Health and Care Overview and Scrutiny Committee – Proposal to improve Mental Health Outcomes for Older People (Shackleton and Afton)

Introduction

The Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust, Isle of Wight Local Authority and their partners from both the health and voluntary sector are committed to promoting, protecting and improving our Island residents' Mental Health and Wellbeing. Whilst there are already pockets of excellence on the Island, we recognise that significant improvements are still needed in order to ensure that all people on the Isle of Wight, including those with particular vulnerabilities including older people's mental health and dementia, can easily access high quality, outcome focussed, evidence based services appropriate to their need when required.

In order to achieve a service that meets these goals, we are fully committed to co-producing and engaging with our local residents and their families; this is at the heart of all of our strategic development and service delivery. Based on these consultations, national best practice and clinical expertise, we have written this proposal document to improve mental health outcomes for older peoples (Shackleton and Afton). It aligns with the Isle of Wight Mental Health Blueprint to deliver transformation on the IOW in line with the Mental Health Five Year Forward View.

The Local Care Board with representation from the CCG, Local Authority and NHS Trust have developed a joint vision and set principles of how we will work in partnership. These principles help to shape not only the way in which we will work, but also the outcomes we wish to achieve for our Island residents. This proposal is part of their top ten priority areas.

Dementia is an umbrella term describing a serious deterioration in mental functions, such as memory, language, orientation and judgement which impacts the ability to carry out everyday tasks. There are many types of Dementia with Alzheimer's disease being the most common one accounting for 62%. Approximately 17% have vascular Dementia and many have a mixture of the two. Dementia is progressive and so the symptoms gradually get worse. The condition is currently incurable. Medicines and other interventions can lessen symptoms and people may live with Dementia for 7-12 years during which their health and social care needs change.

Age is the most significant known risk factor for Dementia. After the age of 65, the likelihood of developing Dementia roughly doubles every five years. With 1 in 14 people over 65 and 1 in 6 over 80 having some form of Dementia. However, Dementia can start before the age of 65 (Early Onset Dementia).

Dementia is rapidly becoming the UK's largest health and social care challenge. There are around 540,000 carers of people with Dementia in England. It is estimated that one in three people will care for a person with Dementia in their lifetime.
As of 2016, there were 1944 people diagnosed with Dementia and, the Island being a popular destination for people to retire to, this number is predicted to increase significantly by 2024.

Older people's mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia as the majority of mental illness experienced by older people is not dementia.

It is also important to acknowledge that older people often have a combination of mental and physical health problems. Older people with long term conditions, greatly increases the risk of depression. Integrated working and joint working protocols will be the best and most cost effective way to manage complex care going forwards.

A great deal can be done to help people overcome the problems of functional mental illnesses and dementia, to prevent crises and to improve the quality of life of all involved. We must remove the stigma attached to dementia, which is similar in many ways to the stigma that cancer used to carry in the past.

This proposal aligns with all the above Island and national vision and values. We are seeking Health and Care Overview and Scrutiny (H&COSC) support to proceed to implement the proposal set out below.

Current provision

The CCG commissions a range of mental health services from the IOW NHS Trust including the current older people's mental health and dementia provision. Shackleton ward is a 7 bedded dementia assessment/care area and was originally commissioned as an interim solution. Afton ward is a 10 bedded inpatient ward for older people's functional mental health illness i.e. severe depression, severe psychosis within Sevenacres.

Shackleton Ward is located on the first floor of St Mary's Hospital and is converted from an Acute Medical Ward. It consists of 7 single bedrooms, shared dining and living space as well as single gender space for privacy. Typically the unit has four to six residents at any one time. The Shackleton staff, also provide support to 4 off-site step down beds within a residential home in the community.

Shackleton Ward provides assessment and treatment for people who are presenting with severe behavioural or psychiatric disorders associated with dementia, for example severe restlessness, restiveness during personal care, depression and distressing hallucinations. The optimum length of stay for these individuals is 4-6 weeks with some individuals requiring more intensive complex care for an ongoing period of 4-6 months. The overall ambition of the service is to support individuals to return home or usual place of residence such as a nursing home.

Case for Change

The current resource is a traditional model that supports individuals through a clinical model that relies heavily on inpatient acute provision and needs to refocus on an integrated pathway and community resource.

The current inpatient provision for both Shackleton and Afton wards is for individuals who may be detained under the Mental Health Act 2007 such as section 2 and 3.

The Shackleton Ward was not intended to be a permanent solution and previous reviews have recognised the need for a longer term purpose built inpatient provision.

The Shackleton ward has a number of very serious shortcomings which were identified in the two CQC inspections carried out in November 2016 and April 2017. The CQC clearly outlined the view that the area was not fit for purpose in the longer term and should be replaced.

An example of this is that Shackleton Ward is located on the upper floor within the main acute hospital, adjacent to a medical ward which presents a number of constraints. Being inside the main body of the hospital and adjacent to a medical ward, Shackleton is subject to the same strict infection control requirements that the rest of the hospital wards are. This is not necessarily a welcoming or comforting environment for the residents of Shackleton.

A number of ligature points were identified on both wards, which the Trust has mitigated. However the result is that the units are now even more clinical and restrictive because some of the ligature point's involved external windows which have now had protective grills installed resulting in reduced external visibility for residents of the unit and staff.

The layout of the service user areas reveals that there are no opportunities or routes that a service user can travel continuously when in an agitated state without meeting barriers. This can often lead to an increase in agitation in the people who use services anxiety and agitation.

