AGENDA ITEM 4.2

IMPROVING SERVICES FOR OLDER PEOPLE

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SITUATION

The UHB’s Integrated Medium Term Plan 2014/15-2016/17 identified that there were proposals to change services for a small number of frail older people – specifically in Clinical Gerontology and Mental Health Services for Older People. Engagement discussions have been ongoing over recent months, and this paper sets out the outcomes of those discussions.

BACKGROUND

Cardiff and Vale UHB’s stated purpose is “Caring for People, Keeping People Well”. To support this the UHB must ensure that the care it provides for people must help and enable them to live as independently as possible – either in, or as close to their homes as possible, and when they do need care in hospital it should be provided from facilities which are fit for purpose.

A significant proportion of the care which the UHB provides is for older people – primarily people with physical health needs due to their frailty and multiple conditions requiring treatment, and also people who are recovering from surgery, or for example strokes. Care is also provided for older people who primarily have mental health needs; these people may also have general physical health needs due to their age, but this is not the main reason that they are in our care.

The UHB regularly reviews and refines models of care to ensure that services support our strategic intent of becoming the UK’s leading integrated care organisation by working in an integrated way to deliver the best possible outcomes for people. The ideas for service change in the two different areas being engaged upon reflect these reviews. Both sets of ideas have been developed by clinicians working in the services and both:

• Support the provision of care for older people in, or as close to their homes as possible;
• Focus on maximising an individual’s independence;
• Support the integration of care across the UHB and with partner organisations
• Represent clinical best practice in terms of evidence of outcomes of care.
However, the two services respond to very different needs of different groups of people and reflect the decision to undertake separate, focused engagement processes.

**ASSESSMENT**

**Service Change Ideas**
The detailed ideas for service change are set out in the Appendices (Clinical Gerontology - Appendix 1; Mental Health Services for Older People – Appendix 2), and are summarised below:

**Clinical Gerontology**
- Establish a Frail Older People’s Assessment and Liaison Service (FOPAL) for the Vale of Glamorgan at UHL to mirror the one at UHW;
- Increase specialist gerontology presence at UHW and UHL;
- Create a single specialist co-located hub for medical, stroke and orthopaedic rehabilitation in-patient beds at UHL;
- Provide complex frail care and comprehensive geriatric assessment services from St David’s and Barry Hospitals;
- Expand day care capacity at Barry and St David’s Hospitals and close Rookwood Day Hospital;
- Explore the potential to co-locate Elderly Care Assessment Services (ECAS) to UHL.

These ideas would mean that older people would receive the same level of expert care whichever hospital setting they are in; they would receive care in better environments, and there would be more focus on maximising people’s independence and rehabilitation at all points of the pathway to support people to go home.

**Mental Health Services for Older People (MHSOP)**
- Expand and complete the community REACT service (MHSOP Crisis Service);
- Extend the liaison service to support DGHs and local nursing homes;
- Close the in-patient Continuing Health Care beds in Glan Ely ward (currently 22 beds in St David’s Hospital).

These ideas would mean that more older people would be cared for at home or in community based settings, and there would be more support to people in hospitals and nursing homes. Older people would receive any medical care required either through their GP, or if necessary, through an admission to the gerontology service (as happens now).

It should be noted that some of the proposals for change were included within the Making a Difference programme.

**Outcome of Engagement**
Two engagement exercises have been undertaken simultaneously for the two different services, and the issues raised during engagement are set out below.

**Clinical Gerontology**
The UHB first linked in with Cardiff and Vale Community Health Council (CHC) for advice on the ideas and how to engage in February 2014. The CHC were broadly
supportive of the initial ideas, and agreed we should move to undertake a wider engagement and discussion process which they supported us with shaping.

Seventeen face to face engagement events took place between March and the end of May 2014, and there have also been:

- discussion meetings with key stakeholder groups internal and external to the organisation including voluntary organisations, Age Cymru, Age Connects, Red Cross;
- wider front line staff engagement and discussion including staff consultation on changes and impacts;
- presentations to Third Sector, Local Authorities, 50+ Forums, Trade Unions, Older People’s Commissioner, AMs/MPs;
- wide sharing of the written engagement document; and
- wider public awareness placing the engagement document on the UHB website, local Media press release, and document shared with local councillors and Town and Community Councils.

The feedback we have received through this process has indicated that:

- the aims are right;
- changes will result in improved patient experience in better quality environments;
- there will be a better ability to care for deteriorating patients without transferring between hospital sites;
- there will be a move towards a rehabilitation focus throughout the hospital based parts of the pathway;
- there is support and belief that changes would help deliver good quality services, improved equity of access and expertise around the patient not moving the patient between services;
- the aims are aligned to the wider and growing Framework for Older People and service models;
- there are no objections to no longer providing services from West Wing or Rookwood Hospital sites;
- people welcomed the importance being placed on FOPAL, Day Hospital, ECAS services and multi-disciplinary approach in general.

There are, as expected, a number of areas and concerns for the UHB to consider further.

