MENTAL HEALTH SERVICES FOR OLDER PEOPLE

PROPOSAL OF WARD AND COMMUNITY DEVELOPMENT IN MHSOP

1. Executive Summary

Bestwood and Daybrook Wards are provided by Nottinghamshire Healthcare NHS Trust (NHT) within the Mental Health Services for Older People directorate (MHSOP). The wards are based at the St Francis Unit (Nottingham City Hospital) in Nottingham city and have 20 beds on each ward, providing organic and functional assessment respectively for older people. These wards receive patients from Nottingham City CCG, Nottingham North and East CCG, Nottingham West CCG and Rushcliffe CCG.

In line with national policy, and in response to local commissioning intentions, NHT will consult on the re-provision of these wards, and in their place provide a community model of care which supports older people to remain within their homes wherever possible. This particular change constitutes the third stage of implementing service transformation across MHSOP, where bed based provision is re-engineered into community focused models of care.

Over the last five years the Mental Health Services for Older People directorate has developed services in line with best practice, QIPP and CIP requirements. This has resulted in numerous small changes to the service. There has also been investment in parts of the service which has led to significant change. These include Intensive Recovery Intervention Service teams (IRIS) in County and Bassetlaw, Memory Assessment Services, Dementia Outreach Team (in the City locality) and Dementia Outreach Service (County including Bassetlaw). However, more fundamental systematic changes to the model MHSOP provides have been identified by the directorate to meet the increased demand for the service in line with the importance of person centred care, recovery and risk enablement, that have led to less of an emphasis on inpatient care.

The fundamental principles of a future service model[1] are:

1. The service will provide care for those of any age with dementia and those over 65 with moderate and severe functional mental health conditions. (NB for people with a primary learning difficulties diagnosis who present with dementia, their care will continue to be provided by specialist services with advice provided via Working Age Dementia Services as required).

[1] The fundamental principles of a future service model for MHSOP closely links into the Guidance for Commissioners of Older People's Mental Health Services (May 2013), meeting nine of the ten key messages for commissioners. Report available at http://www.jcpmh.info/good-services/older-peoples-services/

2. The focus will be on managing people within the community rather than inpatient care.

3. The services will be provided with an ethos of positive risk taking and recovery focused care, reducing dependency on services.

4. Functional services will be equivalent to those provided in Adult Mental Health for people of working age but will meet the specific needs of older adults.

5. Services will be aligned to their primary care physical health counterparts to ensure the holistic management of patients.

6. The service will continue to need a stock of organic assessment and treatment beds to assess and treat the most complex patients.

7. The service will continue to need a stock of functional assessment and treatment beds specifically for older people with severe functional illness and those with co morbid physical frailty.

8. The wards should remain separate in their function; i.e. organic or functional not a combination.

9. An average length of stay will be agreed for each type of ward.

10. Services will not be closed without alternatives being secured, in place and functioning.

This service change has been agreed in principle by commissioners and this paper has been developed to outline the alternative service model that will be provided in response to the closure of the two wards. This paper is in addition to papers already presented to commissioners via QCRM. **It should be noted that for longer term demand and capacity for the City and the whole of the County the Community Development plan, as listed below should be negotiated.**

This paper forms part of a suite of documents which should be considered in conjunction.

1. MHSOP clinical strategy.
2. MHSOP recovery and risk enablement strategy.
3. Community development plan
4. In-patient development plan.
5. DICU Evaluation paper, including responses to commissioner queries.
6. EMPACT bed utilisation review.
7. Organic bed clinical model.
8. Functional bed clinical model.
9. Integrated CMHT operational procedure (to be developed).
10. Medical workforce model and plan (to be developed.
11. Day Services update (to be developed.
12. Service re-design and implementation plans (x 2).
13. Service redesign workforce plan.
14. Service modelling papers (x 2).
15. Care homes currently served by the Dementia Outreach Service.