Access to safe outside space is available at Afton ward, although the steep garden area was criticised by CQC. People on Shackleton ward can access outside space with staff support although the garden is not co-located.

The Island currently has a fragmented pathway for older people with dementia and a serious mental health diagnosis. A significant percentage of the budget is spent on traditional inpatient provisions, with limited older people's community provision. Where the community services do not operate effectively or all the components are not in place, there is a greater demand for hospital beds and institutional placements as is the current position.

Clinical

In considering options for an improved service model we have reviewed the best practice guidance for commissioners in 2013 by Joint Commissioning Panel for Mental Health (JCPM)

1. Joint Commissioning Panel for Mental Health, Guidance for Commissioners of older peoples mental health services www.jcpmh.info
2. Joint Commissioning Panel for Mental Health, Guidance for Commissioners of dementia services www.jcpmh.info
3. MSNAP accreditation http://www.dementiapartnerships.org.uk/archive/wp-content/uploads/msnap-standards.pdf

More recently in their 2017 publication Accreditation for Inpatient Mental Health Services they set out a number of requirements for inpatient settings a sample of which are detailed below:

- All people who use services have single bedrooms
- People who use services are cared for in the least restrictive environment possible, whilst ensuring appropriate levels of safety and promoting recovery

- Facilities ensure routes of safe entry to and exit from the ward/unit in the event of an emergency related to disturbed/violent behaviour
- where personal and confidential discussions are held, such as interview rooms and consulting/examination/ treatment spaces, conversations cannot be heard outside of the room
- Male and female people who use services (self-defined by the individual) have separate bedrooms, toilets and washing facilities
- There are lounge areas that may become single-sex areas as required
- Social spaces are located to provide views into external areas
- The dining area is big enough to allow people who use services to eat in comfort and to encourage social interaction, including the ability for staff to engage with and observe people who use services during mealtimes
- People who use services are able to leave the ward/unit to access safe outdoor space every day

Due to the challenges identified by the CCG, Trust, Adult Social Care and the CQC within the current provision a different older people's mental health and dementia (Shackleton and Afton) provision needs to be recommissioned urgently.

The Proposal

A number of options have been explored and developed together by the NHS Trust, Adult Social Care and the CCG in co-production with people and their carers who are using or have used this type of provision alongside the Dementia and Older Peoples Mental Health Steering Group. The preferred option has been supported by the CCG Clinical Executive and still needs to be considered formally by the IW NHS Trust Board.

The new model of provision needs to prioritise care, close to family and friends, with an emphasis on 'at home' or normal place of residence as far as possible, is vital to maintaining people's independence. Periods of care in any 'institutional' placement should be as short as possible and in the most appropriate environment to avoid lessening independence. The aim should always be that people are enabled to live in their normal place of residence by flexible care where possible, or returned to their normal place of residence, or adapted home placement, as soon as possible if they have been placed elsewhere.

The new model of care needs to have a wide range of generic and specialist mental health services that meet the needs of people with a serious mental health and/or dementia and their carer's in many settings and is based on need and not age alone;

- In their home
- In acute general hospitals
- In sheltered and extra care housing
- In residential care homes and nursing homes
- In hospices

GPs and other agencies will be able to refer to the intensive older peoples support team, who will assess and support people with dementia with the aim of maintaining in or returning to their normal place of residence. The team will provide support, advice, treatment and care in people's homes, care homes, nursing homes and if necessary in an adapted assessment.

The multi-disciplinary team will be co-located alongside 2 new units within one building, providing an enhanced Older People and Dementia Intensive Support and Beds provision, based on the principles of Crisis Resolution Home Treatment. The Team members will manage a caseload of up to 25 maximum depending on acuity with the emphasis on maintaining maximum independence following settling crisis.

With a shift of focus and resource from a traditional acute inpatient provision to a mixed inpatient/community team with a new purpose built inpatient provision, we feel only 4 dementia beds will normally be required for short term management, and treatment interventions. The adapted environment will be designed so as to be able to admit the carer with the person being cared for to ensure continuity, allow full involvement, gain fully accurate assessments and help 'teach' and model care techniques to enable the carer to continue to be actively involved and cope as desired. There will also be 12 older people's functional beds i.e. for people with depression, schizophrenia. The new build will have two swing beds to support fluctuations in presenting. The proposal would also invest in 4 step-down beds as piloted in 2017 within residential/nursing home in the community.

A single storey unit is required to ensure compliance with the best practice design regulation's, this will also allow the maximum amount of free movement for individuals whilst staying in the unit and accessing outside space.

The proposal has an ambitious timeline for the completion of the re-provision. The timeline is driven by the need to complete the re-provision within a two year window as stipulated by the CQC.

The CCG Executive approved the proposal on the 21st December 2017.

Stakeholder Engagement

People and carers using and supporting these services have been involved in co-producing the proposal for the provision of older people's mental health intensive support and beds (Shackleton & Afton). There have been a number of public consultations on this subject;

- 2015 – The Future of Inpatient Provision
- 2016 - Whole Integrated System Redesign – Shackleton Inpatient Provision
- 2017 – Dementia and Older peoples Mental Health Steering Group have developed and critiqued options that led to the proposal as set out in the paper

Quality impact assessment (QIA) and Equality Impact Assessment (EIA)

Both the quality impact assessment and equality impact assessments have been completed.