than that of Rowan ward. During the baseline period the average length of stay for service users at Alexander House ranged between 17.7 and 27.5 days (average 22.3 days). During the evaluation period this was held in the middle of this baseline range at a fairly constant rate of between 23.2 to 23.6 days (average 23.4 days). Therefore, there was a slight increase in length of stay.

Rowan ward historically experiences a more variable length of stay owing to a mixed population of service users, some who are admitted to the acute mental health ward on a voluntary basis and some whose illness requires admission under the Mental Health Act. There is also usually a proportion of service users who are delayed transfers of care on the ward at any one time. During the baseline period the average length of stay for service users on Rowan ward was 48.1 to 104.8 (a range of 56.7 and an average of 71.9 days). During the evaluation period there was a similar range of length of stay which was between 43.6 to 98.2 (a range of 54.6 and an average of 74.6 days).

**Conclusion:** The monthly length of stay for service users admitted to Alexander House and Rowan ward did not vary significantly between the baseline and evaluation periods, and there was a slight increase in the average length of stay for both units. Therefore, the hypothesis that a decrease in bed capacity would result in shorter lengths of stay owing to pressure on bed capacity was NOT supported.
Figure 2: Average length of stay
2.2 Bed occupancy

2.2.1 Hypothesis to be evaluated:
- that a reduction in bed capacity will lead to an increase in bed occupancy rates on Rowan Ward and Alexander House residential Unit.

Bed occupancy percentages were taken from monthly ward activity data which is routinely collected for acute provider services and is provided in Figure 3. Bed occupancy data is provided as a monthly average and received as an excel spread sheet by each service’s general manager.

2.2.2 Results:
The baseline period average monthly occupancy for Rowan ward was 83% and during the evaluation period the average was almost identical at 83.75%, a fractional rise of only 0.75%.

The baseline period average monthly occupancy for Alexander House was 77.25% and during the evaluation period the average was slightly higher at 83.25% which was a rise of 6%. This represents just under one bed (1/16 beds ≈ 6.25% occupancy). However, bed occupancy was artificially low at Alexander House in late August and early September because some beds were temporarily closed as they became vacant in preparation for moving over 5 patients from the Orchards around mid September. So the baseline period does not represent a usual picture of bed occupancy for this unit.

The increased bed occupancy seen in September and October 2006 coincides with service users being moved to Alexander House and Rowan ward when the last beds remaining at the Orchards were closed for refurbishment.

Although, there was a small rise in the average occupancy percentage for Alexander House during the evaluation period the percentage was very similar to the occupancy rate on Rowan ward during both the baseline and evaluation periods (83% and 83.75% respectively). In addition, the average monthly occupancy percentages for Alexander House (83.25%) and Rowan ward (83.75%) fall comfortably close to the national average of 85.6% (as can be seen in Appendix D which shows the average daily number of available and occupied beds by sector in England for 2005-06, with the average occupancy percentage for mental health beds across England given as 85.6%).
Figure 3

Monthly average percentage occupancy data

- **Rowan**
- **Alexander House**
- **Orchards**
Staff felt that there had been weeks where occupancy had been higher than the monthly averages indicated and the service had experienced a couple of times when clinicians were unable to admit to an OPMH bed. Therefore, the General Manager for OPMH and Unit Managers for Rowan ward and Alexander House reviewed nursing returns for baseline and evaluation periods. They looked at the returns for the same day each week and provided weekly bed occupancy percentages, these are provided in Figure 4. To put the occupancy rates in context bed numbers expressed as percentages are provided in Table 3.

<table>
<thead>
<tr>
<th></th>
<th>Alexander House</th>
<th>Rowan ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/16</td>
<td>6.25%</td>
<td>1/20</td>
</tr>
<tr>
<td>2/16</td>
<td>12.5%</td>
<td>2/20</td>
</tr>
<tr>
<td>3/16</td>
<td>18.75%</td>
<td>3/20</td>
</tr>
<tr>
<td>4/16</td>
<td>25%</td>
<td>4/20</td>
</tr>
<tr>
<td>5/16</td>
<td>31.25%</td>
<td>5/20</td>
</tr>
<tr>
<td>6/16</td>
<td>37.5%</td>
<td>6/20</td>
</tr>
</tbody>
</table>

[Note: Alexander House has a capacity of 16 beds and Rowan ward has a capacity of 20 beds]

Based on the weekly occupancy percentages provided by Rowan ward, the average occupancy rate during the evaluation period (10 October 2006 to 11 February 2007) was 87.63% this represents an average of about 2.5 vacant beds. The highest rate was recorded on 10/10/06 when the remaining patients were transferred from the Orchards to Alexander House and Rowan ward in order to close the Orchards for refurbishment. A rate of 105% indicates that a patient was admitted to a bed designated as a leave bed and so two patients were counted for the same bed, one who was occupying the bed and one who was on leave and who was having a bed held in their name. This rate dropped to 95% (1 vacant bed) by the following week. The lowest rate recorded during this period was on 23/01/2007 when occupancy fell to 70%, this represents 6 vacant beds. To put these figures in some context, The Mental Health Act Commission’s (MHAC) Bed Occupancy Survey reported that “in the twelve months to the end of July 2006, the national average for bed occupancy in acute admissions wards visited by the MHAC was 101%” (Desai and Kinton, 2006, p. 2) and an independent survey by the Sainsbury Centre for mental Health (2005) found the average occupancy rates for acute adult psychiatric beds to be 100%. So whilst the occupancy rates seen on Rowan ward in August, September and October (80 – 105%) and at Alexander House in September and October (93.75 – 100%) were very high, these figures are not out of the ordinary across acute mental health in-patient services in England.
Figure 4

Weekly bed occupancy percentages

- Rowan ward
- Alexander House
What is reassuring is that once the bed capacity had been brought down to 36 beds on 10 October 2006, and the closure of the Orchards for refurbishment was achieved, the bed occupancy rates began to come down steadily. By 31 October 2006 the weekly occupancy on Rowan ward had dropped to 75% (5 vacant beds) and for the remainder of the evaluation period ranged from 70 – 100%, with the 100% occupancy only occurring in one week around 5 December 2006. At Alexander House the occupancy rate dropped from full capacity at the point of the Orchards closure to one vacant bed the following week, and for the remainder of the evaluation period the weekly occupancy percentage varied quite considerably ranging from 68.75% (5 beds) to 100%, with the 100% occupancy only occurring in one week, which like Rowan ward, occurred around 5 December 2006. A comparison of average weekly occupancy rates for Alexander House and Rowan ward for the two periods are provided in Table 4.

Table 4: Comparison of baseline and evaluation period weekly average occupancy percentages

<table>
<thead>
<tr>
<th></th>
<th>Average weekly occupancy rate for baseline period (10.06.06 – 07.10.06)</th>
<th>Average weekly occupancy rate for evaluation period (17.10.06 – 06.02.07)</th>
<th>% difference in average weekly occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander House</td>
<td>89.9%</td>
<td>88.6%</td>
<td>1.3%↓</td>
</tr>
<tr>
<td>Rowan ward</td>
<td>91.7%</td>
<td>86.8%</td>
<td>4.9%↓</td>
</tr>
</tbody>
</table>

2.2.3 Conclusion: the hypothesis that that a reduction in bed capacity will lead to an increase in bed occupancy rates on Rowan Ward was NOT supported for both the analysis of monthly average occupancy rates (reduction of 0.75%) and weekly occupancy rate (reduction 4.9%). The hypothesis that that a reduction in bed capacity will lead to an increase in bed occupancy rates at Alexander House was NOT supported by the analysis of weekly occupancy rates (reduction of 1.3%) but WAS supported when the average monthly occupancy rate was used for the analysis (increase 6%). This increase equated to under 1 bed. However, it should be noted that some beds were held vacant during the baseline period to facilitate the transfer of a group of patients from the Orchards to Alexander House in mid September and this will have served to artificially lower the bed occupancy figures for Alexander House during the baseline period.
2.3 Readmission rates

2.3.1 Hypothesis to be evaluated

- that a decrease in bed capacity would lead to an increased readmission rate

Concern was expressed that a reduced bed capacity would lead to an increased pressure to discharge service users to maintain throughput and that this would in turn lead to increased readmission rates owing to people being discharged to early.

The number of readmissions to OPMH beds at Alexander House residential unit and Rowan ward was collected during a four month baseline and a four month evaluation period. Data was obtained for the date admitted, date discharged, date readmitted and the number of days between discharge and readmission.

2.3.2 Results

Baseline period 10 June – 9 October 2006 (52 bed capacity)

There were three people who were readmitted to OPMH beds
  1. readmitted after 5 days
  2. readmitted after 5 days
  3. readmitted after 15 days

Evaluation period 10 October 2006 – 10 February 2007 (36 bed capacity)

There was one person who was readmitted to OPMH bed
  1. readmitted after 18 days

Therefore, there was a reduction in readmissions during the evaluation period, from three readmissions during the baseline period to only one readmission in the four months following the reduction to 36 beds. This was a 66.6% reduction.

2.3.3 Conclusion: The hypothesis that a decrease in bed capacity, from 52 to 36 beds, would lead to an increased readmission rate was NOT supported by the data.
2.4 OPMH Bed availability

Staff evaluated whether the OPMH service had beds available for timely admissions when needed:

- Crisis admissions from the community
- Transfers from General wards

This had not been formally monitored before and historically was only recorded thorough financial monitoring systems when a person had to be admitted to an independent health care provider at a cost to the PCT when beds were not available within the OPMH service. Both health care staff and external stakeholders (carers, social care staff and voluntary sector staff) had expressed concerned about the impact of reducing bed capacity on timely bed availability. So this was a very important variable to review for the evaluation. Therefore, qualitative information was recorded and whenever an incident arose where doctors or senior managers were aware that there had been an inability or challenge to find an appropriate bed for an older person with a mental health problem, then the circumstances of the incident were communicated to the Modernisation Manager (OPMH), usually via an e-mail from the consultant psychiatrists’ secretaries.

Qualitative information recorded:

- What type of bed was needed.
- Reason bed was not available (e.g. no male beds available on Rowan ward).
- Length of time taken to resolve situation.
- Outcome

The Modernisation Manager then investigated the incident further to check the reasons why a bed was not available and also the history and outcome of what then happened to the service user. As this data had not been collected before there was no baseline data available. However, staff agreed to start collecting data from 1 September 2006 so we could monitor incidents that arose as the bed capacity gradually reduced, in addition to any that might arise during the 4 month evaluation period.

2.4.1 Hypothesis to be evaluated:

- that a decrease in bed capacity would lead to an increased pressure on capacity resulting in more incidents of beds not being available for an admission or for a transfer to an OPMH bed from other wards when required.
2.4.2 Results

Admission to OPMH beds from community and long term care settings

Baseline period 1.09.06-09.10.06

Incident 1:
- No appropriate bed on Rowan ward so the patient was admitted to Cedar ward (acute mental health ward for adults of working age). Patient remained on Cedar ward for 12 days and was discharged back to same long care placement they had resided in prior to admission. During the 12 days 2 beds did become vacant on Rowan ward but were not suitable (e.g. could have not been for appropriate gender).

Incident 2:
- No appropriate bed on Rowan or Cedar ward so the patient was admitted to private provider for 48 hour period. PCT paid for the cost of the private bed. Patient was transferred to Rowan ward after 2 days.