- There are minimal concerns about bed reductions overall, but questions were raised about the potential disproportionate impact on Barry local residents. It has been confirmed that during 2013/14 there were only 16 direct admissions to the Gerontology Wards at Barry Hospital - all others transferred from other acute hospital settings.
- Regardless of potential changes, Community and Local Authority services require further strengthening as part of the wider development of the Older Peoples Framework for the future.
- The UHB needs to ensure that all our services/staff are able to support sensory impairment and equality considerations for patients – and sensory impairment is a priority for the UHB during 2014/15.
- Vale of Glamorgan Council Health and Social Care Scrutiny referred the ideas to Cabinet, as there were concerns about the potential increased costs to
social care budgets associated with patients being discharged home and wish to work jointly with the UHB to manage any short term cost with the placement of patients in the community.

- Integration of the Elderly Care Assessment Service (ECAS) within the Vale Community Resource Team is viewed as very valuable and questions were raised about reconsidering the centralisation of ECAS.
- The role that Barry Hospital plays needs to be considered as part of the UHB’s developing Clinical Services Strategy so that its important role now and in the future is clearly set out.

Based on the feedback during engagement, the Clinical Board is considering making the following changes to the initial ideas:

- Delay implementing and review the ECAS elements of the proposals
  - Retain the integrated service in Barry (VCRS)
  - Continue with moving Rookwood ECAS to St David’s
  - Look at options to strengthen UHL ECAS service regardless

- The further strengthening of services over the next 1-3 years as a priority (particularly dedicated therapies and social work) – to be reflected in the next Integrated Medium Term Plan (IMTP).

Based on the outcomes of the engagement exercise, and subject to CHC approval, it is therefore proposed to proceed with the plans, subject to the changes set out above. If the plans are accepted, patients would be moved from West Wing Hospital between the middle and the end of July 2014. This would mean that West Wing Hospital would be vacant, apart from the Renal Dialysis Unit, and once alternative accommodation has been found for this service, meeting patient requirements, then plans to dispose of the West Wing site can be developed (following appropriate processes).

Patients in the Neale and Kent ward at Barry Hospital will be discharged as part of normal care planning. Any patients still requiring care in Barry Hospital at the time of the closure of Neale and Kent ward would be transferred to the Sam Davies ward.

Mental Health Services for Older People
The ideas to change the mental health services for older people are part of an ongoing strategic change plan for services which focuses on the provision of as much care as possible at home and in community based settings to facilitate maximising the independence of individuals. For this reason, engagement has been on a much smaller scale and has been primarily with carers of people currently cared for in Glan Ely ward in St David’s Hospital. A number of meetings have been held with carers, which have been organised and facilitated by the CHC, which the UHB has attended to discuss potential changes, service ideas and any concerns.

Four main points have arisen:

1. When people are admitted to mental health rehabilitation beds for older people, staff need to be clear with relatives that these should not be considered as a permanent bed. The aim of the service is to help people maximise their independence and move onto alternative care settings where appropriate.
2. When patients are cared for in a nursing or residential care home and need an admission to an acute hospital bed for a physical health need, relatives need to understand that arrangements for this type of care will not change. Patients will be admitted to UHW/UHL as appropriate and once they have recovered from their medical illness they should return to their previous place of care.

3. The process for undertaking ‘decision support tool’ (DST) assessment within the UHB needs to be more robust, so that the assessment for eligibility to stay in NHS facilities or NHS funded Continuing Health Care is undertaken more quickly and appropriately involves carers.

4. Ongoing discussions need to be held with relatives on availability of care home places and associated funding arrangements to facilitate service change and the onward care of patients for whom this is appropriate.

The UHB will have further discussions with the CHC at the end of June to address concerns and agree further action, including ensuring there is clarity about the gerontology changes and the relationship with the MHSOP service model (as set out in this paper).

Based on the engagement to date, and subject to the outcome of further discussions with the CHC and carers, it is proposed to proceed with these changes.

Cardiff and Vale Community Health Council
The Community Health Council (CHC) has provided helpful advice on the presentation of the ideas for service change and the engagement process. It has also facilitated a number of discussions – in particular those with the carers of patients in the Glan Ely ward.

At its development day in early June, the CHC received an update on the service change ideas, including the feedback that had been received during the engagement process. (This presentation was received by the Board on 5th June). The comments from the CHC were positive overall about the ideas for changing the way services are delivered and the engagement process. The concerns about the MHSOP engagement process, as referred to above, were noted, and suggestions about the next stages of engagement with individual patients and their families and carers have been acted upon.

The CHC Executive Committee met on 19 June to consider the final proposals from the UHB which have reflected the feedback from the engagement process. Following this, the CHC has indicated that there are some outstanding issues regarding the proposals which need to be addressed and the UHB is providing further information to give the necessary assurance and clarity on these points.

Transition Process
For any patients directly affected by the change proposals, individual care and transition plans will be developed and families and carers will be involved as appropriate.

Conclusion
The UHB has undertaken comprehensive and robust engagement around these two areas of potential service change. If agreed and implemented, these ideas will support the development of a consistent and overarching approach to improving services and care for older people across Cardiff and the Vale of Glamorgan. These
are in line with the emerging Strategic Framework for Older People which is also being engaged upon.

The UHB is also developing a more consistent and comprehensive approach to continuous engagement with local people, and the lessons learnt from this process will be incorporated within that Framework.

RECOMMENDATION

The Board is recommended to:

- NOTE the ideas for service change for clinical gerontology and mental health services for older people;
- NOTE and COMMENT on the outcomes of the engagement exercises;
- NOTE that lessons learnt and experience will be built into the developing engagement framework;
- RECEIVE and CONSIDER the outcome of the CHC’s considerations (which were not available at the time of writing); and
- APPROVE the proposed service changes.