1. Context for Service Change

The key reasons for the re-provision of Daybrook and Bestwood Wards and in their place providing a community model of care are:

- To implement the recommendations for required bed numbers for Nottinghamshire's population projected for 2023/24[2] which equates to 44 organic and 49 functional beds
- The independent EMPACT Bed Utilisation Review 2012 indicated 54% of organic admissions were to support breakdowns in care at home, rather than evidence based clinical need for admission. Furthermore, length of stay in organic assessment beds was extended by up to 60% due to lack of alternative and more clinically appropriate provision within the community.
- The EMPACT review also highlighted 25% of functional admissions did not require admission and could have been managed in an alternative setting. Once admitted, alternative levels of care, i.e. step down provision, was often cautiously introduced (56%). There is a lack of clinically appropriate provision within the community (25%), which inappropriately impacts on lengths of stay for these patients.
- Supports NICE guidance for people with organic and functional mental illnesses and inpatient admission by having a stepped care approach and a focus on person centred care.
- Based on the evidence presented there is a need for a skilled multidisciplinary workforce working in a variety of services with different intensities of care provision.

In light of this NHT is proposing the closure of Bestwood and Daybrook Wards based at St Francis Unit Nottingham City Hospital. NHT will consult on the re-provision of these wards, and in their place provide a community model of care for the CCGs who access these wards, which supports older people to remain within their homes wherever possible.

The priorities for the savings made from the ward closures:

- Staffing the remaining wards to be efficient in assessing, formulating, treating and discharging patients to the appropriate next setting with a focus on psychological approaches to care

- Enhancing community services over 7 days / week to provide intervention from state registered staff at a weekend for both organic and functional patients

The paper also considers reinvestment is required, outside of the service redesign, into:

- Enhancing dementia outreach services to manage patients within care homes to reduce admission to the wards

2. Current & Proposed Inpatient Configuration

The key aim is to significantly reduce unnecessary admissions, and therefore fundamental changes are required. At present inpatient beds within the MHSOP directorate are spread across four sites; Bassetlaw District General Hospital, Millbrook Unit, Nottingham City Hospital and Highbury Hospital (Table 1):

Table 1

Functional		**Organic**	
Ward B1	5 beds	Ward B1	10 beds
Daybrook Ward	20 beds	Bestwood Ward	20 beds
Cherry Ward	20 beds	Amber Ward	20 beds
Kingsley Ward	15 beds	Silver Birch Ward (DICU)	20 beds
Total	**60 beds**	**Total**	**70 beds**

Proposed bed numbers on closure of Bestwood and Daybrook wards:

Functional		**Organic**	
Kingsley Ward	20 beds	Amber Ward	15 beds
Cherry Ward	20 beds	Silver Birch Ward (DICU)	20 beds
Ward B1	5 beds	Ward B1	10 beds
Total	**45 beds**	**Total**	**45 beds**

3. Organic Wards Service Model and Staffing

The new service model proposes three organic wards; Amber, Silver Birch and B1 Wards, providing a total of 45 beds. The community model plans to utilise IRIS teams to gate-keep ward admissions. All admissions, other than referrals by DOT, MHA Assessments and RRLP will go through IRIS to ensure all alternatives to an admission to an acute ward have been considered. It is expected that the number of people admitted to hospital beds will reduce due to better and increased support within the community, improved gate-keeping and only patients with complex presentations of dementia will be admitted (PBR cluster 20). These are people with dementia who are having significant problems in looking after themselves and whose behaviour challenges their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high-risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down. In recognition of this Amber Ward will be converted in to a second Dementia Intensive Care Unit (DICU). At present Ward B1 will continue to operate as an assessment ward and will be able to transfer its more complex patients to both of the DICU wards. This may be reviewed.

A recent review of the DICU (Dementia Intensive Care Unit) identified its evident success in managing dementia with associated challenging behaviour. These include: length of stay reduced by 65%, only 2 failed discharges, reduced use of anti-

psychotics as a result of enhanced access to psychology, nurse/psychology led care and discharge as well as access to dementia outreach services.

In future the referral pathway into Silver Birch and Amber Wards will only be for the most complex patients with a wide range of health, social and behavioural needs. Patients who traditionally may have been admitted to inpatient care will be assessed and treated by the enhanced community services identified in the community services model.