Evaluation period: 10.10.06 – 10.02.07

Incident 1:
- No appropriate bed on Rowan ward so the patient was admitted to Cedar ward. Stayed on Cedar ward for 16 days. During this period there were 2 vacant beds on Rowan, but clinically it was not in the best interests of the patient to be moved once settled on Cedar ward for the assessment period and a discharge date was set.

Incident 2:
- Patient was under 65 years and initially there was a clinical decision to admit to Cedar ward (4 beds vacant on Rowan) but once admitted the person appeared to have an organic impairment (note: people with dementia are generally served by OPMH services regardless of age). Patient was transferred from Cedar ward to an acute medical ward as medically unwell. Returned to Cedar ward once medically stable and at that point was assessed as more suitable for OPMH service because of an organic impairment. At this point there was no appropriate bed on Rowan ward. 18 days later when there was pressure Cedar ward’s capacity and Rowan had a suitable bed, the patient was transferred to Rowan ward.

Senior OPMH clinicians noted that historically there have been similar incidents in the past, where the PCT has had to pay for a private sector bed or admit an older person to Cedar ward. The consultants felt that the pressure on bed availability had not increased as anticipated when the bed capacity was reduced. The number of incidents in the baseline period and the evaluation period were the same (note: the baseline period was a much shorter period than the evaluation period)
Transfers to OPMH beds from acute general hospital wards at Harrogate District Hospital (HDH) as recorded by the mental health liaison service

No baseline data was available. A form was developed for recording availability of beds for transfers to OPMH beds from general wards (see Appendix C). This was completed by either the Associate Specialist Psychiatrist who leads the liaison service or by the mental health liaison nurse (who is an RMN).

Evaluation period: 10.10.06 – 10.02.07

Incident 1:
- Patient seen by Associate Specialist Old Age Psychiatrist for assessment on ward and was waiting for more investigations (e.g. scan) whilst on general ward. At the point of this initial referral to Mental health liaison there were 5 beds available on Rowan, but by the time the patient was ready for transfer there was no capacity on Rowan ward, the patient remained on the medical ward for about 10 days before a transfer to Rowan ward could be undertaken.

Incident 2:
- A patient, who had been discharged from Alexander House 5 days before, was admitted to a medical ward following falls and no acute medical problem was identified. Staff reported that the person’s behaviour was difficult to manage on this general ward. The Associate Specialist Psychiatrist requested a transfer to Alexander House where the person was already known to staff, but there were no beds available at Alexander House residential unit (note: Rowan ward not approached because the patient was already known to Alexander House – but 4 beds were available on Rowan at the time of the request to Alexander House). Person remained on the medical ward and a decision was made with the family to look for a long-term care (LTC) placement staff on the medical ward agreed for the patient to remain there and the person remained on the medical ward until he was discharged to long-term care.

At the review meeting at the end of February 2007, the Associate Specialist Psychiatrist reflected that historically there have been similar incidents in the past and that 2 incidents over a 4 month period was not an increase on her perception of the previous frequency of such events. If anything, transfer to OPMH beds had been easier than previously and the pressure on OPMH bed availability had not increased as anticipated when the bed capacity was reduced.

2.4.3 Conclusion: the hypothesis that a decrease in bed capacity would lead to an increased pressure on capacity resulting in more incidents of beds not being available for an admission or for a transfer from other wards when required was NOT supported.
2.5 Availability of OPMH beds for Respite admissions

Staff evaluated whether the amount of respite received by service users and carers who were previously receiving planned respite had been not negatively impacted by the reduction in bed capacity.

Both health care staff and external stakeholders (carers, social care staff and voluntary sector staff) had expressed concern about the impact of reducing bed capacity on respite bed availability. So this was a very important variable to review for the evaluation. Staff wanted to ensure the OPMH service could meet demand for new respite admissions, booked respite admissions and emergency respite admissions when needed. This had not been formally monitored before and no routinely collected baseline data was available. Therefore, qualitative information was recorded and whenever an incident arose where doctors or the unit manager at Alexander House were aware that there had been an inability or challenge to find an appropriate respite bed for an older person with a mental health problem, then the circumstances of the incident were recorded on the “Form for recording availability of beds for Respite admissions” (see Appendix B) and submitted to the Modernisation Manager (OPMH). The qualitative information recorded included:

- Number of booked respite admissions cancelled and reason for cancellation.
- Number of planned regular respites where length of respite stay was reduced from usual amount of respite received.
- Number of respites that have to be changed and rebooked and the length of the delay from planned respite date to actual respite received.

As this data had not been routinely collected before there was no four month baseline data available. However, staff agreed to start collecting data from 1 September 2006 so they could monitor incidents that arose as the bed capacity gradually reduced, in addition to any that might arise during the 4 month evaluation period.

2.5.1 Hypothesis to be evaluated
- that a decrease in bed capacity would lead to an increased incidence of required respite admissions being delayed or cancelled.

2.5.2 Results

Baseline period 1.09.06-09.10.06

Staff began data collection 1st September and whilst we were reducing beds at the Orchards and transferring people to other OPMH beds we experienced some capacity pressures related to respite. Eight incidents were recorded during the baseline period. These are summarised in Table 5. But since the 16 beds at the Orchards were closed for refurbishment on 10.10.06 staff have had sufficient capacity to meet further new referrals for respite and to address any changing needs amongst existing recipients of respite care. No further incident forms have been submitted since 28 September 2006.
<table>
<thead>
<tr>
<th>Problem</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New referral for respite. Unable to offer immediate respite bed owing to lack of capacity in early September at Alexander House owing to anticipated transfer of patients from the Orchards residential unit.</td>
<td>Service user offered respite in 3rd week in November.</td>
</tr>
<tr>
<td>2. Urgent request for respite. New referral. Unable to offer immediate respite bed owing to lack of capacity.</td>
<td>Service user now in Long-term care</td>
</tr>
<tr>
<td>3. During a respite admission an extended period of respite was requested because the carer was unwell. OPMH service could not accommodate request and service user had to be discharged as planned at end of booked respite. Additional home based support was considered however carer expressed a preference not to have additional people coming into the home.</td>
<td>Next planned respite readmission occurred as planned. During this time carer became unwell again and service user remained as an in-patient and was discharged to a long-term care facility</td>
</tr>
<tr>
<td>4. Discharged after a planned one week respite assessment but staff could not offer the next respite admission as soon as preferred. Unit Manager’s clinical judgments following first respite admission assessment was the service user’s needs were not best met at Alexander House, because the service user’s physical needs outweighed the mental health problems.</td>
<td>Carer accepted a 2nd respite admission but the service user is now receiving respite at an independent care home that can better meet the physical health needs.</td>
</tr>
<tr>
<td>5. Further respite needed after a respite assessment. Ideally the service user should have been offered a 1 week respite to 5 – 6 weeks at home respite ratio, but there was a 12 week wait for the next available booked respite slot.</td>
<td>2nd respite received after 12 weeks and service user is now getting regular respite. Carer has received respite dates for 2007.</td>
</tr>
<tr>
<td>6. Carer asked for respite to be brought forward because of carer burden. Asked for respite to be brought forward by one week, after only 3 weeks at home (instead of the usual 4 weeks). Respite could not be brought forward as no capacity. Family managed during the week.</td>
<td>Came in for respite as planned and stayed for 10 days. Service user is now residing in a nursing home, so no further respite is required.</td>
</tr>
<tr>
<td>7. Respite delayed by 1 week, because the person receiving respite the week before was unwell and could not be discharged home as planned.</td>
<td>Carer managed during that week. Service user came in for respite 10 days later and has received regular planned respite since.</td>
</tr>
</tbody>
</table>
Nine service users who previously received respite admissions at The Orchards were transferred for respite at Alexander House during the refurbishment. In February 2007 three of these nine service users continued to receive planned respite at Alexander house, of the remaining six:

- 1 person the carer is no longer requesting respite from OPMH service
- 2 people have ceased owing to a nursing staff decision that respite provision at Alexander House did not best meet needs
- 3 people have been admitted to long term care homes

The 22 people receiving booked respite as of February 2007 have been given respite dates for the whole of 2007. If OPMH allocate 6 of the 16 beds in the community residential unit (currently Alexander House) for respite then there were 112 respite care weeks available from 11/2/07 until 31/12/07 to provide for new referrals, emergency respite admissions and requests for planned respite admissions to be altered and people who can not be discharged from a respite admission as planned (e.g. person or carer becomes ill). This is considered sufficient to meet current and projected levels of demand.

Separate from any decision related to capacity, as of January 2007 staff made a clinical decision, in response to carer feedback, to change booked respite ratios. The OPMH service is now offering 1 week admissions usually on a more frequent ratio, for example 1 week admission followed by 3 – 4 weeks at home compared with 2 week admission and 5 - 6 weeks at home. Carers had reported that their loved ones were disorientated on return home following the longer 2 week respite admission and took several days to settle. Some carers reported the service users had disrupted sleep patterns when he / she first returned home following respite. Service users can become adapted to the routine of the institutional setting after around 10 – 14 days, and the shorter (but more frequent) respite ratio reduces the level of disorientation experienced when the person is discharged back home after respite.

To ensure that no service user is disadvantaged by the changed ratio, staff have compared the total number of days received by people who had respite in 2006 compared to the total number of respite days offered for 2007 using the new respite ratios. There has been considerable throughput of clients receiving respite in the past year and so only a couple of people had received respite for the full year in 2006 and are due to receive respite throughout 2007.

1. 1 person who received 70 days respite in 2006 has been offered 94 days respite in 2007
2. 1 person who received 49 days respite in 2006 has been offered 56 days respite in 2007.

To increase this small sample we look for service users who had been accessing respite for at least the last 6 months of 2006:

3. 1 person who received 21 days respite in the last 6 months of 2006 has been offered 35 days in first 6 months of 2007.
2.5.3 Conclusions:

- respite provision for 8 service users was negatively impacted during September and early October when the bed numbers were being reduced ready for the refurbishment of the Orchards.

- the hypothesis that a decrease in bed capacity would lead to an increased incidence of required respite admissions being delayed or cancelled was NOT supported during the four month evaluation.

2.6 Staffing Levels:

We monitored where staffing levels have to be increased above the usual level owing to increased dependency levels amongst patients and recorded:

- Number and type of additional staff required.
- The reason for increased staffing levels.
- The length of duration of increased staffing level.

Recorded per incident as it occurred. Staff agreed that the circumstances of the incident would be communicated to the Modernisation Manager (OPMH) by the General Manager via e-mail when a request for additional staffing was approved.

2.6.1 Hypothesis to be evaluated

- that a decrease in bed capacity would lead to an increased need to enhance staffing levels for in-patient areas owing to increased dependency levels of patients.

2.6.2 Results

Baseline 09.06.06 – 09.10.06

There were no increased staffing requested during the baseline period.

Evaluation period from 10.10.06 – 10.02.07

There was one request received in November from Rowan ward to increase increased staffing for a period of 5 days; an extra unqualified staff member was requested 10 shifts (early and late but not nights). Although this request was approved it was not filled owing to lack of available staff. Staff felt that an occasional request for increased staffing is not unusual.