<table>
<thead>
<tr>
<th>Financial Impact</th>
<th>The financial implications of changes are included within the UHB’s IMTP</th>
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<tr>
<td>Quality, Safety and Experience</td>
<td>The changes will result in improved patient safety, quality and experience</td>
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| Standards for Health Services | This report supports the following Standards for Health Services:  
5: Citizen Engagement and Feedback  
7: Safe and Clinically Effective Care  
8: Care Planning and Provision  
10: Dignity and Respect  
11: Safeguarding children and Vulnerable Adults |
| Risks and Assurance | The Report mitigates against risks identified in the corporate risk register |
| Equality and diversity | Equality Impact Assessments have been developed to support both sets of service change proposals. These continue to be reviewed in light of the feedback received during engagement with stakeholders and staff, facilitating a greater focus on building mitigating actions into implementation plans |
APPENDIX 1

IMPROVING OUR SERVICES FOR OLDER PEOPLE
IN CARDIFF AND THE VALE OF GLAMORGAN

THE DEVELOPMENT OF CLINICAL GERONTOLOGY SERVICES

Why older people’s services one of our key priorities?

People in Cardiff and Vale of Glamorgan, like the rest of the UK, are living longer and the balance of life is changing. There are more people aged over 60 than children under 16. Older people can now look forward to many more years of health life after retirement than ever before, though the health need of an ageing population put more demands on the need for care and support.

As part of the Integrated Health and Social Care Programme between Cardiff and Vale Health Board, Cardiff and the Vale of Glamorgan Councils and our Third Sector Partners C3SC and VCVS, a draft Framework for Older People has been developed, “Meaningful and Purposeful Lives”. The key aims of this approach are to promote high quality and joined up care, with timely assessment and the availability of services that place older people at the centre of our joint support and care.

This promotes supporting people in the community to live independently at home for as long as possible, with clear and coordinated care that is joined up. Importantly, when older people do access hospital based care, we need to ensure it is as equally coordinated and continuous, and is focussed not only on the care of people’s medical needs but also ensures we support people returning to independent living.

How do we care for Older People in hospital at the moment?

In August 2013, Cardiff and Vale UHB created the Directorate of Clinical Gerontology recognising the specialist expertise in the care of older people, and the central and pivotal role of older people’s medicine in the services provided by the Health Board.

Linked to the key aims of the developing strategy for Older People, it is important that we adapt our services to ensure that when older people do require hospital care, it is coordinated and focused, of high quality, and supports putting the expertise around the patient at all points during their care. It should not simply be a process of moving the patient through our current services. We need to put our expertise around individuals if we are to ensure they receive the best possible care and are able to return to their home environment as quickly as possible after receiving the medical care for which they were admitted to hospital.
The clinical team leading the Gerontology services have, therefore, developed a set of change proposals that are focused on ensuring the following:

- That we recognise and have expert care of the older person throughout a patient’s care, from community to hospital based, whether their needs are acutely medical or rehabilitative.

- That we need to develop and deliver more integrated and continuous care of older people across the community and within hospitals.

- That we have a real opportunity to put Older People’s care at the centre of medicine in Cardiff and the Vale.

- That there is a pressing need to improve how, and from where, some of our services are currently delivered.

**Why do we need to change?**

We know that our current in-patient hospital services are not always organised in the right way, and some of the poor environments in which we are providing our care are not what our patients need or deserve. We know that the longer older people stay in hospital, the more they lose their independence. There are a number of significant challenges for the services that form the core of specialist older people’s in-patient care within our hospitals.

The main areas where we know we need to further improve the care we give are as follows:

- Services are currently based on separate and sometimes isolated sites across Cardiff and the Vale, which despite the best efforts of staff, can impact on the ability to provide comprehensive, joined up, effective and efficient care.

- Services are still, in part, based on old long stay hospital models of care, which don’t reflect the changing needs of our patients, or the driving aim to support older people who don’t need to be in hospital with care within their own homes and the community.

- Many services are operating out of poor quality and isolated buildings which are becoming increasingly difficult to maintain, and are not of a standard we want to continue to deliver care in.

- Because our services for older people are spread too thinly, we sometimes find it difficult to provide the right medical care for older people who become more unwell whilst still in our care and need increased medical support. This can mean patients are admitted back into our major hospitals, which can delay their rehabilitation and ongoing care.

- Our hospital based services are not currently configured to deliver integrated, expert older people’s care for the time they need when admitted to hospital. We know this means that some patients stay in hospital longer than necessary. Recognising this, we need to ensure that when patients do need hospital care, we have specialist input as soon as the patient arrives at the emergency Unit, whilst they are acutely unwell,
ensuring we are providing specialist medical rehabilitation, and through to longer stay hospital based care and assessment where it appropriate.

**What do we need to do to make our older people’s services better?**

Changing the overall way we deliver services for our population is constantly changing and will continue to fundamentally change over the next 10 years in line with our over-arching aims of providing earlier and more community based care to prevent reliance on hospital based services. Essentially we want to do initially is make small changes to our hospital services that will enable us to provide increased and co-located specialist Gerontology services, on a smaller number of sites. This needs to be in an improved physical environment with services set up more sustainably for the future with improved Medical cover both in and out of hours.