The DICU model aims to achieve a 12 week assessment and treatment pathway. This includes assessment and treatment of patients using a multidisciplinary approach to identify patients' physical and psychological needs to ensure that individuals are placed within the least restrictive environment on discharge. This approach includes the use of standardised clinical assessment materials, access to psychology, occupational therapy, physiotherapy and speech and language therapy, and a structured and individualised activities programme. Regular case formulation sessions will be held on the ward to discuss clinical cases and reflect on best practice. The enhanced staffing levels will ensure the optimum intervention and length of stay for the patients.

In summary the previous 60 dementia beds (Bestwood, Amber and Silver Birch wards) will be reduced to 35 (Amber and Silver Birch wards) and will only be used for people in PbR cluster 20. Both remaining wards (Silver Birch and Amber) will be DICU wards. The loss of 25 beds across the system will mitigate the current under activity on the existing DICU. On the basis that demand for dementia beds will continue to grow at the predicted rate future activity for this ward has been established at 85% occupancy in line with national good practice. MHSOP will continue to monitor and improve length of stay via operational meetings which will change from their current structure to reflect the patient pathway.

Staffing: Amber and Silver Birch Wards (Ward B1 will remain unaffected)

Staffing	Amber (15 beds)			Silver Birch (20 beds)		
Ward Manager	1.0			1.0		
Deputy Ward Manager	1.0			1.0		
Nursing staff	E	L	N	E	L	N
	2	2	1	2	2	1
HCA	3	3	2	4	4	3
Activity Coordinator (M- F)	0.8			1.0		
Environment Care Coordinator (M-F)	1.0			1.0		
Ward Clerk (25 hours per week) (M- F)	0.5			0.5		

Currently there is 1.0 wte 8a Psychologist on Silver Birch. The intention is for this role to work across both Amber and Silver Birch and have additional support from a 1.0 wte band 4 psychology assistant also working across both wards.

4. Functional Wards Service Model and Staffing

The new service model proposes three functional wards; Cherry, Kingsley and B1 Wards, providing a total of 45 beds, as opposed to existing 60 beds. The community model plans to utilise IRIS teams to gate-keep ward admissions. All admissions will be facilitated through IRIS to ensure all avenues other than admission to an acute ward have been considered. Patients admitted through MHA assessments and RRLP will be directly admitted to inpatient wards. It is expected that the number of people admitted to hospital beds will reduce due to better and increased support within the community, improved gate-keeping and only patients with complex presentations of depression, various anxiety disorders and psychosis will be admitted. Patients who traditionally may have been admitted to inpatient care will be assessed and treated by the enhanced community services identified in the community services model.

Patients referred to Kingsley, Cherry and B1 Wards will continue to receive high levels of specialist and on-going clinical interventions from a wide range of healthcare professionals so that higher complex needs can be managed. All three wards will be multidisciplinary in approach and treatment will be person-centred and psychologically based.

In line with the introduction of PbR only patients assessed to be the cluster pathways outlined in the table below will be admitted and this will determine their treatment timescales;

Non-Psychotic Inpatient Admissions	
Cluster 5	This group of patients will be severely depressed and/or anxious and/or other. They will not present with distressing hallucinations or delusions but may have some reasonable beliefs. They may often be at high risk for non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living.
Cluster 6	Patients with moderate to severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc where extreme beliefs are strongly held, some personality disorders and enduring depression.
Cluster 8	This group of patients will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependant engagement and often hostile services.
Psychosis Inpatient Admissions	
Cluster 13	These patients will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.
Cluster 14	These patients will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

Cluster 15	This group of patients will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present, It is likely that this group will present a risk of non-accidental self injury and have disruption in many areas of their life.
Cluster 16	These patients have enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and co-existing problem drinking or drug-taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.
Cluster 17	This group of patients have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable and engage poorly with services.

Discharge planning will commence from admission to the ward through the development of the appropriate care plan with the patient and carer as appropriate. Discharges from inpatient wards will be to the most appropriate community teams based on patient need. This will be facilitated at the earliest clinically appropriate stage by IRIS teams.