2.6.3 Conclusion

The hypothesis that a decrease in bed capacity would lead to an increased need to enhance staffing levels for in-patient areas owing to increased dependency levels of patients WAS supported as there were no requests during the baseline period and 1 request for increased staffing during the evaluation period. However, since December 2006 there has been no increased staffing requested for either Rowan ward or Alexander House.
2.7  **Staff Short term sickness rates**

Change can be stressful for staff, as well as for service users and carers, and so it was important to consider the impact of the refurbishment and the resulting redeployment of staff. Staff short-term and long-term sickness rates are routinely monitored by the PCT. Long-term sickness is more usually related to planned operations and recuperation and more serious illnesses and is less likely to be related to service reconfiguration issues. It was therefore decided to monitor the short-term sickness rates for this evaluation. Staff short-term sickness rates can fluctuate according the time of year and so the baseline selected to evaluate this variable was the same time period the previous year.

### 2.7.1 Hypothesis to be evaluated
- that the changes associated with redeploying staff would lead to an increased short-term sickness rate

### 2.7.2 Results

**Baseline October 2005 – January 2006**
During the baseline period the OPMH staff short-term sickness monthly percentages had ranged from 2.4 to 3.6 and had an average 2.98 %

**Evaluation period October 2006 – January 2007**
During the evaluation period the OPMH staff short-term sickness monthly percentages had ranged from 2.1 to 5.3 and had an average of 4.3% and increase of 1.32 from the baseline average.

Results are shown in Figure 5 which illustrates the higher short-term sickness experienced by OPMH staff during the evaluation period. It was important to establish whether this high short-term sickness rate was unprecedented. A review of figures for 2005, 2006 and early 2007 showed that short-term sickness had been higher than 5.3% in the past, for example in April 2005 it was 6.3% and in May 2005 it was 6.4%

It is interesting to know that during the evaluation the OPMH service has had no issues with staff retention and no increase in staff turnover.

### 2.7.3 Conclusion
The hypothesis that the changes associated with redeploying staff would lead to an increased short-term sickness rate WAS supported.
Figure 5

OPMH staff Short-term sickness rates

Percentage of staff on short-term sickness leave

- 2006 / 07
- 2005 / 06

Months:
- October
- November
- December
- January
2.8 RRICE referrals

RRICE stands for Rapid Response and Intermediate care for Elderly Mentally Ill team. The RRICE Team provides a community based rapid response intermediate care service to clients who are experiencing a crisis or are facing a transitional period in their mental health. The service is aimed at clients with an organic based dementia to include early age onset (less than 65 years). The service is also accessible to clients with a functional illness who are over the age of 65 and have not been known to adult mental health services in the last 12 months, unless they have developed specific needs in line with the psychiatry of old age. The service provides specialist mental health assessments and support in the client’s community setting, aiming to prevent inappropriate admission to hospital or a 24 hour care facility, as well as supporting timely discharge from these settings.

2.8.1 Hypothesis to be evaluated:
- that a decrease in bed capacity would lead to increased referrals to the RRICE team.

2.8.2 Results

Figure 6 shows the monthly referral rates for RRICE and Table 6 describes the range and average number of referrals for the baseline and evaluation periods.

<table>
<thead>
<tr>
<th>RRICE referrals</th>
<th>Baseline June – September 2006</th>
<th>Evaluation October 2006 – February 2007</th>
<th>% difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>19 – 26</td>
<td>12 – 24</td>
<td>-</td>
</tr>
<tr>
<td>Average</td>
<td>23.75</td>
<td>19.2</td>
<td>4.55 ↓ (19.2% ↓)</td>
</tr>
</tbody>
</table>

The Community Services Manager for OPMH reflected that the higher rate of referrals in summer may be seasonal, for example there were 25 referrals in July 2005. The RRICE team managed the referrals by triaging, being more proactive with closures and changing the shift pattern so more staff were available during the day. As can be seen in Figure 6, there has been no increase in referrals since October 2006.

2.8.3 Conclusion
The referral rate went down during the evaluation period and the hypothesis that a decrease in bed capacity would lead to increased referrals to the RRICE team was NOT supported.
Figure 6

RRICE team monthly referral rates

Number of referrals received per month

Months

Jun-06 Jul-06 Aug-06 Sep-06 Oct-06 Nov-06 Dec-06 Jan-07 Feb-07
2.9 Community Mental Health Team (CMHT) waiting lists

Within OPMH services there are two CMHTs, the Rural team and the Harrogate and Wetherby team. Both community mental health team provide a service for older people (over age of 65) with severe or acute mental health problems who have been assessed by the Sector Team (ST) as requiring the input of specialist community mental health services and appropriate for Care Co-ordination under the principles of the Care Programme Approach. They include people needing ongoing specialist care for:

- Those with moderate/severe dementia who have significant problems and complex needs e.g. behaviour and/or whose carers require specialist input.
- Severe and persistent mental disorders associated with significant disability, psychoses and depressive illness.
- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up.
- Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression).
- Mental health disorders requiring skilled or intensive treatments (e.g. rehabilitation, medication maintenance requiring blood tests) not available in primary care.
- Complex problems of management and engagement and severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by the assertive community treatment team.

2.9.1 Hypothesis to be evaluated:
- That increasing staff capacity within the two CMHTs would lead to a reduced number of people waiting for initial assessment.

2.9.2 Results

Results are shown in table 7 and in figures 7 and 8. The Harrogate and Wetherby team experience a significant (38.1%) reduction in their waiting list during the evaluation period. The percentage reduction in the waiting list for the Rural CMHT was smaller than anticipated (9.7%) however this team had an existing one qualified staff member on long term sickness leave during a significant part of the evaluation period.
Table 7: CMHT waiting times

<table>
<thead>
<tr>
<th></th>
<th>Baseline 01.06.06 to 05.10.06</th>
<th>Evaluation 12.10.06 to 13.02.07</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harrogate and Wetherby CMHT</strong></td>
<td>Average number of people on waiting list (range)</td>
<td>Average number of people on waiting list (range)</td>
<td>9 ↓ (38.1% ↓)</td>
</tr>
<tr>
<td></td>
<td>23.6 (20 – 31)</td>
<td>14.6 (9 – 21)</td>
<td></td>
</tr>
<tr>
<td><strong>Rural CMHT</strong></td>
<td>22.6 (14 – 29)</td>
<td>20.4 (10 – 32)</td>
<td>2.2 ↓ (9.7% ↓)</td>
</tr>
</tbody>
</table>

Because of the increased capacity achieved through the redeployment of staff, the total cases held across the two teams have increased.

- In June 2006 249 people were on the caseload of 8 WTE qualified staff
- In January 2007 275 people were on the caseload of 10.5 WTE qualified staff

At one stage in the summer the longest waiting time was more than a year. The longest waiting time is now less than 3 months. The new staff (who were redeployed to the CMHT) were able to triage new referrals, undertake an initial assessment and bring the results back to multi-disciplinary team (MDT) meetings for discussion. This meant that not all referrals had to be picked up. Some could be signposted and closed. The CMHTs also used the mixed skill base created through the redeployment of staff by asking the nurses transferred from the residential units to specifically deal with referrals from care homes where sometimes the need was for advice to staff about behaviour rather than assessment or clinical intervention. We established there is a need for more liaison work to be done in this area.

2.9.3 Conclusion
The hypothesis that increasing staff capacity within the two CMHTs would lead to a reduced number of people waiting for initial assessment WAS supported.
Figure 7

Harrogate and Wetherby CMHT waiting list

- Number of people waiting vs. dates
- Dates range from 07.06.06 to 31.01.07
Figure 8

Rural CMHT waiting list figures June 2006 - February 2007

- Dates
- Number of people waiting
Figure 9

Funded Nursing Care
EMI total of outstanding new, unplanned or routine reviews
(April 2006 - January 2007)
2.10 Capacity for Funded Nursing Care Contribution reviews

Hypothesis to be evaluated:
- That increasing staff capacity for undertaking funded nursing care contribution (FNCC) reviews would reduce the number of outstanding FNCC new, unplanned and routine reviews.

Increased capacity was provided through training a redeployed staff member (Registered mental Nurse; RMN) and allocating 0.5 WTE of her time explicitly for funded nursing care reviews and by increasing the hours of the current mental health liaison nurse (from 18.75 to 26.25 hours per week).

From mid October 2006, additional staffing capacity, released by the closure of beds at the Orchards residential unit for refurbishment, transferred to the community mental health service CMHT. Of this 0.5 WTE was allocated for increasing the capacity for assessments related to funded nursing care contributions (FNCC), both continuing care applications and registered nursing care contribution (RNCC) applications and for both initial assessments and reassessments. During the course of the evaluation this increased capacity made a significant impact on the throughput of reviews and the numbers of outstanding FNCC assessments have reduced significantly.

Figure 9 shows that increasing staff capacity for undertaking FNCC reviews, provided through training a redeployed a staff member (Registered mental Nurse; RMN) and allocating 0.5 WTE of their time explicitly for funded nursing care reviews, made a significant impact on the number of outstanding reviews within the Harrogate and Rural Area. By September 2006 the number of outstanding EMI new, unplanned and routine reviews had climbed to 91. However, after four months increased staffing for reviews this had dropped by 73 cases to 18 outstanding reviews, a reduction of 80.2%.

Conclusion: the hypothesis that increasing staff capacity for undertaking funded nursing care reviews would reduce the number of outstanding EMI FNCC new, unplanned and routine reviews was SUPPORTED by the data.

2.11 Conclusion

At the end of February 2007 a group of senior clinicians and managers who lead the OPMH service had a one day meeting to closely review and discuss the results of the evaluation. This meeting was attended by:
- Consultant Psychiatrist
- Associate Specialist Psychiatrist
- Consultant Psychologist
- General Manager (OPMH services) – Registered Mental Nurse (RMN)
- Unit Manager for Rowan Ward and Day Hospital (RMN)
- Unit Manager for Alexander House Residential Unit and Day Hospital (RMN)
• Community Services Manager (OPMH) for CMHTs, RRICE, Mental Health Liaison nurse and specialist team for younger people with dementia - Social Worker(SW)
• Modernisation Manager (OPMH) – Occupational Therapist (OT) with PhD in Psychology.
• The Director of Mental Health (RMN) attended for the last 2 hours to discuss the group’s conclusions and recommendations.

The group agreed that results indicated that, following the reduction of the in-patient bed capacity from 52 to 36 beds, bed occupancy rates, readmission rates, level of delayed transfers of care, bed availability for crisis and planned admissions and bed availability for booked and emergency respite were not problematic as had been feared by some stakeholders.

This group of senior managers and clinicians gained full consensus in agreeing that the results demonstrated that the beds could remain permanently at a capacity of 36 without detrimental impacts on service provision.

It is recognised that the decision as to which of the two CUE residential units should be re-provided is not a straight forward judgement and OPMH staff have generated pros and cons pertaining to maintaining each of the units. The recommendation is to take the question as to where the CUE beds should be re-provided to public consultation.

The senior clinicians and managers also considered that positive benefits had been achieved by the redeployment of staff. This had led to:
• the filling of some vacant posts on in-patient areas leading to better consistency of care and a reduced spend on agency nursing;
• the enhancement of community mental health team staffing, with a positive impact on waiting lists and an improved ability to triage new referrals;
• and to increased capacity for funded nursing care assessments which had resulted in a dramatic reduction in the number of outstanding reviews.

