**PROPOSAL FOR OLDER PEOPLE'S MENTAL HEALTH INTEGRATION PROJECT**

## 1.0 Introduction

1.1 This paper has been compiled by Christine Moody, Joint Service Manager, Cathey Walker, Clinical Services Manager and Julie Bootle, Joint Commissioning Manager. Further input has been gained from members of the Older Peoples Mental Health Service. The paper and proposals were discussed and agreed at a Strategic Meeting of key operational managers and commissioners in Health and Social Care on 23 May 2003.

1.2 The paper draws upon the findings and recommendations of the NSF for Older People, NSF for Mental Health, Forget Me Not reports, District Audit report 2001, Day Service Mapping and recommendations completed by the Day Services group, and the evaluation of JEMHS and service mapping completed by Oxford Brookes University. The content of discussions in the Older Persons Mental Health Planning Group and with other stakeholders has also been utilised.

1.3 The paper outlines an integrated service model for an Older Peoples Mental Health Service and highlights advantages and disadvantages and potential blocks. The paper also proposes that the decisions regarding the service model should be taken separately to the proposed reporting lines to avoid confusion and also to focus on the outcomes for service users rather than organisational pressures. For this reason, these issues are dealt with separately in the paper.

1.4 The Partnership Project Team is asked to agree the recommendations laid out in the paper.

## 2.0 Service Objectives

2.1 The aim of the service would be to enable older people with mental health needs to be able to choose to live safely in the community with the appropriate support in the least restrictive way. Where this is not possible due to the users needs, the service would aim to support appropriate admissions to a variety of long term care. The service will provide early identification of mental health

needs, integrated care pathways with an emphasis on prevention, and early and appropriate discharge from hospital care.

## 3.0 Proposed Service Model

3.1 The proposed integrated service model is shown in **Appendix A**. The advantages and disadvantages of the model are summarised below.

**Advantages** – CSOs are linked with Care Management

Day Services are integrated allowing for development of a functional/organic service.

More flexible interface with Adult Social Care

Identification of Early Onset Dementia and Memory Screening as specialist elements of the service

Alternatives to hospital and delayed discharges can be addressed more effectively

Multi –disciplinary function at the point of admission

Links to policy drivers

Support more people in their own homes

Intervention to sustain rather than disrupt care arrangement

Single point of referral

**Disadvantages** –Major cultural shift

Potential isolation from generic older peoples services

3.2 The Older Peoples Mental Health service would provide a specialist mental health service and it is assumed that generic assessments and services would be provided by other services as agreed in the Best Value Review for Older People.

3.3 The components of the service are now considered in more detail.

## 4.0 Integrated Older People Community Mental Health Teams

4.1 It is proposed that the current JEMHS Team and the two Community Mental Health Team (health staff) be integrated to provide two teams covering North and South Milton Keynes. The teams will have a primary role in supporting people in their own homes and preventing breakdown and hospital/residential admissions. Each team would comprise a Team Manager, social workers, community mental health nurses, occupational therapy, psychology and medical input, and admin support and would be co-located. Clinical leadership would be provided by the Consultant Psychiatrist. It is proposed that some

community mental health nurses take on a care management function following the JEMHS model.

4.2 A duty function would be shared by the teams with lead responsibility for this being held by one of the Team Managers. All referrals will be made to the duty system. The second Team Manager would have responsibility for the Community Support Service. The teams would provide multi-disciplinary assessment and care planning with therapeutic interventions provided particularly from the community mental health nurses. A Reviewing Officer would be located in each team, which may need to be a post derived from existing resources.

4.3 Considerable work has been undertaken with the staff from the current teams to bring working practices together and to agree shared value bases and aims and to begin to effect the cultural shift which will be needed. The teams have already strengthened joint working practice with a shared referral procedure. Work has begun on locating team bases and this has been problematic. However as an interim solution further office space has been negotiated at Hawthorn Clinic and scoping work is underway to ascertain how many staff could move there to provide a South Team Base. The North Team Base, Duty function and CSOs would be located at Bassett Court. Funding has been obtained via SCA for office moves, IT links etc. The funding for another Team Manager needs resolving.