MHSOP will continue to monitor and improve length of stay, allowing Kingsley, Cherry and B1 Wards to provide a high quality inpatient assessment facility. That is; able to assess and treat the more complex patients presenting with severe depression, various anxiety disorders and psychosis on functional wards, with less acute patients being treated at home or in care homes. In recognition of having the most complex patients being admitted into inpatient wards, the increase in the number of beds at Kingsley ward and to continue to provide high quality services to patients, staffing levels will need to be enhanced.

Staffing: Cherry and Kingsley Wards (Ward B1 will remain unaffected)

Staffing	Cherry (20 beds)			Kingsley (20 beds)		
Ward Manager	1.0			1.0		
Deputy Ward Manager	1.0			1.0		
Nursing staff	E	L	N	E	L	N
	2	2	1	2	2	1
HCA	3	2	2	3	2	2
Activity Coordinator (M – F)	1.0			1.0		
Environment Care Coordinator (M-F)	0.6			0.6		
Ward Clerk (25 hours per week) (M- F)	0.5			0.5		

N.B. Cherry and Kingsley ward there will be 5 days (Mon-Fri) extra shift (mid/twilight or late as required) and for Cherry ward two further shifts (Tue and Fri) for ECT days at Band 5 level.

Psychology intervention is currently provided by the Consultant Clinical Psychologist to the functional wards, in order to move to a more psychologically focused service an additional 0.5 WTE clinical psychology post will be recruited to.

5. AHP and Medical Staffing enhancements to wards

Allied Health Professionals

Occupational therapy (OT) and Physiotherapy (PT) are essential to support ward staff in assessment, formulation, treatment and discharge planning as part of a multi-disciplinary team.

At present the wards in the south of the county have a dedicated inpatient therapy team and those at Millbrook have had an in-reach service from the CMHT with an additional preceptorship occupational therapist. An inpatient therapy team will be developed which would provide consistent input across all wards. The skill mix for this would be:

Role	Current	Proposed	Difference
Band 6 OT	1.0	1.0	0
Band 5 OT	1.0	1.6	0.6
Band 6 PT	0.8	0.8	0
Band 5 PT	1.5	1.5	0
Band3Therapy Assistant	1.72	2.0	0.28

This represents an increased cost of £25 000 which would equate to each ward having access to 0.65 wte OT, 0.57wte PT and 0.5 Therapy TI.

Medical

Increased consultant psychiatry sessions will be provided to the remaining wards from the current inpatient psychiatry establishment. This will support both increased clinical complexity and reduced length of stay. The frequency of patient reviews would be increased to accommodate increased clinical need as well as a focus on reviewing treatment and discharge planning. Daybrook and Bestwood wards currently have 8 psychiatry sessions and these sessions will be re-allocated. Silver Birch will be allocated 6 additional sessions and 2 sessions will be allocated to the Millbrook Unit covering Amber and Kingsley wards.

6. Re-investment planning

MHSOP will reinvest into:

1. Increased staffing levels and multi-disciplinary working for the remaining wards to mitigate increased clinical complexity, reduce length of stay and increase throughput with a focus on psychologically appropriate treatments.

2. Enhancing community services over 7 days / week to provide intervention from state registered staff at a weekend for both organic and functional patients who have increased risks
3. Enhancing dementia outreach services to manage patients within care homes and thereby reduce organic admission to the wards

Direct budgets for Bestwood and Daybrook wards total £2.1m. In order to enhance the staffing levels on the remaining wards and re provide an alternative level of care for patients who would usually access these wards £1.321m is the amount of reinvestment required. Future optimum staffing levels for community services as the population increases can be seen in the Community Development Plan.

7. Clinical Benefits

Inappropriate admissions and increased lengths of stay in hospitals are not in the best interests of people with organic and moderate to severe functional illness. Protracted lengths of stay increase the risk of infection, boredom, depression, frustration and a loss of independence and confidence.[3] Furthermore the service model proposed meets objectives 9 and 11 of the Dementia Strategy 2009[4] by improving intermediate care services for people with dementia and improved quality of care for people with dementia in care homes. MHSOP will continue to provide high quality care to people with organic and moderate to severe functional illness, but in a more appropriate care setting. The care delivered will be based on person centred, risk enablement and recovery principles in line with those developed as part of the PbR care pathways.