The group of senior clinicians and managers then reviewed the proposed service redesign that was presented to, and accepted by, the Craven, Harrogate and Rural District Primary Care Trust (CHRD PCT) Board in March 2006. They reviewed the recommendations of the:
• Harrogate and Rural OPMH Strategy and Planning group,
• EMI Development Group
• Managed Learning Network for Everybody’s Business (MLN EB) for the North East, Yorkshire & Humber (NEYH) and North West Regions [Note: Everybody’s Business is a service delivery guide published by the Department of Health (DoH) and the Care Services Improvement Partnership (CSIP) in November 2005]
The senior managers and clinicians considered a number of service pressures and illmet or unmet needs that have become more apparent over the past year to ensure that the proposed redesign would result in investment being made in areas of greatest need and / or where the biggest impacts for improved service outcomes could be achieved.

The group agreed that funding should be allocated to the service areas that had been identified in March 2006 redesign proposal, with some changes to the number and banding of staff within the areas.

In the budget agreed by the CHRD PCT Board in March 2006 a one off was included sum had been agreed for “Reprovision of 16 beds in an alternative care setting for a period of 12 weeks”, this sum of £115,200 had represented 12 weeks long-term care at an approximate cost of £600 per week for up to 16 service users and was used to facilitate the discharge for people who had been delayed transfers of care. The senior clinician and manager group, also discussed the redesign element that is to be funded from this sum in future years. The Harrogate and Rural OPMH Strategy and Planning group has been highlighting the critical role played by the voluntary sector for the integrated pathways of care for people with organic impairment (such as dementia) and for people with functional illnesses (such as people with depression, anxiety and schizophrenia, the cost effectiveness of voluntary provision, particularly in terms of reducing the need for statutory provision, and also the vulnerable funding streams for voluntary services. Therefore, as well as some additional investment into health services, the group has recommended that a budget be set for commissioning further from voluntary sector providers (such as Age Concern, Alzheimer’s and Carer’s Resource) to make a number of pilot and proposed interagency service provision models sustainable.
SECTION 3: OPMH service redesign proposal

3.1 Summary of redesign proposal
The proposal is to reconfigure OPMH services to provide a more robust infrastructure for both community and in-patient services and to shift care from secondary care to primary care. The proposal is to re-provide 16 beds at one of the community residential unit (either at Alexander House or the Orchards) and redesign the service within the current budget by:

1. commissioning an enhanced community mental health team service;
2. shifting service provision for people with mild to moderate mental health problems from secondary to primary care by providing capacity for primary mental health services (PCMHS) for OPMH;
3. developing a partnership with voluntary services to provide a weekend day care service at a Day Hospital building;
4. enhancing partnership with voluntary sector partners (such as Age Concern, Alzheimer's and Carer’s Resource) to contribute to integrated care pathways thus:
   a. improving throughput through services (such as Memory clinics, CMHT and Day Hospitals)
   b. preventing crises through monitoring and timely referral when secondary care is required (such a sign posting to RRICE)
   c. reducing need for acute secondary care OPMH services (such as in-patient care)
5. increasing nursing capacity on Rowan ward and in the remaining CUE;
6. increasing hours for the mental health nurse liaison post;
7. increasing hours for the assistant psychologist post;
8. increasing medical secretary hours for the consultant psychiatrist.

This proposal will release staff from one community unit for the elderly (CUE) residential in-patient service to provide the necessary resources within the OPMH service for the proposed developments. This will release staff for redeployment and should reduce the risk of failure of the proposal owing to staff recruitment problems.

The existing Revenue Budget for a Community Unit for the Elderly is £694,810 for a full year. The disaggregated Day Hospital revenue budget is £158,410 which comprises £1128,120 per annum for staff pay (4.6 WTE staff in post) and an estimated non-pay budget of £30,280. Therefore, the total sum from the current revenue budget allocated to run the 16 bedded residential unit, and the sum identified for reinvestment with the re-provision of these beds, is £536,400.

3.2 Increase the capacity of the Community Mental Health Team service

3.2.1 Redesign proposal for CMHTS: The first priority for redesign using revenue released by re-providing 16 beds is to increase the capacity of the community mental health teams (CMHT) for the elderly. The CMHT service
supports older people with severe, complex and/or enduring mental health problems to reside in community settings, maintain maximum possible independence and improve quality of life. The service has a significant role in preventing in-patient admissions and the need for long-term care placements. The NSF for Mental Health (DoH, 2000) states “community mental health teams provide the core of local specialist mental health services...Service users are more likely to stay in contact with community rather than hospital based services and are more likely to accept treatment. Studies suggest that these services help to reduce suicide rates” (page 47). Everybody’s business (DoH and CSIP, 2005) states that “the community mental health team is the backbone of the modern specialist older people’s mental health service” (p. 44).

Currently, the two CMHTs are configured to provide services for the older population served by GPs in the Harrogate Central and Wetherby consortia and the Rural consortia. Data from a Winter Pressures Audit (2000) and a CMHT Caseload Audit (2003) have clearly demonstrated a need to increase the staffing levels in the OPMH CMHTs service to meet need. There is disparity in core staffing, caseload figures, waiting lists and waiting times between workers / teams in adult mental health and OPMH. At present demand for the CMHT service outweighs the staff capacity to accept new referrals in a timely manner. In addition, the Approved Social Worker (ASW) role takes Social Workers away from CMHT caseload work and commitments to providing standardised assessments for the memory service takes occupational therapists away from CMHT caseload work.

The proposal is to:

- increase the Harrogate Central and Wetherby CMHTE staffing by 1.5 WTE mental health professional and 2 WTE health care assistants (HCA);
- increase the Rural CMHTE staffing by 1 WTE mental health professional and 1 WTE health care assistant;
- increase the overall CMHTE service staffing by an additional Registered Mental Nurse (RMN), who will be trained to undertake RNCC assessments across the whole district

(Please see Appendix E for details of projected costs)

This increased staffing level is required for a number of reasons:

3.2.2 Policy drivers: This proposal has been developed in response to a number of national directives including: Everybody’s Business (DoH / CSIP Nov 2005) section on Integrated community mental health teams (p. 44-46); Who Cares Wins (RCP; 2005); NSF for Mental Health (DoH, 2000) standards 6, 7 & 8; NSF for Older People (DoH, 2001) standard 7. An important national target is to reduce the length of wait between referral and first contact. Department of Health (DoH, 2005b) New ways of working for psychiatrists focuses on enhancing effective, person-centred services through new ways of working in multidisciplinary and multi agency contexts. Most recently the Department of Health (January 2006) “Our health, our care, our say: a new
direction for community services” highlights the need to move services from hospital to community settings wherever possible.

3.3.3 Reduction of waiting lists: Increased capacity is required to reduce waiting times. The Community Services manager reports as of March 2006 there was a waiting list of 60 service users across the CMHT service. In particular we need to reduce the risk of patients becoming more acutely ill whilst on the waiting list. In March 2006 the average length of wait for a CMHT assessment was around four months. For some time the CMHT has identified the need to implement a Triage system for assessing and prioritising referrals to CMHTs. Each referral would be picked up within seven working days and an initial assessment undertaken to:
- identify if the referral is appropriate;
- assess need and allocate appropriate waiting list priority;
- identify the most appropriate professional to take on the case;
- signpost / refer to other required services straight away.

Increasing CMHT capacity will enable this triage system to be implemented. The need for increased staffing is particularly acute in the Harrogate CMHT for the elderly, which consistently has the longest waiting times, biggest waiting lists and highest caseloads. Historically the Harrogate CMHT had two Community Psychiatric Nurses (CPNs) in the past. During the refurbishment 3 qualified staff were redeployed into the CMHT service and this had a positive impact on waiting times (see section 2.9, Table 7 and Figures 7 and 8), the benefit was particularly seen in the Harrogate and Wetherby team where the waiting list was reduced by 38.1%. The longest wait in the CMHT service was brought down to less than 3 months.

3.2.4 Timely transfer from RRICE to CMHT: The CMHT needs to have the capacity to be more responsive to referrals from the Rapid Response and Intermediate Care (RRICE) team when patients have finished a period of intermediate care but continue to have needs requiring longer term intervention. Increasing the capacity of the CMHT will enable referrals to be accepted from RRICE as needed and this will increase RRICE throughput and enhance the RRICE team’s capacity to meet the demand for rapid response and facilitated discharge services.

3.2.5 Frequency of contact: The Winter Pressures project and audit (2000) identified the need to reduce CMHT staff caseload size to increase frequency of contact where needed to support people to remain in the community. In March 2006 the average number per WTE staff was 36 service users per caseload. This is a high caseload, particularly bearing in mind that occupational therapists (OT) are seconded to the memory service to undertake standardised assessments and both Approved Social Workers (ASW) have to do rota / duty work.

3.2.6 Support for memory assessment and treatment service:
Everybody’s business (DoH and CSIP, 2005) states that one of the functions
delegated to more specialized teams are the “assessment of cognitive function in a memory assessment service and psychological therapies” (p. 44). Since 2003 four occupational therapists, from each of the CMHTs and Rowan ward, have been seconded for approximately one session per week to undertake standardised assessments for the memory clinic service. This commitment to undertake memory clinic assessments provides a valuable role but reduces capacity for the therapists’ CMHT caseloads. In addition, the CMHTs do not have the capacity to meet the needs of clients newly diagnosed with dementia at the memory clinic for early intervention. The identified need to increase memory clinics to meet referral demand will require double the current OT input into the memory service in future. As of March 2007 the majority of outstanding referrals on the CMHT waiting lists are for occupational therapy assessments linked to memory clinics.

Registered mental nurse input is needed for the OPMH memory service. A number of memory assessment and treatment services across the UK are staffed by RMNs; the OPMH service has not had the capacity to release RMNs from elsewhere in the service to support the memory clinic services in Ripon, Harrogate and Wetherby. Input from the occupational therapists in the CMHTs has proved effective. If people require CMHT input when their dementia becomes more severe / complex they are already known to a member of the CMHT. Two roles for RMN input have been identified as beneficial for the memory clinic service. First, all new patients with dementia and suspected dementia are currently referred to the memory clinics. Given the shortfall between current demand for this service and existing resources there is a need to review and refine the criteria / protocol for referral to memory clinics. With suspected early onset dementia cases, differential diagnostic needs and complex presentations being given priority. This would require the screening of referrals to the memory clinic service and this is a role that has been developed effectively elsewhere in the UK by RMNs. A nurse led initial assessment / screen / brokerage will be cost-effective because implementation should reduce the increasing burden on memory clinics and associated disciplines (as expensive Medical, Occupational Therapy and Clinical Psychology standardised assessment procedures services might be engaged more sparingly and where most needed). This would enable older People’s Mental Health Services to better focus service delivery and still fulfill NSF requirements by better tailoring our memory service to individual needs. Second, follow-up appointments for people post-diagnosis at the memory clinics, and particularly for service users on anti-dementia medication, are currently been dealt with by consultant psychiatrists and an Associate Specialist Psychiatrist in out-patients clinics. NICE guidelines state that patients should be followed up every six months, even when the GP has taken over prescribing after the first three months. Elsewhere in the UK follow-up clinics are being run effectively by RMNs. This would be a more cost-effective use of resources.