By creating a hub of expertise in the Vale, based at University Hospital Llandough (UHL), supported by a strong acute Gerontology presence in both major hospitals and rehabilitation and assessment focused services in Barry Hospital in the Vale, and at St David’s Hospital in Cardiff.

**What would change as a result of these proposals?**

To address the challenges within the current services and to make improvements in the overall patient care pathway we are proposing the following changes:

- Increase our Specialist Gerontology input at the first point of entry into all acute services by establishing Frail Older People’s Assessment and Liaison Services (FOPAL) Service for the Vale at the University Hospital of Llandough (UHL) comprised of Consultant, Therapies, Social Work and other specialist experts. These teams are experts in ensuring that wherever possible older people accessing our emergency hospital services are appropriately assessed, and where appropriate supported to return home, without the need for hospital admission.

- Increase Specialist Gerontology presence on both major acute sites by providing expertise and rehabilitation whilst patients are medically unwell. We can do this by aligning some of our current wards directly with the Clinical Gerontology team.

- Create a single specialist co-located hub for Medical, Stroke and Orthopaedic Rehabilitation, with improved medical cover and an overall increase in Rehabilitation inpatient beds at the University Hospital of Llandough by transferring Rookwood Ward 6, West Wing Medical Rehabilitation Unit, and West Wing Orthopaedic Rehabilitation Unit to the University Hospital of Llandough (UHL).

- Provide Complex Frail care and Comprehensive Geriatric Assessment services from St David’s and Barry Hospitals only with a focus on ensuring that patients who no longer require hospital care are assessed, supported and discharged to an appropriate location with the right care. This would mean the closure of Elizabeth Ward in West Wing Hospital and Neale & Kent ward in Barry Hospital, whilst increasing St David’s Hospital capacity.
- Re-balance Day Hospital capacity across three sites, by closing the Rookwood Day Hospital and expanding capacity in Barry and St David’s Hospitals.

- Explore the potential to co-locate Elderly Care Assessment Services (ECAS) by basing ECAS capacity at UHL, increasing to 5 days per week and doubling new patient capacity.

The clinical teams who have led the development of the proposed changes believe that these changes will not only improve the clinical services provided but, importantly, will also enable the move of some services from less modern physical environments such as West Wing and Rookwood Hospitals, and the re-aligned services will be able to provide a more continuous and comprehensive service for our patients.

All of the clinical resource currently spread across the services will be reinvested into the realigned services, enabling us to increase staffing levels, improve medical cover and provide more concentrated therapy input for those patients who need it.

**How will these proposals make services for older people better?**

By making these changes our clinicians believe:

- That older people requiring hospital care will receive the same expert input throughout their pathways, regardless of where they access our acute care.

- That by increasing our rehabilitation focus and capacity and concentrating resources we will be supporting older people to return to the community and live as independently as possible.

- That we no longer provide our services from poor quality and/or isolated locations, delivering an improved patient experience when in hospital, and by co-locating our services ensure we have more flexible and robust medical cover, and the ability to avoid transferring patients between sites unnecessarily if they become ill.

**How can you help us decide on the next steps?**

In line with the Welsh Government Guidance for Engagement and Consultation on changes to Health Services (WG 2011) the proposals are not considered to be significant service change. As part of developing the clinically led plans the Health Board is, however, making a concerted effort to engage with its key stakeholders potentially affected by the changes, and most importantly the patients, families, and staff involved in the services everyday.

We think the changes could really help improve the care we provide for older people when they do need hospital care. The aim is to ensure we get consistent and expert input from our Gerontology teams at all points of the pathway.

1. As someone either affected directly or indirectly by the proposed changes, we want to know if you think we have missed anything in our vision for the services, and our aims?
2. Are there other changes to the Gerontology services you think would further enhance the potential changes either immediately or in the longer term?

The UHB will be making the information on our proposed changes widely available, with the opportunity to discuss and feed back in a number of different ways over the coming weeks. We are already actively engaged in discussions with our partners regarding the changes and your input will help us shape and plan these changes further.
SERVICE CHANGE PROPOSAL
MENTAL HEALTH SERVICES FOR OLDER PEOPLE
RECONFIGURATION OF IN PATIENT RESOURCE
TO COMMUNITY SERVICES

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Mark Doherty – Lead Nurse MHSOP

Version:
2.0 – May 2014
Service Proposal - Community Health Council Briefing

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1. Purpose and scope

The current Mental Health Services for Older People’s (MHSOP) 3 – 5 year business plan builds on work already undertaken within the service and is reflective of the National Strategy ‘Together for Mental Health’. The strategic intent of the MHSOP directorate remains consistent in continuing to develop community based crisis, home treatment and liaison services reconfigured from in patient resources. Partial developments of these services over the last 2 years in the directorate have seen a ‘good news’ clinical change story emerge with reductions in admission rates and reduced demand on NHS continuing health care (CHC) beds. This has progressed to a current position where there is sufficient reduction in demand on beds to specific CHC areas to require an immediate need for service redesign. Specifically, this redesign would include disinvestment in CHC beds in order to redirect resources into expansion and completion of the current community REACT service (MHSOP Crisis Services), and further investment in liaison to support the District General Hospitals and local nursing homes. This proposal is in the context of high levels of staff sickness within inpatient areas, coupled with associated governance concerns.