**5.0 Community Support Officers**

5.1 A new role as Senior Community Support Officer (CSO) has recently been created using existing resources and the reporting structure for CSOs has changed to reflect this. The CSOs and Community Support Assistants (CSAs) (from both the health teams and JEMHS) will work as a team under the management of the Senior CSO and be able to work more flexibly to develop the service. The Senior CSO would report to one of the Older People Community Mental Health Team Managers and link closely with the assessment and care management function but remain a resource for the entire service. The Senior CSO would have a liaison function with both the Inpatient facility and day services. This would allow for a greater flexibility and creativity in setting up alternatives to hospital admission and facilitating early discharge.

5.1 The CSO Service will have a focused role providing specialist intensive support, the aim being that this is short term with the care being transferred to HomeCare when the situation stabilises. It is therefore proposed that the Senior CSO have access to dedicated homecare hours so that the direct community services can be managed more holistically and efficiently. The Senior CSO would of course need to work closely and co-operatively with Homecare managers.

## 6 Day Services

6.1 An Older People's Mental Health Day Services working group has been established for some time and has undertaken significant work on developing day services. It is proposed that Day Services become an integrated service. A seamless service would be provided by working closely with Age Concern and Red Cross. Further work is required to agree a service specification and structure with full consultation with service users, carers, staff and other stakeholders. As such, it is envisaged that this would be achieved in the medium term.

6.2 In the short term, it is proposed that an Older Peoples Mental Health Day Services Panel be formed which will hold the responsibility for assessing, care planning and reviewing service users requiring day services. A Chair should be elected who does not directly manage a day service. The panel will receive assessments recommending day services and referrals asking for a day service assessment. The proposed care pathway is set out in **Appendix B.** This would result in fewer assessments being carried out and a more efficient use of resources. The service user would be able to gain swift access to the service they are assessed as needing and only be assessed once for day services. It would also reduce the workloads of the Older Peoples Community Teams allowing them to focus on the complex and intensive cases.

6.3 The panel could operate within existing resources. Further work is required to identify the thresholds for services, and to put in place training on assessment, reviews and CareFirst inputting. It is also recommended that mentoring take place for assessors and reviewers in the first instance.

## 7 Inpatient Admission Unit

7.1 Within the integrated service, the Inpatient Unit will work in partnership with other aspects of the service to achieve intensive, timely assessment and treatment for people in crisis that cannot be supported at home. The service

will provide whole system working to jointly plan for the care needs of individuals prior to admission, during the admission and in planning for discharge. Integration will enable holistic working to ensure that health and social care needs of the individual are considered.

7.2 It is proposed that a Modern Matron/Senior Nurse post be established to provide managerial responsibility and clinical leadership for the Inpatient Unit. This post will continue to develop and enhance the services provided by the clinical team and would be responsible for the service user environments. Considerable work across the service has been achieved during the previous two years to prevent admission to hospital where possible and to ensure that discharge planning is effective. This post will be responsible for overseeing the delayed discharge process across the service and will provide the assessor role for Continuing Healthcare Funding.

7.3 The Transitionary Care service provided by the inpatient team has demonstrated a positive reduction in the breakdown of placements following discharge. The improved experience of service users and the support provided by the team to residential and nursing home placements has been welcomed. The Modern Matron post will oversee and further develop this service. The Modern Matron post would establish effective liaison with St.Giles Residential Unit, Milton Keynes General Hospital and the other parts of the service.

**8 Early Onset Dementia Development Worker**

8.1 This post is due to be established. It is planned that this post will support the development of an Early Onset Dementia service and will identify resource requirements. The postholder will provide a specialist practitioner role supporting colleagues working with service users with Early Onset Dementia within other services.