3.2.7 Capacity for funded nursing care contribution reviews: Increasing RMN staffing by 1 FTE and training this professional to undertake Registered Nursing Care Contribution (RNCC) assessments will increase the OPMH liaison nurse’s time for other key parts of the liaison role. The addition of an
RMN trained to undertaken RNCC work will release time for the current part-time OPMH Liaison nurse to undertake more liaison work on the general medical wards. There is local identification that significant numbers of older people with mental health problems stay in acute hospital beds longer than is necessary or desirable. There is a local need to “support timely discharge, breaking into the vicious cycle of institutionalisation”. At present there is only part-time service to provide liaison with medical wards to assess potential EMI patients in medical beds and to facilitate discharge planning. An increasing amount of her time has been spent on RNCC assessments. In the period April 2005 to January 2006 64 referrals were received for funded nursing care new assessments or unplanned reviews and all 64 were found to be required. This assessment workload reduces the time the OPMH Liaison nurse has available for consultation on the general medical wards. By September 2006 the number of outstanding EMI new, unplanned and routine reviews had climbed to 91. However, after four months increase staffing for reviews this had dropped by 73 cases to 18 outstanding reviews a reduction of 80.2% (see section 2.10 and Figure 9).

3.2.8 In-reach and support services: Everybody’s business (DoH and CSIP, 2005) states that one of the “key” functions of a CMHT is to advise and support other health and social care professionals, both from mainstream services and mental health services for younger adults” (p. 44) it also discusses the important roles of “in-reach support to the general hospital” and “support to care homes” (p. 44). Increasing the capacity of the CMHT will enable staff to offer more advice, education and support to other health and social care professionals, care home staff and voluntary service providers.

3.3 Re-provision of some secondary care work in an OPMH Primary Care Mental Health service (PCMHS)

3.3.1 Redesign proposal for PCMHS: The second priority is to redesign the service to provide an alternate, and more accessible and cost-effective, service for older people with mild to moderate mental health problems in primary care. At present this population is either referred to CMHTs and out-patients clinics (which adds an inappropriate pressure to secondary care waiting lists) or they are treated by their GPs, predominately with medication. The proposal is to enhance the capacity of the Primary Care Mental Health Services (PCMHS) to expand the provision to serve older people with common mental health problems. This would be achieved through increasing the current PCMHS skill mix with the addition of the following posts:

- 1 x 0.5 wte Band 7 CBT Post
- 1 x 0.5 wte Band 6 CBT Post
- 2 x 1.0 wte Band 5 Link worker posts
- 1 x 0.5 wte Band 4 Graduate Worker
- 1 x 0.5 wte Band 3 Secretarial Post

(see Appendix E for details of projected costs)
Older people develop common, mild to moderate mental health problems, secondary to a number of factors, loss of role following retirement, abnormal grief reactions following the loss of a loved one, secondary to other physical health problems (such as stroke and falls) and secondary to taking on a care-giving role. A PCMHS service is in place for working age adults but the existing Primary Care Mental Health Link-worker service does not cover older people. The proposed development would provide equity in access for common mental health problems as stated in NSF (2000). The proposed redesign would enhance the existing PCMHS enabling the service to take referrals for older people with moderate to mild mental health problems thus reducing pressure on secondary care services, particularly out-patient clinics and the CMHTs.

In addition to GP support and drug therapies, people will have access to a range of psychological therapies to address mild to moderate mental health problems, thus reducing the proportion of people who go on to develop severe and enduring MH problems. People with severe MH illness / at risk will be identified and referred to secondary services, such as the CMHT, consultant psychologist, consultant old age psychiatrist and Memory assessment and treatment service, thus reducing crises necessitating admissions to in-patient care.

3.3.2 Local needs - prevalence of common mental health problems in older people: The proportion of older people in the area serviced by NYYPCT is increasing steadily. The population aged 65 and over in the Yorkshire and Humber region has increased and now forms around 18% of the locality population. This proportion is projected to increase to 22% over the next fifteen years. The functional illness that is most discussed in the NSF for Older People, Standard 7 is depression. Depression is the most common mental health problem of later life, affecting approximately 15% of older people (Beekman et al, 1999), and 3% of older people have “severe”, or “psychotic” depression (DoH, NSF for Older People, 2001). The Royal College of Psychiatrists (RCP; 2005) found that the prevalence of depression increased in older people admitted to general hospitals and affected around 29% in this group. Given a population estimate of people over the age of 65 years of 26,300 in Harrogate and Rural (2001 Census) and a rate of 15% we would estimate that 3945 older people would have some form of depression. Suicide in older people is strongly associated with depression, physical pain or illness, living alone and feelings of hopelessness and guilt. Other common functional mental illnesses include (prevalence rates from the Royal College of Psychiatrists, 2005) anxiety disorders affect 3% of older people giving an estimated population of 789 older people with anxiety in Harrogate and Rural District; alcohol misuse affects 2% of older people giving an estimated population of 526 older people with alcohol dependency in Harrogate and Rural District; drug misuse, including dependency on prescribed drugs, affects 11% of older people giving an estimated population of 2893 older people dealing with drug misuse in Harrogate and Rural District.
The growing older people will have a substantial and increasing need for psychological services owing to their greater susceptibility to both mental and physical ill health and their increased risk of suffering adverse life events. “Psychological therapies are part of essential healthcare. There is overwhelming evidence for their effectiveness in treating wide variety of mental health problems and illnesses....The term 'psychological therapies' covers a wide range of different models, including psychodynamic, cognitive behavioural, arts-based and systemic approaches. No one therapy, or one group of practitioners, is able to provide effective treatment for the range of difficulties experienced by people with mental health problems” (DoH, 2004, p.3).

3.3.3 Policy drivers: This proposal has been developed in response to a number of national directives including:

- Everybody’s business (DoH / CSIP, Nov 2005) p. 24-27: Primary care;
- NSF for Mental Health (DoH, 2000) standards 1, 2 & 3: “Any service user who contacts their primary care team with a common mental health problem should: have their mental health needs identified and assessed; be offered effective treatments”;
- NSF Older People (DoH, 2001a) Standard 1: “services will be provided, regardless of age, on the basis of clinical need alone” and standard 7.23 “Early recognition and prompt treatment of depression...” and 7.27 “offering psychological therapies...”
- Most recently the Department of Health (January 2006) “Our health, our care, our say: a new direction for community services” highlights the need to move services from secondary to primary care wherever possible to increase earlier identification and remediation of problems in primary care settings.

3.3.4 Shift towards evidenced based practice: There is ample evidence that psychological approaches and interventions are effective in meeting the psychological needs of older adults and their carers across all programs of care and at all levels of service. The Everybody’s Business service development guidance from DoH and CSIP (2005) for “Integrated mental health services for older adults” states “users of mental health services consistently place access to psychological therapies at the top of their list of unmet needs: they are deemed a useful addition to other approaches, or are the therapy of first choice” (p. 49). The DoH (2001b) Evidenced Based Clinical Practice Guidelines on “Treatment choice in Psychological Therapies and Counseling” specifically recommends that particular attention is given to the needs of older people. Evidence has demonstrated that the person’s age is not an important factor in choice of therapy (DoH, 2001b). In its guidance on “Organizing and Delivering Psychological Therapies” the Department of Health directed providers and commissioners to “ensure that service delivery is not restricted by extraneous factors such as ethnicity, age, gender, and diagnosis and pay special attention to marginalised groups such as people with learning disabilities, older people and people from black and minority ethnic communities”. (DoH, 2004, p. 46)
3.3.5 Stepped Care Model: The developing PCMHS model is based on the stepped care approach described in NICE guidelines for common mental health problems. The proposed skill mix will assist in the effective delivery of a stepped care model. The Primary Care Link Workers, CBT therapists and graduate worker will work with GP practices to offer direct clinical work (assessment, short-term interventions, medium term CBT interventions and signposting to relevant services) and provide support and education to primary care colleagues. PCMHS have also introduced a successful group based intervention for people with stress related problems and this model should be expanded for older people experiencing stress.

The Princess Royal Trust for Carers surveyed 5,000 carers and published results during Carers’ Week 2006 (http://www.carers.org/news/cks-carers-face-health-crisis-of-their-own,923,NW.html accessed 28 March 2007). “The vast majority of those questioned (79%) reported that caring had made their health worse, and yet just one in four (27%) had been offered a health check by their GP. 89% of carers thought they should be offered an annual health check. 71% of carers said that health problems affected their own ability to care and, in turn, 57% said their health problems were affecting the person they cared for. The most common complaints, stress/worry (91%), depression (58%) stem from the emotional impact of caring, while backache (50%) demonstrated the physical toll on the health of carers.” Deterioration of a carers health is a major factor in the decision for a person to move to long-term care. With the cost of continuing care rising each year, it is essential that we address the mental health needs of carers as well as of service users accessing secondary care mental health services. PCMHS staff play an important role in educating GPs about the importance of screening carers for common mental health problems. The enhanced PCMHS will be able to expand existing successful models of guided self-help and group / individual brief therapy interventions to provide appropriate intervention for carers experiencing debilitating stress and depression associated with the emotional and physical burden of providing care.

First levels of intervention in the stepped care model include, Guided Self-help (bibliotherapy: the use of written material to help people understand their psychological problems and learn ways to overcome them by changing their behaviour, based on CBT principles) which is to be supported by the Band 4 Graduate worker. Short-term psychological treatment such as problem-solving therapy, brief CBT usually delivered across 6 to 8 sessions over 10 to 12 weeks which is to be delivered by Band 5 Link workers.

3.3.6 Cognitive Behavioural Therapy: An important aspect of the redesign proposal is the enhancement of provision for the delivering of Cognitive Behavioural Therapy (CBT). The redesign design proposal has identified the need for a 0.5 WTE Band 7 and 0.5 WTE Band 6 Mental Health professional trained to deliver cognitive behavioural therapy to increase access of older people with mental health problems to CBT. The PCMHS has a therapists who has trained in CBT to a masters degree level and who is leading the development of CBT provision, she will provide supervision to the proposed
Band 7 and 6 workers. The National Institute of Clinical Excellence (NICE) has published guidelines on the management of common mental health problems (NICE, 2004a, 2004b). Within these guidelines CBT is the psychological treatment of choice for a number of conditions, with interpersonal psychotherapy (IPT) being an alternative. Both CBT and IPT should be delivered by a healthcare professional competent in their use – treatment typically consists of 16 to 20 sessions over 6 to 9 months. In cases of severe depression intensive CBT may be offered, for example providing 2 sessions of CBT per week for the first month of treatment. Where patients have responded to a course of individual CBT or IPT, capacity should enable follow-up sessions, typically 2 to 4 sessions over 12 months.

3.4 Increase in-patient nursing capacity

3.4.1 Redesign proposal for in-patient services: The proposal is to increase the nursing capacity for the in-patient service by four WTE Band 5 Registered Mental Nurses (RMN). Of which 2 WTE RMNs will increase staffing on Rowan ward and 2 WTE RMNs at the remaining CUE residential unit (see Appendix E for details of projected costs).

Although the focus is on maintaining people in the community, “admission is essential on occasions for the assessment, treatment and rehabilitation of older people with a range of [mental health] diagnoses, who cannot be cared for in the community or other settings due to the intensity and expertise of care required. A proportion of people will be detained under mental health legislation for assessment or treatment. Many will have complex physical and mental health needs... There are likely to be very high levels of need on in-patient wards and wards should be staffed accordingly, for the safety and well-being of service users and staff” (Everybody’s business, DoH and CSIP, 2005, 50-51)

This proposal is for a number of reasons.