As a consequence of the presentation of this emerging clinical picture at the local Mental Health Community Health Council meeting and subsequently at the Health Board Community Health Council planning meeting, this proposal document is being compiled for further consideration. It is recognized that this current change in clinical demand is ‘live’ and there is agreement that relevant affected service users, carers and a wider engagement strategy needs to commence without delay. Because of this, the proposal includes scenarios of actions to be progressed when bed occupancy numbers reduce to critical and unsustainable levels.

The Mental Health Clinical Board is now beginning an engagement process with key stakeholders, NHS staff and the public. This is to raise awareness of the changing service model and to listen to comments from key stakeholders to ensure the transition period is optimized. This engagement process will be managed by the Community Health Council and supported by the Health Board. The engagement process is intended to both ensure that affected stakeholders are informed of changes and receive views from service users and carers on how they can continue to receive an optimal care and treatment during the changes.

Effective communication and engagement is an essential component in helping to implement service change and improvement. Communication is more than an exchange of information. It involves two-way written and verbal exchange, listening and understanding; it also involves relationship management. It is as much about values, expressed through attitude and behaviour, as it is about delivering messages. Good and bad communication, or the decision to communicate or not, can have a serious impact on public confidence, staff morale and organisational reputation.
2. **Aim**

As part of the redesign of Mental Health Services and in order to communicate effectively, this case for change and the possible scenarios associated with this change will be put forward by clinicians. This will be to key stakeholders, the wider public and the media if necessary.

This will include shaping the engagement discussions to emphasise the need to create a safe and sustainable model for MHSOP services in the face of increasing demand and the safe redesign of those services.

This communication and engagement plan for this proposal is intended to underpin health board plans, and continue an ‘ongoing engagement’ ethos with the Community Health Councils and key stakeholders.

The overarching aim of this communication and engagement activity is to deliver a successful engagement process. This means that:

- All relevant stakeholders and service users have the opportunity to hear the service proposal and have their say in order that the change should not come as a surprise to any key stakeholder
- To ensure any current and future changes are undertaken through engagement processes to ensure safety and governance requirements re met.

3. **Proposal and Rational for Change**

3.1 There is an ongoing strategic intent for the MHSOP specialist service to become less hospital and more community focused. Whilst the MHSOP Directorate underwent a review 3 years ago and developed a Community REACT (crisis and out of hours) Service, a Care Homes Liaison Service and a Younger Onset Dementia Service, there is a need to further develop community services to make them fit for purpose and future proof.

These services are only partially resourced and developed and evidentially will have the greatest impact on providing appropriate practical support in a crisis. The consequence of this will be the prevention of inappropriate hospital admissions and the promotion and support of care teams, individuals and families to allow care to be delivered at home. The impact of these teams is not yet optimal.

There is currently less demand for MHSOP Extended Assessment Beds for advanced dementia with associated frailty and challenging presentations, than previously – within our frail specialist ward only 14 out of the 22 beds are currently occupied; another 2 patients have been assessed as falling outside of NHS CHC eligibility and 1 patient is currently on the Care Priorities. There is no waiting list for admission. This has been a developing picture for a number of months.
There are further reasons why continued reductions in bed demand are expected, including:

- Benchmarking Results
- Reductions in Average Length of inpatient Stay
- Further reductions in Delayed Transfers of Care
- Ongoing impact of community investment
- The Impact of the Mental Health Measure
- Changes in Eligibility for NHS Continuing Health Care locally
- Community health professionals’ role development

3.2 Bed Numbers/Benchmarking
The Mental Health Clinical Board has participated in national benchmarking and this has determined Cardiff and Vale MHSOP to be an outlier in terms of bed provision (see below graph beds per 100,000 population).

Within MHSOP there are currently:

82 Assessment Beds – New Facility – UHL
33 EPA/CHC beds in Iorwerth Jones – 16 female beds Coed Y Nant; 17 beds Coed Y Felin
Service Proposal - Community Health Council Briefing

20 EPA/CHC beds in St Barruc’s ward – 14 Younger Onset Dementia beds; 6 EPA beds for Vale patients
22 EPA/CHC beds in Glan Ely, St Davids

Total Beds – 157

The MHSOP Directorate has assessed that the current bed provision is over and above that which is required. It has determined that there is a high level need for its 82 assessment beds in the new MHSOP Acute Assessment Inpatient Unit at University Hospital Llandough, but that it is over-provided for in terms of its extended assessment inpatient bed provision. These results should be seen as only one element in the supporting case for the CHC bed reductions as these bed types are commonly categorized differently between organizations under a general heading of NHS CHC beds. It does not take into account the local service provision to support community services.

3.3
In-Patient Efficiency – Average Length Of Stay (ALOS) and Transfers of Care (DTOCS)
A reduction in acute inpatient ALOS, and community services reinvestment to avoid acute hospital admission wherever possible, are the ways in which increasing dementia population need, including that in the Western Vale, will be met.

Benchmarking data have informed the clinical board that MHSOP in patient ALOS, both within assessment as well as long stay CHC wards is high. With dedicated ‘Move On’ Team support, average length of acute inpatient stay has already reduced to an average of 148 days from circa 200 days. However, this figure includes several complex DTOCs and the average ALOS for the female dementia assessment ward of 96 days is nearer the 90 day ALOS target for MSHOP acute beds which is being worked to. The average ALOS for EPA wards is 763 days, with one particular ward at 1001 days currently. Capacity modelling has revealed that if ALOS were reduced to benchmarked norms, for assessment alone - even with current admission rates, a reduction of ALOS from current 96 to 70 (12 Days above national norms), a further 18 fewer overall beds would be required.