8.2 The postholder will work closely with the Alzheimers Society to develop and oversee local support networks for service users and carers. The postholder will be responsible for implementing 'Living with Dementia' and other best practice recommendations in Milton Keynes.

**9 Memory Screening Services**

9.1 Following the successful pilot project, Memory Screening Clinics have now been established as an integral part of the Older People's Mental Health services. The second phase of service development is now underway to provide a seamless diagnostic and support service. This service will be

enhanced through partnership with the Alzheimers Society to provide non-statutory support to people during the earliest stages of Dementia.

9.2 Funding is currently being pursued to provide dedicated resources to this service. A Service Co-ordinator post is planned to facilitate the clinics, co-ordinate the diagnostic process and to manage the Memory Group process. The postholder will care co-ordinate cases during this pathway. In addition the postholder will support the Alzheimers Society to develop the branch activities and to provide supervisory support to the Carer Support Workers.

## 10 Budget

10.1 It is proposed that the Care Purchasing budget be managed by the Operational Manager to allow for efficient and flexible use of resources by the service. A clear system for allocating resource based on comprehensive risk assessment would need to be devised which is both robust and efficient of time.

10.2 It is proposed that the pooling of some budgets, for example, the community teams be considered further once the service model is implemented.

## 11 Other Issues

### 11.1 Professional Leadership

Each professional group will have an identified lead who will work together with the Operational Manager to ensure that the continued professional development of each group is maximised. Professional Leads will provide advice to the operational manager and will be involved in decisions related to service delivery, e.g., workforce planning, clinical governance, policy development. The Professional Lead responsibilities will be part of the portfolios of senior members of the service.

### 11.2 Supervision

Supervision will be provided in line with the Joint Mental Health Services Supervision policy. Supervision will be provided by an individuals line manager, though additional clinical/professional supervision will be provided as required.

### 11.3 Single Assessment Process and CPA

Shared Assessment and documentation is current practice within the service based on the Care Programme Approach Framework. It is anticipated that the current system will, for the majority of service users, be replaced by the Single Assessment Process (SAP). The SAP process will enable greater sharing of assessment across all Older People's Services. It is anticipated that the Mental

Health Services will primarily complete Comprehensive and Specialist Assessments.

11.4 **Clinical Governance**

Older Peoples Mental Health Services will continue to be an active part of the Mental Health Clinical Governance Action Group.

## 12 Reporting

12.1 It is proposed that the Operational Manager for the Older People's Mental Health Service report to the Joint Service Manager for Mental Health.

12.2 This would be a medium term arrangement, which would be reviewed. Subsequent arrangements would be developed taking into account the Best Value Review recommendations and evaluation of the proposed reporting structure and in full consultation with affected staff.

## 13 Recommendations

13.1 That the Partnership Project Team agree the following recommendations.

a) To approve the proposed service model

b) To approve the funding for the additional Older Peoples Community Mental Health Team Manager post jointly across health and social care.

c) To agree that detailed work commences on the integration of the Community Teams as the first stage of integration.

d) To progress the current scoping of accommodation

e) To agree the proposed Day Services Care Pathway and progress work on integrating day services linked with the Day Service Review.

f) To agree work is progressed on the Early Onset Dementia, Memory Screening Services and the Modern Matron Role

g) To agree the proposed reporting structure.

h) To agree the reporting process to the Health and Social Care Board.