3.4.2 Increasing dependency levels: First, the mental health directorate’s experience of reducing beds on Willow Ward resulted in an increase in the dependency levels, complexity and severity of cases admitted to the remaining beds on Cedar ward. It was anticipated that similar increases in dependency levels, complexity and severity of illness will be experienced on Rowan ward and the CUE residential unit when we reduced from 52 to 36 OPMH beds. This has already been noted during the four month evaluation period. Staff have observed that dependency levels amongst in-patient populations have increased since the proportion of people who are delayed transfers of care and fit for discharge has been reduced. The Unit manager at Alexander House reports that owing to the mixed needs of the client group at this point, even when the unit is only at 75 – 80% occupancy the staffing level needs to be maintained at 5 staff for early shifts across Tuesday – Friday (note: the unit always has 5 staff on Mondays because it is the admission day for booked respite admissions and more staff are required during week days, as opposed to weekends, because of assessments, doctors needing access to patients, increase phone calls being received, etc.). In the past the unit
manager reports that he was frequently able to reduce to 4 staff on Tuesdays to Fridays if the bed occupancy was less than 80% because lower dependency levels allowed it. Before when the unit has a substantial proportion of clients waiting for transfer, the mix had less dependent people. Now the majority of clients have high dependency needs that require health provided respite or are admitted for intensive assessment and rehabilitation. Staff on Rowan ward have noticed an increase in the number of people displaying challenging behaviours such as verbal and / or physical aggression and sexual disinhibition. Increased qualified staffing is required to deliver person-centred interventions and to provide the level of rehabilitation required to enable successful discharge back to community settings. The DoH and CSIP (2005) recommend “the number of ward based nursing and care staff necessary will be contingent on the dependency level and the needs of the patient group at any one time. It is essential that intensive and close supervision can be provided where necessary” (p. 52).

3.4.3 Impact of Agenda for Change and mandatory training requirements: Second, this increased staffing is proposed in response to staffing levels required to cover additional annual leave entitlement from Agenda for Change and to release staff for mandatory training.

3.4.4 Clinical leadership: Third, it is also required to release Unit managers from clinical demands to fulfil their management and leadership responsibilities.

3.4.5 Overtime and agency cost reduction: Fourth, the current staffing ratios are lower than those for OPMH beds elsewhere in NYYPCT. Harrogate and Rural have a significantly higher agency and overtime spend than OPMH services where the staffing ratios for inpatient areas are more robust. The current staffing ratios on Rowan ward are lower than the staff ratios on Cedar ward and this was identified as a concern in a review of nursing staff capacity.

3.5 Partner with other agencies to provide joint weekend day care

3.5.1 The redesign proposal for day services: Day services for older people with mental health problems are defined as any service provided by a statutory or non-statutory organisation that is available during the daytime, evening or weekends for an older person with a mental health problem to use. It does not include services that have a residential or overnight element. Day services are required for people with both organic (e.g. dementia) and / or functional (e.g., depression, psychosis) mental health problems. The proposal is to extend day service provision in partnership with Adult and Community Services and voluntary service sector in order to provide a jointly staffed day care provision at weekends based in one of the CUE Day Hospitals. OPMH will fund:

- 1 WTE registered mental nurse (RMN)
- invite tenders from 3rd sector to manage the service and provide additional staffing.
3.5.2. **Policy drivers**: This proposal is in response to a number of national and local policies and priorities: The NSF Older People 7.51 states “Community based mental health services should include: day care providing a range of stimulating group and one to one activities”. The District Audit “Mental Health Services for Older People, North Yorkshire Audit 1999/2000”: Action plan 5: was to “increase day care tailored to needs.” Forget Me Not (Audit Commission, 2000) Section 3, 101, 103, 105 & 109.

The DoH and CSIP (2005) recommend that “specialist day services provide care for people with more moderate and severe needs who may need specific personal support with day to day activities, including people with functional mental illnesses like depression, anxiety and schizophrenia; and people with moderate to severe dementia. Centres should have flexible operating hours, being able to offer care at weekends and in the evening if this is required” and it recommends that “specialist staff might be used to help people settle in and to support unqualified staff” (p. 30).

3.5.3 **Local day services mapping**: Evaluation of day services undertaken 2000-2003 and a more recent interagency OPMH Day Service Review (April 2006) have both identified a lack of flexible, accessible and stimulating day care options for older people with mental health problems, particularly people with moderate to severe dementia. Within Harrogate and Rural areas there is very little service provision for clients who are ready to be discharged from the day hospitals and this leads to reduced throughput. Carers require flexible respite options, including day care available at weekends. Respite is needed in order to reduce carer burden, and thereby reduce the risk of in-patient admissions related to a breakdown in the informal care provision. OPMH needs can be complex and staff and volunteers from voluntary sectors can deliver care to people with higher levels / more complex mental health needs if a service is delivered with support from a qualified mental health professional. Older people with mental health problems, particularly people with organic mental health problems, can develop sudden changes in mental functioning. The availability of an RMN will allow service users to be monitored and a prompt assessment of changing condition and needs to be made.

3.6 **Increase the mental health liaison nurse hours**

3.6.1 **Redesign proposal for mental health liaison**: *Everybody’s Business – Integrated mental health services for older adults: a service development guide* (DoH and CSIP, 2005) states that “a systematic review of the literature shows that up to 60% of people aged 65 and over have or develop a mental health problem during admission to a general hospital. These disorders are independent predictors of poor outcome in terms of increased mortality and length of stay, loss of independent function and increased likelihood of transfer to long-term institutional care. They are also associated with
increases in hospital-acquired complications, increased likelihood of readmission and use of health and social care services. There is evidence that mental health problems are poorly detected and managed by general hospital staff” (p. 41).

There is local identification that significant numbers of older people with mental health problems stay in acute hospital beds longer than is necessary or desirable. There is a local need to “support timely discharge, breaking into the vicious cycle of institutionalisation”. At present the mental health liaison nurse for OPMH is only employed 26 ¼ hours per week. Additional hours are required to meet demand; the proposal is to increase the post to fulltime. The role involves:

1. Providing initial assessment of older people with mental health / suspected mental health diagnosis in the acute hospital setting to promote safe effective discharge where possible.
2. educating and training staff on general wards about the management of mental health problems.
3. Reducing crisis transfer of people to Mental Health wards.
4. Prioritising referrals from for Old Age Psychiatrists.
5. Undertaking RNCC assessments.

The proposed additional hours to increase the liaison role on the wards, will allow more time for the education and training role and more time for the supervision and CPD of this staff member. The post holder undertakes FNCC assessments and this is taking a significant and increasing amount of time. The RMN in RRICE has now been trained to undertake RNCC assessments and reviews. The CMHT proposal will provide a second trained RMN for RNCC work. But even with two RMNs to assist with RNCC work, there is still a need to increase capacity for direct liaison work on the general medical wards. The Associate Specialist old age psychiatrist has been identified as the medical lead for the liaison service. Who Carers Wins (RCP, 2005) highlights the need for a team approach to liaison. Increased hours are required to increase time available for the liaison nurse to work more closely with the Associate Specialist, for example for undertaking joint assessments of service users who might be transferred to an OPMH bed.

3.6.2 Policy drivers: This service model is recommended by the National Beds Enquiry (1998), Planning Priorities Guidance: targeted delayed discharges (DoH, Sept ’02), Audit Commission (2000 / 2002) and NSF Older People standards 3 & 7: 7.56 which state “Specialist mental health services for older people should provide advice and outreach to those providing: hospital care, where are known to be particularly high levels of mental health problems in older people”

This proposal is in response to the Royal College of Psychiatrists (RCP; 2005) “Who Cares Wins: improving outcomes for older people admitted to general hospital. Guidelines for the development of Liaison Mental Health Services for Older People”. This document was produced in collaboration with the Royal College of Nursing, the Alzheimer’s Society and the British Geriatric Society and is being highlighted by the Dementia Services Collaborative (DSC) and
the National Institute for Mental Health for England (NIMHE). In the recommendations for Mental Health services (p.9) recommendation 17 states that mental health services “need to ensure that the development of liaison mental health services for older people in acute hospitals is clearly identified as a priority in business planning”. It also states that MH services “must ensure that time for education and training of general hospital staff is built into the description of service and job plans” and “must ensure that all mental health professionals with liaison responsibilities receive proper induction, clinical supervision and opportunities for personal development with access to relevant training”.

3.7 Increase capacity in psychology assistant post

3.7.1 Redesign proposal for OPMH psychology services: The proposal is to increase the psychology assistant post from 0.5 WTE for 1 FTE to meet the increased demand for assessment and intervention for people with memory problems.

The psychology assistant administers the CANTAB for the memory service pathway and utilises the computerised version of this standardised measure. In the past this post was increased to 1 WTE short-term from savings occurred from vacancies within OPMH and psychology and the increased capacity helped to reduce waiting times for psychology assessment. The current 0.5 WTE Psychology Assistant is not sufficient to meet the demand for standardised psychometric testing to aid diagnosis in the expanding memory service. A dedicated full-time psychology assistant is required for the memory service and also to provide input into the Memory Activity and Self-Help (MASH) group. Without additional funding for a psychology assistant the Clinical Psychologist will not have the capacity to provide any post diagnostic interventions for people with complex presentation.

3.8 Increase medical secretarial support for Old Age Consultant Psychiatrist

The proposal is for an additional 12.5 hours Band 4 secretarial time for one of the consultant psychiatrists in OPMH increasing the post to fulltime. One of the two old age psychiatrists has only 25 hours secretarial support per week compared all the other MH psychiatrists who have a 1WTE secretary (see Appendix E for details of projected costs). Over the past three years this consultant has taken on additional workload related to service developments, such as memory clinics in Harrogate and Wetherby and her role as lead consultant for the Rapid Response and Intermediate Care for EMI (RRICE) service. However, she has had no additional secretarial support for these roles. The consultant has been the lead for the OPMH Clinical Effectiveness Group and for Mental Health Audit; this has led to an additional workload for her secretary typing minutes and circulating minutes and agendas for these groups.
3.9 Enhancing collaborative working to deliver integrated care pathways

3.9.1 Redesign proposal for increased commissioning of services from voluntary sector

Alzheimer’s offer a range of services including one to one support, carers group, social groups for people with dementia and their carers, newsletter and they telephone each service user/carer on a three monthly basis. Alzheimer’s has agreed to co-ordinate the interagency Memory Activity and Self-Help Group (MASH) which people are referred to from the memory service. Funding is required to address the increased referrals to Alzheimer’s from the OPMH service and to support the transfer of the organisation of the MASH service from the CMHT to Alzheimer’s.

Carer’s Resource provides a detailed carer assessment at the OPMH outpatient and memory clinics, including a standardised Carer Strain measure. They contact carers and service users prior to follow-up appointment to increase clinic attendance. They offer information on benefits and services. They provide one to one and group based emotional support for carers and they have a regular newsletter. Funding is required to expand the role of the CSO from the Carers’ Resource to serve the new clinics and to address the increased referrals from OPMH.