3.4
Impact of Expanded Crisis Community and Liaison Services on Admission Rates
Further reinvestment into MHSOP community service development is crucial to ensure appropriate care management for patients discharged to EMI Nursing placements via Care Homes Liaison Service monitoring; also to ensure the Community REACT Service can better respond in crises and out of hours to avoid unnecessary admissions to acute care, both mental health and District General Hospital. There are difficulties in predicting the impact of further reductions in admission rates into assessment beds but the current Crisis Service (REACT) has been operational since 2012. The first annual review of the impact of this service on admission rates into assessment beds are summarized:

MSHOP leadership of the Dementia Intelligent Target for anti-psychotic prescribing in care homes has led to significant training activity for care home staff. In addition, the
Service Proposal - Community Health Council Briefing

Care Homes Liaison Service has developed psychiatric Outpatient Clinics in EMI Nursing Homes to support early interventions to maximise potential for admission avoidance.

A 12 month evaluation of the impact of the partially developed REACT MHSOP team has shown:

<table>
<thead>
<tr>
<th>Impact of MHSOP Crisis &amp; Home Treatment (REACT)</th>
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<tbody>
<tr>
<td>MHSOP Community REACT Service referrals received in 1st 12 months</td>
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<tr>
<td>Admission Avoidance referrals of the 310</td>
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<tr>
<td>Admissions avoided of the above 96</td>
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<tr>
<td>Average length of Assessment stay</td>
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<tr>
<td>Bed days Saved</td>
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<tr>
<td>Beds required</td>
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3.5 The Mental Health Measure

The Wales Mental Health Measure (2010) requires the service to focus its efforts on meeting the needs of patients who are eligible for secondary mental health care, i.e. those who have serious mental illness and require care coordination, and care and treatment planning. The service needs to rebrand its extended assessment beds as a Challenging Behaviour Inpatient Service for those with advanced dementia who are active and behaviourally disturbed such that they need frequent psychiatrist review and mental health care management. The MHSOP Directorate wishes to change this current position and move patients on as soon as their severely challenging behaviours become manageable in a Nursing Home setting, i.e. it believes it should no longer be providing care to patients who have advanced dementia and who become chair or bedbound (unless they are assessed as being in the last days of their lives). Thus, eligibility criteria for MHSOP extended assessment inpatient care will be re-written to describe the service as a Challenging Behaviour specialist secondary mental health care service.

EMI Nursing Home capacity is increasing (50 new EMI Nursing beds are being commissioned in 2014 – BUPA in Whitchurch; Penylan House) and liaison service development is ensuring more appropriate care within independent sector establishments.

3.6 Community service integration and role redesign

Currently the health professionals based within the local authority led specialist MHSOP Community Mental Health Teams (CMHTs) have moved from being professionals with a health focus, to ones with predominantly case manager responsibilities more akin to the role of the social worker in the team. Within the service plan for mental health this year will be an expressed intent to reverse this position and restore health leadership to these professionals. This change will lead to greater professional capacity to offer greater direct practical support to those cases in need, and contribute to admission avoidance and consequently dependency on beds.
The Mental Health Clinical Board recommends that the Mental Health Clinical Board supports the MHSOP directorate to increase the pace of change with the schemes described in this paper in reducing demand on, and increasing efficiency of, in patient pathways. This is with a view to the movement of resource that is currently within CHC/EPA beds to reinvestment into Community crisis, home treatment and liaison services to support care and treatment within homes. The preferred disinvestment would be from CHC/EPA beds in St Davids Hospital.

Fundamental to this proposal is an assurance that individual patient assessments using the Decision Support Tool process will result in appropriate onward placement, noting that all patients on Glan Ely are already subject to 6 monthly review re their CHC eligibility. For patients still meeting CHC eligibility, alternative in-house placements either in Iorwerth Jones or St Barruc’s ward, Barry Hospital, will be considered if the patient requires ongoing frequent psychiatrist review and mental health care and treatment under the Mental Health Measure. If patients meet CHC eligibility but do not require psychiatric inpatient care, they will be placed in EMI Nursing Homes according to the Choice Protocol.

4. Governance

There are governance issues related to engagement, as well as project management, reporting arrangements.

4.1 Engagement

Section 183 of the National Health Services (Wales) Act 2006 requires health bodies to involve and consult citizens in:

- Planning to provide services for which they are responsible;
- Developing and considering proposals for changes in the way those services are provided; and
- Making decisions that affect how those services operate.

In March 2011, the Welsh Government issued new Guidance for Engagement and Consultation on Changes to Health Services. The guidance stresses the need for continuous engagement with citizens rather than ad-hoc consultation on specific proposals.

In terms of this proposal, as this is an emerging service change resulting from remodelling of community services, the Mental Health Clinical Board has a responsibility to ensure all stakeholders are informed and that engagement is a dynamic process which allows consideration to be given to all factors as the change occurs to ensure effective planning and decision making and optimization of outcomes for service users within a changing model.

This will take place through the implementation group, the membership of which is based on a stakeholder analysis. The implementation group reports to the Clinical Board and the Community Health Council and Health Board executive team.
Equalities Impact Assessment will be completed as part of the project plan (Equality Act 2010) and risk register.