e) To agree the process of formal consultation

## Appendices

**A** – Proposed Structure for Integrated older People's Mental Health Service

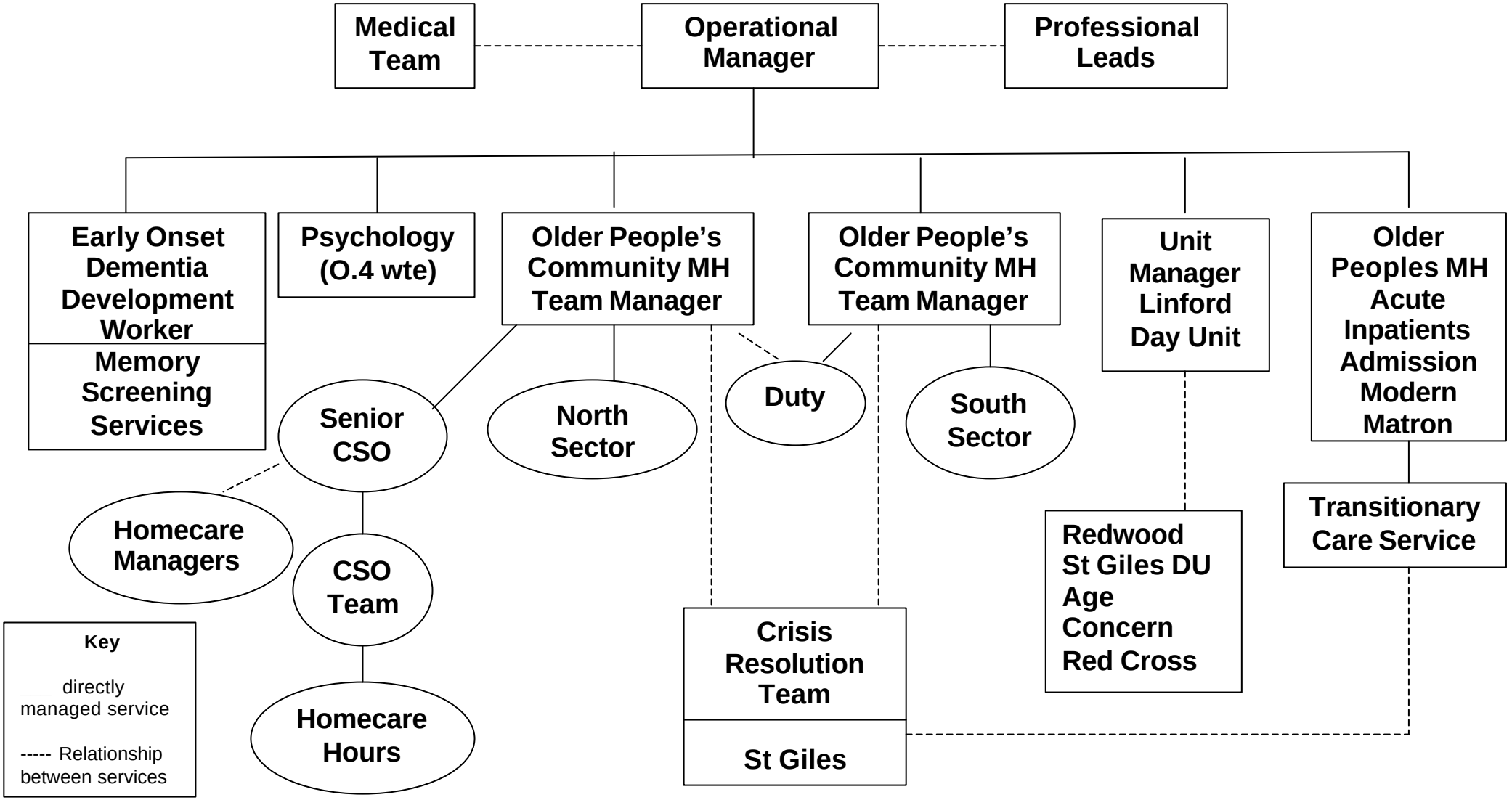
**B** – Proposed Older Peoples Mental Health Day Services Pathway

**C** – Project Plan for Older Peoples Mental Health Integration Project

**D** – Role of the Older People's Mental Health Day Services Panel

**Appendix A**

**Proposed Structure for Integrated Older People's Mental Health Service**




NB: Crisis Resolution Team is a developing service and work is ongoing regarding its links with OPMH
The proposed OPMH Service and the Joint MH Commissioning Manager will be involved in the redesign of St. Giles

**APPENDIX B**

**Proposed Older Peoples Mental Health Day Services pathway**