Age Concern has developed a range of very valuable services at Cliff House in Knaresborough. Referrals to both weekday day care and weekend day respite services from OPMH have increased. This supports throughput through the secondary care day hospital services. The weekend Respite Service for older people with mental health problems developed at Cliff House will accept referrals from across the District, but at present can only be accessed by those carers who can organise their own transport for service users. Funding is required for transport costs to enable more people to access weekend respite service and to address the increased referrals to Age Concern from OPMH services.

3.9.2 Policy drivers: When Everybody’s business was launched in November 2005, Ian Philp, National Clinical Director for Older People said: "Providing services for people with mental health needs can be complex as they cut across health and social care, physical and mental health and mainstream and specialist services. It is essential to make sure that people’s needs are met in a co-ordinated way, and that they don’t fall between gaps in the system." (http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4123254 accessed 28.03.07). Service users and carers are often confused as to which organisation is providing the service and what the qualification of the worker is and many do not really care who provides the services, as long as they are timely and what they need. People with dementia and their carers often cite lack of co-ordination in service provision as a major problem they face. The Department of Health encourages health service providers to look
for new ways of working with private and voluntary organisations to help create more choice and encourage innovation in the NHS. The 10 High Impact Changes for mental health (CSIP and NIMHE, 2006) recommends that we optimise service user and carer flow through the service using an integrated care pathway approach. Everybody’s business states “there are various ways in which systems can work together to secure a broad range of services to meet local population needs. These include … integrated services, involving restructuring of existing service provision” (p.22) and that “voluntary organisations have a role not only in advocating for people with mental health problems but also in providing or supporting the provision of services (DoH and CSIP, p. 21).

3.9.3 The importance of an interagency approach: Joint working with the voluntary sector is a critical part of our developing integrated pathways for different groups of services users. For sometime, the OPMH service has been working closely with the voluntary sector; particularly around the development of an integrated pathway for people with dementia. Input from Carers Resource and Alzheimers into the memory service is very cost-effective and valued by service users and carers. The role of the Carers Resource Officer, developed at the memory clinics, has now been expanded to other out-patient clinics and referrals from health to Alzheimers continue to rise. However, this additional voluntary provision has not been funded by health and the organisations continue to rely on a substantial amount of charitable funding leaving services vulnerable. It is important for service users and carers to have someone who can help to facilitate their journey through the care pathway and who “walks the journey” from the onset of symptoms right through to the end of the pathway. This enables the health service to discharge service users knowing that they will be in regular contact with skilled workers who will signpost them back to health care services if their function changes or problems start to increase. This leads to a smooth transfer back to secondary services when needs increase thus preventing the need for crisis in-patient admissions.

3.10 Re-provision: Outcomes Intended

CMHT proposal outcomes:
- Provide initial assessment of all referrals to CMHTs as soon as possible and not exceeding 7 working days
- Prioritise cases for intervention.
- Reduce waiting time for assessment for all patients to under 13 weeks.
- Increases frequency and amount of contact between CMHT service and service users / carers when required.
- Provides capacity for interventions with people in the early stages of dementia.
- Increase service capacity for FNCC assessments.
- Education and support of staff in mainstream services improves the care of people’s mental health needs in these settings.
PCMHS proposal outcomes:
- Reduce referrals for people with mild to moderate mental health problems to the CMHTs and out-patients clinics releasing capacity for the CMHT and clinics to more effectively serve people with severe and enduring mental health problems.
- Provide a stepped care model for older people with mental health problems.
- Increase access to psychological therapies for carers of older people with mental health problems who are experiencing stress and anxiety related to their caring role.
- All appropriate referrals of older patients with a common mental health problem to be seen by a Primary Care Link Worker to have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.
- Provide parity of access to PCMHS service for older people.

Weekend day care proposal outcomes:
- Provide suitable longer-term day care option for OPMH service users thus allowing increased discharges from the OPMH day hospital service and increasing throughput.
- Provide a realistic alternative to hospital admission through the provision of weekend respite day care to carers.
- Partnership working with voluntary sector.
- Use of purpose built environment that is currently under used at weekends.

Increase commissioning from voluntary sector proposal outcomes:
- to facilitate the user’s journey through the integrated care pathway
- voluntary sector workers stay in contact with the service user and carer from the onset of symptoms right through to the end of the pathway.
- Increases throughput through secondary OPMH services as staff can discharge service users with confidence knowing that they will be in regular contact with skilled workers who will signpost them back to health care services if their function changes or problems start to increase.
- Ensure smooth transfer back to secondary services when needs increase thus preventing the need for crisis in-patient admissions.

Increase In-patient RMN capacity proposal outcomes:
- Ensure adequate staffing levels to address anticipated increase in the dependency levels of service users in the reduced 36 beds.
- Ensure adequate staffing levels to cover additional annual leave entitlement from Agenda for Change
- Ensure adequate staffing levels to release staff for mandatory training.
- Increase RMN levels to release Unit managers from clinical demands to fulfil their management and leadership responsibilities.
- Reduce overtime and agency costs.
Increase mental health liaison nurse capacity proposal outcomes:
- To increase the liaison role on the Harrogate District Hospital general medical wards.
- To increase the provision of education and training of staff in general medical settings on mental health issues.
- To increase time for working closely with the Associate Specialist old age psychiatrist who is leading the liaison service;
- To allow more capacity for supervision and CPD of this staff member (as recommended in Who Cares Wins, RCP, 2005).

Increase psychology assistant capacity proposal outcomes:
- Reduce waiting times for psychology assessment.
- Increase input into the Memory Activity and Self-Help group intervention.
- Increase Consultant Psychologist capacity for individual post-diagnostic intervention for people with complex presentation.

Increase medical secretary hours for OPMH consultant psychiatrist – proposal outcomes:
- Provide OPMH consultant psychiatrist with adequate level of medical secretary support to the equivalent staffing level of the other consultant psychiatrists.
- Ensure secretarial support for the consultant psychiatrist for memory clinic service and RRICE work

3.11 Next steps

3.11.1 Support of the commissioner
The modernisation manager has been liaising closely with the MH commissioner during this project. The commissioner fully supports the proposed OPMH service redesign.

3.11.2 Future use of vacated space:
A number of options are being considered, including:
- relocating teams or clinics in leased buildings thus releasing savings.
- Current discussions with commissioner to use space for a elderly challenging behaviour unit for NYY PCT with approx 10 beds and bring people back from out of area (each person currently costing between £70,000 - £90,000 per year). Commissioner would invest in staffing new unit and anticipated substantial savings from providing care within North Yorkshire.
- Commissioner has also discussed the need for an intensive rehabilitation unit for working age adults in the Harrogate area.
References


Care Services Improvement Partnership (CSIP) and National Institute for Mental Health for England (NIMHE) (2005) 10 High Impact changes for mental health services. Available as a pdf file from: www.nimhe.csip.org.uk/10highimpactchanges

Department of Health (DoH; 2006) “Our health, our care, our say: a new direction for community services” Available from www.dh.gov.uk


Department of Health (DoH; 2001b) Treatment Choice in Psychological therapies and Counselling. Evidence based Clinical Practice Guidelines. DoH. www.doh.gov.uk/mentalhealth


National Institute for Clinical Excellence (NICE) (2004a). Anxiety: Management of Anxiety (panic disorder, with or without agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care.


List of abbreviations

ASW   Approved Social Worker
CBT   Cognitive Behavioural Therapy
CHRD PCT  Craven, Harrogate and Rural District Primary Care Trust
CMHT  Community Mental Health Team
CPD   Continuing Professional development
CSIP  Care Services Improvement Partnership
CUE   Community Unit for the Elderly
DoH   Department of Health
DSC   Dementia Services Collaborative
DTOC  Delayed Transfers of Care
EB    Everybody’s Business service development guide
EMI   Elderly Mentally Ill / Infirm
FNCC  funded nursing care contributions
HCA   Health Care Assistant
HDH   Harrogate District Hospital
LTC   long-term care
MASH  Memory Activity and Self-Help Group
MATS  Memory assessment and treatment service
MDT   Multidisciplinary team
MLN   Managed Learning Network
NEYH  North East Yorkshire and Humber
NICE  National Institute for Clinical Excellence
NIMHE National Institute of Mental Health for England
NYY PCT North Yorkshire and York Primary Care Trust
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>nmhp</td>
<td>National Mental Health Partnership</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>NYCC</td>
<td>North Yorkshire County Council</td>
</tr>
<tr>
<td>OPMH</td>
<td>Older People with Mental Health Problems</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PWD</td>
<td>People with dementia</td>
</tr>
<tr>
<td>RRICE</td>
<td>Rapid Response and Intermediate Care for Elderly mental Ill</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Nurse</td>
</tr>
<tr>
<td>RNCC</td>
<td>registered nursing care contribution</td>
</tr>
<tr>
<td>SITREP</td>
<td>Situation Report related to delayed transfers of care</td>
</tr>
<tr>
<td>SSI</td>
<td>Social Services Inspectorate</td>
</tr>
<tr>
<td>SW</td>
<td>Social Worker</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole time equivalent</td>
</tr>
</tbody>
</table>
### Harrogate and Rural Older People’s Mental Health (OPMH) Service: Evaluation of reducing bed numbers during refurbishment of the Orchards

<table>
<thead>
<tr>
<th>Area to be measured</th>
<th>Data to be collected</th>
<th>Frequency of data collection, e.g. Daily, weekly, monthly</th>
<th>Is this routinely collected, if yes who has access to this data and will submit.</th>
<th>If No, who has taken responsibility to collect this data and submit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delayed transfers of Care (DTOC)</strong></td>
<td>- Record number of DTOC and % of total bed capacity represented by this number.</td>
<td>Weekly (note mental health SITREPS are monitored fortnightly so this was changed to every 14 days)</td>
<td>Yes, through the Situation Reports (SITREPS). Base-line data available. Belinda Goode and Margaret Cooper have access to data.</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>- Number of bed days waiting per person on the DTOC list</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Category (self funding, continuing care etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reason for wait (lack of suitable placement, waiting for place of choice, waiting for funding)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bed occupancy percentage</strong></td>
<td>- Record % occupancy across OPMH beds for Alexander House and Rowan ward</td>
<td>Monthly</td>
<td>Yes, quarterly figures reported to Governance.</td>
<td>Alison to check where she can access data.</td>
</tr>
</tbody>
</table>
Appendix A (continued)