4.2 Project Implementation

A project Implementation group has been established within the MHSOP directorate to oversee the clinical safety and pathway arrangements within Glan Ely ward during its current changes whilst the Community Health Council, the Health Board service users and carers and other stakeholders consider the issues within this proposal. In addition it has given consideration to possible scenarios, highlighted in this paper, when bed occupancy levels reach critically low. Terms of Reference, membership and a project plan is being developed to meet the responsibilities for:

- Engagement & Communication
- It being a multi-agency change
- Ensuring high clinical standards of care throughout any change process
- Workforce requirements with staff redeployment and engagement
- Consideration of reinvestment to ensure strategic remodelling is complied with

The implementation group reports into the MHSOP directorate and Joint Operational Group for governance purposes, and into the Clinical Board within monthly performance meetings. Project implementation will follow a standardized Prince 2 methodology with supporting project tools within the Mental Health Clinical Board.

5. Action/Scenarios in the event of Critically Low Bed Occupancy

The MHSOP Directorate will remain in touch with the Glan Ely ward team on a daily basis to monitor the changing requirements of the ward as patient numbers diminish. It is recognised that there will come a point at which it will be feasible to move staffing resources out of Glan Ely to other areas of the service and that this point must be determined as soon as possible. However this needs to be balanced against the need to continue providing a safe and high quality service from Glan Ely ward, for as long as it remains open and during the engagement process.

The factors that need to be considered include:

- Patient numbers on Glan Ely
- The level of acuity / challenging behaviour on Glan Ely
- The separate male / female environments on Glan Ely and the need to manage both safely
- The need to maintain an effective medical and nursing team on the ward who can continue to work through the often complex decision-making process that are necessary to move patients on and, ultimately, close the ward.

Ward Closure Scenarios

As the multi-disciplinary team works through the All Wales Decision and Support Tool (DST) move-on process, the ward will reach a point at which there remains only a critically low number of patients. This may happen to a short timescale with no current waiting list within the service for MHSOP NHS CHC beds. This is complicated
Service Proposal - Community Health Council Briefing

by the fact that there are separate male and female facilities on the ward. Staff numbers will remain fully established until such time that;

- Either the male or female unit only is occupied where staff numbers will reduce to accommodate the single ward ‘sub unit’ – staffing levels will however remain at least Royal College recommended minimum staffing levels otherwise. There are separate 16 and 6 bedded areas or sub units, which could accommodate males or females.

- If both of the sub units remain operational with small numbers of males or females in each, totalling 7/8 patients overall, the ward will be unviable to continue in terms of the deployment of resources – a decision will be made in conjunction with the Community Health Council and Health Board at that time to consider the relocation of those patients into beds elsewhere in the directorate or Glan Ely maintains a “skeleton” staff proportionate to the numbers of patients, however low, until this is no longer necessary.

6. Stakeholder analysis

The key stakeholders analysis has been completed and invitations made to join the implementation team. The stakeholder analysis identified the full range of key internal (NHS staff) and external stakeholders with whom there must be effective communication to ensure their proper involvement in the communication and engagement process.

The engagement process must also consider and meet the needs of seldom-heard, hard-to-reach and under-represented groups who will be directly affected by the issues under consideration as part of the service redesign.

This plan also calls for consideration to be given to identifying the national charities, professional and pressure groups that will have an interest in elderly care issues and who will need to be involved in the engagement process.

Stakeholders identified include:

- Service Users
- Carers
- Staff
- Clinical Board
- UHB Executive Team
- Community Health Council
- Local Authority
- Primary Care Practices
- PCIC Clinical Board
- Medicines Clinical Board
- Local MPs and AMs
- NEXUS
- Alzheimer’s Society
7. Communication, Media relations & Equality

7.1 Communication

Principles:
- Be honest and open
- Communications should be designed with the reader in mind
- Should be clear, consistent and in plain language
- Avoid jargon, explain technical language
- Explain any acronyms or initials – in first instance spell out word and introduce abbreviation/acronyms.

The project lead for the implementation group will also act as the communication lead and include this element as a standard agenda item for meetings. All notes of project work will be circulated to all stakeholders identified. Further to this, an information briefing will be prepared for all stakeholders at significant stages of change. Communication methods will occur via the Health Board Mental Health intranet site and cascading through CAVAHM/NEXUS. Regular Community Health Council updates will be provided.

7.2 Engagement

An engagement document and presentation will be prepared and forwarded or presented to all stakeholder groups identified – to include:
- Why change is happening and provide clear evidence
- Include a clear vision of the future service and reinvestment
- Explain the consequences of change or of maintaining the status quo
- Impact of changes on different stakeholder groups such as relatives, carers, service users, local population, residents’ representatives.
- Include information on outcomes for patients and service users
- Demonstrate how community services will in future be provided within an integrated service model
- Explain any risks and how they will be managed
- Identify how will results be fed back to patients, staff and citizens who have been involved, either directly or indirectly? Will they be published through the media to inform a wider public
- Explain what evaluation of the consultation is going to be undertaken, and how
- Provide details on when it is necessary to complete a full equality impact assessment
- Give a clear picture of the financial implications of the different proposals
- Spell out who will be affected by the proposed changes and how their interests are being protected
Materials to be available in a range of formats, such as “Easy Read”, large print
Due to the pace of change, a carers’ engagement event has already taken place on
27th March 2014 with another arranged for 29th April 14 & 27th May ‘14. A broader
engagement timetable will be developed through the implementation team for the
stakeholders identified including local general practitioners, the community health
council, local politicians, the public and third sector organizations.