<table>
<thead>
<tr>
<th>Area to be measured</th>
<th>Data to be collected</th>
<th>Frequency of data collection, e.g. Daily, weekly, monthly</th>
<th>Is this routinely collected, if yes who has access to this data and will submit.</th>
<th>If No, who has taken responsibility to collect this data and submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed availability:</td>
<td>Are OPMH beds available to timely admissions when needed:</td>
<td>Per incident as it occurs</td>
<td>Only recorded if lack of bed results in PCT having to pay for a bed elsewhere. Need more data to be collected during evaluation period</td>
<td>Linda Denham agreed to monitor community demand for admissions through the Capacity Risk Assessment meeting (CRAM) and to add a paragraph on pressures in the notes from CRAM meetings. Consultants to ask their secretaries to e-mail Alison Laver if they have difficulty finding a bed for admission. Dr Bhat and Margaret Cooper to e-mail Alison Laver with details of people waiting on General wards.</td>
</tr>
<tr>
<td></td>
<td>• Crisis admissions from the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transfers from General wards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Record:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What type of bed was needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reason bed was not available (e.g. no male beds available on Rowan ward).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Length of time taken to resolve situation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area to be measured</td>
<td>Data to be collected</td>
<td>Frequency of data collection, e.g. Daily, weekly, monthly</td>
<td>Is this routinely collected, if yes who has access to this data and will submit.</td>
<td>If No, who has taken responsibility to collect this data and submit</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Staffing Levels</td>
<td>Monitor where staffing levels have to be increased above the usual level owing to increased dependency levels amongst patients. Record: • Number and type of additional staff required. • Reason for increase. • Length of duration of increased staffing level.</td>
<td>Per incident as it occurs.</td>
<td>Yes, have baseline since April 2006 Pauline Whitehead to pass data to Alison Laver</td>
<td>N/A</td>
</tr>
<tr>
<td>Readmission Rates</td>
<td>Monitor changes in readmission rates to Alexander House and Rowan Ward.</td>
<td>Monthly</td>
<td>Yes, reported at Governance. Baseline data available. Alfonso to check where she can access data.</td>
<td>N/A</td>
</tr>
<tr>
<td>Staff short term sickness rates</td>
<td>• % of staff on short term sick leave</td>
<td>Monthly</td>
<td>Yes, HR collect and Emma Finch provides to Pauline Whitehead</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Appendix A (continued)

<table>
<thead>
<tr>
<th>Area to be measured</th>
<th>Data to be collected</th>
<th>Frequency of data collection, e.g. Daily, weekly, monthly</th>
<th>Is this routinely collected, if yes who has access to this data and will submit</th>
<th>If No, who has taken responsibility to collect this data and submit</th>
</tr>
</thead>
</table>
| **Respite admissions:** Need to evaluate whether the amount of respite received by service users / carers currently getting planned respite is not negatively impacted. Need to evaluate whether the service can meet demand for new respite admissions and for respite / assessment admissions when needed. | - Number of booked respite admissions cancelled  
- Number of planned respites where length of respite stay was reduced from usual amount.  
- Number of respites that have to be changed and rebooked and the length of the delay from planned respite date to actual respite received.  
- Record:  
  - What type of bed was required, e.g. emergency respite as carer was ill, booked respite.  
  - Outcome.  
  - Reason respite bed was not available (e.g. respite admission patient became ill and was unable to be discharged as planned) | As each incident occurs. | No.  
No baseline, but OPMH refurbishment project group and the Harrogate OPMH Strategy and Planning group agree that this has not been a problem in the past and only a couple of incidences could be remembered. | Graham Youhill and Alison Holmes to record each incident and provide details to Alison Laver.  
Form developed to record data. |
<table>
<thead>
<tr>
<th>Area to be measured</th>
<th>Data to be collected</th>
<th>Frequency of data collection, e.g. Daily, weekly, monthly</th>
<th>Is this routinely collected, if yes who has access to this data and will submit.</th>
<th>If No, who has taken responsibility to collect this data and submit</th>
</tr>
</thead>
</table>
| RRICE pressures     | • Monitor any changes in referral rates  
                     • Monitor capacity and waiting time issues  
                     • Record if an appropriate referral is refused owing to capacity issues. | Monthly  
                     Per incident as it occurs. | Yes, Belinda Goode and Caroline Gomersall monitor and collect data. Baseline data available. | Yes, Belinda Goode now keeping records  
                                                                                 For refused referrals Caroline Gomersall to email Alison Laver with details of each incident. |
| CMHT pressures      | • Waiting list numbers and category  
                     • Waiting times  
                     • Caseload sizes | Monthly | Yes, Belinda Goode monitors and collects data. Baseline data available. | Not applicable |
Appendix B

Harrogate and Rural Older People’s Mental Health (OPMH) Service:
Evaluation of reducing bed numbers during refurbishment of the Orchards

Form for recording availability of beds for Respite admissions

Please complete this form for EACH incident when:
- a booked respite has been cancelled or delayed
- an emergency respite can not be accommodated
- a new request for respite cannot be accommodated with in the referrer’s requested time scale.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of bed was required? e.g.</td>
</tr>
<tr>
<td>- Booked respite</td>
</tr>
<tr>
<td>- Request for booked respite to be brought forward</td>
</tr>
<tr>
<td>- New respite referral</td>
</tr>
<tr>
<td>- Emergency Respite</td>
</tr>
<tr>
<td>What was the reason the respite bed was not available? e.g.</td>
</tr>
<tr>
<td>- Previous booked respite patient became unwell and could not be discharged as planned</td>
</tr>
<tr>
<td>What was the outcome? e.g.</td>
</tr>
<tr>
<td>- Respite has been rebooked</td>
</tr>
<tr>
<td>- Respite will be delayed by 3 weeks</td>
</tr>
<tr>
<td>- Patient received respite elsewhere (state where and who funded)</td>
</tr>
<tr>
<td>If this was a booked respite that has been cancelled have you been able to offer an alternative date?</td>
</tr>
<tr>
<td>If yes, how long will the patient and carer wait between the original date booked and the rescheduled respite date?</td>
</tr>
<tr>
<td>If this was a booked respite has the length of respite usually received been reduced?</td>
</tr>
<tr>
<td>If yes, how many days less respite is being offered / provided?</td>
</tr>
<tr>
<td>Completed by (name and position)</td>
</tr>
</tbody>
</table>

Once completed please keep a copy on file and e-mail a copy to Dr. Alison Laver at a.laver@btopenworld.com.

AJL, 23.08.06
Appendix C

Harrogate and Rural Older People’s Mental Health (OPMH) Service:
Evaluation of reducing bed numbers during refurbishment of the Orchards

Form for recording availability of beds for transfers from general wards

Please complete this form for EACH incident when:

- an appropriate referral for transfer from a general ward to an OPMH bed cannot be accommodated with in the referrer’s requested time scale.

<table>
<thead>
<tr>
<th>Date</th>
<th>What type of bed was required? e.g.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Rowan</td>
</tr>
<tr>
<td></td>
<td>• CUE</td>
</tr>
<tr>
<td></td>
<td>• Respite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the reason the bed was not available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No beds available on Rowan</td>
</tr>
<tr>
<td>• No beds available in the CUE</td>
</tr>
<tr>
<td>• Beds available but not for a person of this gender (e.g. only male beds available)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the outcome?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient remains on general ward</td>
</tr>
<tr>
<td>• Discharged home with support from RRICE</td>
</tr>
<tr>
<td>• Discharged to another destination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long did it take before an OPMH bed was available?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Completed by (name and position)</th>
</tr>
</thead>
</table>

Once completed please keep a copy on file and e-mail a copy to Dr. Alison Laver at a.laver@btopenworld.com.

AJL/06
## Appendix D

**Title:** Average daily number of available and occupied beds by sector, England, 2005-06  
**Source:** Department of Health form KH03  
**Status:** Published 22 September 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Sector</th>
<th>Available beds</th>
<th>Occupied beds</th>
<th>% occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>All ward types</td>
<td>175,646</td>
<td>148,638</td>
<td>84.6%</td>
</tr>
<tr>
<td>2005-06</td>
<td>General &amp; acute (acute plus geriatric)</td>
<td>133,033</td>
<td>114,044</td>
<td>85.7%</td>
</tr>
<tr>
<td>2005-06</td>
<td>Acute</td>
<td>108,113</td>
<td>91,270</td>
<td>84.4%</td>
</tr>
<tr>
<td>2005-06</td>
<td>Geriatric</td>
<td>24,920</td>
<td>22,774</td>
<td>91.4%</td>
</tr>
<tr>
<td>2005-06</td>
<td>Mental illness</td>
<td>29,802</td>
<td>25,510</td>
<td>85.6%</td>
</tr>
<tr>
<td>2005-06</td>
<td>Learning Disabilities</td>
<td>3,927</td>
<td>3,291</td>
<td>83.8%</td>
</tr>
<tr>
<td>2005-06</td>
<td>Maternity</td>
<td>8,883</td>
<td>5,793</td>
<td>65.2%</td>
</tr>
</tbody>
</table>

Appendix E: Budget for proposed redesign of Harrogate and Rural OPMH services

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget</th>
<th>Pay</th>
<th>Non Pay</th>
<th>Total</th>
<th>Sum Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Year running costs of a Community Unit for the Elderly</td>
<td>694,810</td>
<td>641,740</td>
<td>53,070</td>
<td>694,810</td>
<td></td>
</tr>
<tr>
<td>Disaggregated Day Hospital Costs</td>
<td>158,410</td>
<td>128,130</td>
<td>30,280</td>
<td>158,410</td>
<td>536,400</td>
</tr>
<tr>
<td>Expansion of Community Mental Health Teams for the Elderly by</td>
<td>192,080</td>
<td>185,080</td>
<td>7,000</td>
<td>192,080</td>
<td></td>
</tr>
<tr>
<td>additional 3.50wte Band 6 staff and 3.00wte Band 3 staff. Extra 0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>= £17,140 0.50 wte</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension of Day Services to include weekend working by providing</td>
<td>32,100</td>
<td>31,100</td>
<td>1,000</td>
<td>32,100</td>
<td>312,220</td>
</tr>
<tr>
<td>an additional 1.00wte Band 5 Registered Mental Health Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of a Primary Care Mental Health Service for Older</td>
<td>113,360</td>
<td>108,360</td>
<td>5,000</td>
<td>113,360</td>
<td></td>
</tr>
<tr>
<td>People by providing additional staff as follows:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x 0.5wte Band 7 CBT Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x 0.5wte Band 6 CBT Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 x 1.0wte Band 5 Link worker posts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x 0.5wte Band 4 Graduate Worker Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x 0.5 Band 3 Secretarial Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of a Primary Care Mental Health Service for Older</td>
<td>6,700</td>
<td>6,700</td>
<td>6,700</td>
<td>6,700</td>
<td>192,160</td>
</tr>
<tr>
<td>People by providing additional staff as follows:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.5 hours per week Band 4 Secretarial time for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Psychiatrists OPMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00wte Registered Mental Health Nurse for Rowan Ward</td>
<td>62,200</td>
<td>62,200</td>
<td>62,200</td>
<td>62,200</td>
<td>129,960</td>
</tr>
<tr>
<td>2.00wte Registered Mental Health Nurse for remaining CUE</td>
<td>62,200</td>
<td>62,200</td>
<td>62,200</td>
<td>62,200</td>
<td>67,760</td>
</tr>
</tbody>
</table>
Increase the mental health liaison nurse post from 26.25 to 37.5 hours per week.

<table>
<thead>
<tr>
<th></th>
<th>11,540</th>
<th>10,540</th>
<th>1,000</th>
<th>11,540</th>
<th>56,220</th>
</tr>
</thead>
</table>

Increase the band 5 assistant psychologist from 0.5wte to 1.0 wte

<table>
<thead>
<tr>
<th></th>
<th>11,370</th>
<th>10,370</th>
<th>1,000</th>
<th>11,370</th>
<th>44,850</th>
</tr>
</thead>
</table>

Extension of Day Services to include weekend provision and commissioning from voluntary sector

<table>
<thead>
<tr>
<th></th>
<th>44,850</th>
<th></th>
<th></th>
<th>44,850</th>
<th>00,000</th>
</tr>
</thead>
</table>