7.3
Media

The media plays an important role in communicating key messages to the wider
public and it is crucial to pre-brief key media contacts to ensure they understand the
context, the core elements, the clinicians’ input, the status of the suggested
scenarios and the difference between engagement and consultation, including the
timetable.

7.4
Equality Impact assessment

An Equality Impact Assessment is being developed as part of the project
management arrangements and will be contributed to through the feedback from the
engagement exercises as well as through local expertise and experience.

8. Key messages

- Overall a good news scenario
- Service demand pattern changing as a result of innovative developments in
  MHSOP crisis services
- Changing picture of demand in keeping with service strategy and business
  plan
- Opportunity to further develop a community focussed model in the service
- A dynamic process to be overseen by stakeholder implementation team

9. Timescales

The pace of change will be driven by the speed at which patients can be
appropriately and safely moved on. It is therefore absolutely crucial that the Glan Ely
team work through the move-on processes, including the Continuing Health Care
decision-making process, vigorously. It is not possible to provide a date for
completion at this point, but it is anticipated that the last patient’s decision-making
meeting will take place in the first week of May 2014, and that the final elements of
the process could be progressed soon after this.
<table>
<thead>
<tr>
<th>PLAN/Action</th>
<th>Apr 14</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
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<tr>
<td>Project &amp; Proposal Arrangements</td>
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<td>Agree service proposal in UHB Business Plan</td>
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<td>Establish UHB project Team– agree Leads, TORS, Membership</td>
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<td>Proposal Implementation</td>
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<td>Agree form of Engagement with Community Health Council</td>
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<td>Implement Consultation &amp; Engagement with Key Stakeholders</td>
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<tr>
<td>Present Service Proposal to Comm Health Council Planning Mental Health and Executive Meetings</td>
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<td>Feedback Results into Change Process</td>
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<td>Organizational Change Process</td>
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<td>Staff Involvement in Consultation</td>
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<td>Complete all staff discussions &amp; interviews under Organizational Change Policy</td>
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<td>Transfer of Ward Staff based on bed closure scenario chosen</td>
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<td>Implement Service Model</td>
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<tr>
<td>Agree clinical pathways &amp; Service Spec for consultation</td>
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10. Risks and challenges

<table>
<thead>
<tr>
<th>Risks and challenges</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>Sustainable position</td>
<td>The pattern of bed use has been consistently moving towards this position. Together with the potential to further and significantly reduce average length of stay as well as further investment in the elements of the community model which are successfully preventing unnecessary admission, the Clinical Board is confident, even with rising demand, that the bed provision is sufficient.</td>
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<tr>
<td>Equality issues raised – primarily transport access</td>
<td>The clinical board will continue to provide locality CHC beds in both Cardiff and the Vale of Glamorgan.</td>
</tr>
<tr>
<td>Service User Care Plan Disruption</td>
<td>The Clinical Board, in preparation for decisions to be made about the future of the ward, will continue to review patients using the DST process as per normal practice. If it is required that a small number of patients are moved within CHC NHS bed stock, there is a commitment that this will not happen unless patients are medically fit to do so.</td>
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<tr>
<td>Poor understanding of service change rationale to stakeholders</td>
<td>The consultation/engagement process recommended by the Community Mental health Council will be followed including monitoring through the CHC planning forum.</td>
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</table>
APPENDIX 2

Service Proposal - Community Health Council Briefing

<table>
<thead>
<tr>
<th>Risks and challenges</th>
<th>Mitigation</th>
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</thead>
<tbody>
<tr>
<td>Detriment to Staff through enforced staff moves</td>
<td>A workforce sub group has been established and all staff will be supported through the national Organizational Change Policy with full consultation with local staff side organizations.</td>
</tr>
</tbody>
</table>

11. Evaluation

- Benchmarking Results
- Reductions in Average Length of in patient Stay
- Further reductions in Delayed Transfers of Care
- Ongoing impact of community investment
- The Impact of the Mental Health Measure
- Changes in Eligibility for NHS Continuing Health Care locally
- Community health professionals’ role development

12. Finance

This proposal is driven by a change in clinical service activity. The overall cost implications of this project is partly uncertain as the outcome of the patient reviews on Glan Ely have not been completed. The certainties are that Glan Ely ward expenditure as a fully running service is approximately £1M and the Mental Health Clinical Board is committed to invest further into MHSOP community service developments. The proposed enhanced community model with associated financials is detailed below:

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<thead>
<tr>
<th>Role</th>
<th>Band</th>
<th>WTE</th>
<th>£k</th>
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<tbody>
<tr>
<td>CMHN for REACT &amp; care homes liaison</td>
<td>6</td>
<td>3</td>
<td>109</td>
</tr>
<tr>
<td>HCSW for REACT &amp; care homes liaison</td>
<td>3</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>CMHN for DGN liaison / FOPAL</td>
<td>6</td>
<td>1</td>
<td>36</td>
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<tr>
<td>Carer support worker Solace</td>
<td>3</td>
<td>0.6</td>
<td>13</td>
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<tr>
<td>Dementia care advisor / YOD care coordinator</td>
<td>6</td>
<td>1</td>
<td>36</td>
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<td>8.6</td>
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Mental Health Services for Older People

Board Meeting

1 July 2014