8. Reinvestment into Remaining Inpatient Wards

The costs associated with the enhanced ward model is described below:

Ward	Current budget (£000)	Proposed cost (£000)	Difference (£000)
Amber (to DICU)	730	863	133
Silver Birch	1,141	1,107	-34
Band 4 Psychology DICU 1.0wte	0	26	26
Kingsley	734	862	129
Cherry	828	908	80
Band 8a Psychologist functional 0.5 wte	0	27	27
Enhanced AHP	0	25	25
Total	3,433	3,815	386

[3] Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care 2010, http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/EastMidlands/PandEI/Ready_to_Go_-_Hospital_Discharge_Planning.pdf.

[4] Dementia Strategy: Living well with dementia: A National Dementia Strategy https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy)

9. Reinvestment to community services from ward closures

Prior to the closure of A23, Bestwood Ward was the receiving ward for organic assessment patients from City and Nottingham North and East. A23 was the receiving ward for organic patients in Nottingham West, City South and Rushcliffe. The reinvestment into community services from this closure are continuing to be negotiated.

The number of functional beds in the south of the county has remained the same until this planned closure of Daybrook ward. Therefore it is suggested that the reinvestment from the closure of Daybrook ward is divided between City, Rushcliffe, Nottingham West and Nottingham North and East.

Each CCG will now be taken in turn regarding suggested community reinvestment: in response to the ward closures. Appendix 3 contains the longer term investment for the four CCGs required to respond to the increasing demand from the changing demographics.

All costings are 2 points below top of scale and include non pay.

10. Rushcliffe (Daybrook)

Assuming the level of reinvestment from the closure of A23 is as anticipated the next priority is to enhance dementia outreach staffing as well as nursing staff and CSW capacity within IRIS (for the additional functional patients that would need frequent nursing interventions as an alternative to admission). This would be the minimum reinvestment required to support the ward closures.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
CPN Band 6 CSW	IRIS IRIS	0.50 1.00	24 29	210 840
OT Band 6	DOS	0.60	26	252
Support worker Band 3	DOS	1.00	26	588
Grand Total		**2.10**	**104**	**1890**

11. Nottingham North and East (Gedling and Hucknall) (Bestwood and Daybrook)

There are a large number of care homes in the Nottingham North and East locality, especially in the Hucknall area. The service is currently stretched across 711 nursing/care home beds. An increase in the Dementia Outreach staffing levels is recommended as below to support the closure of Bestwood Ward. An increase in staffing in the IRIS team would be required to support the closure of both wards to provide 7 day / week qualified clinician cover and extra CSW capacity.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
CPN band 6	DOS	0.50	25	300
OT band 6	DOS	0.60	26	252
Support worker band 3	DOS	1.00	26	588
Band 6 CPN/OT/PT	IRIS	2.16	102	907
Assistant Practitioner band 4 CSW band 3	IRIS IRIS	1.00 1.00	33 29	588 840
Grand Total		**6.26**	**241**	**3475**

This would be the minimum reinvestment required to support the ward closures.

12. Nottingham West (Broxtowe) Daybrook only

Assuming the level of reinvestment from the closure of A23 is as anticipated the next priority is to increase the current state registered IRIS staffing compliment to achieve 7 day cover as well as increase the CSW capacity.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
Band 6 CPN/OT/PT Band 3 CSW	IRIS IRIS	1.30 1.00	61 29	546 840
Grand Total		**1.30**	**90**	**1386**

13. City (Daybrook and Bestwood)

City Dementia Outreach Team has had increased investment in the last financial year and further investment has been agreed in principle for the team to cover all City CCG patients in dementia registered care homes including those out of area.

The key area to address in the City is the lack of an alternative to inpatient care for people living in their own homes. This is reflected by the higher than anticipated admission rate for City patients. They make up 11.3% of the over 65 population in Nottingham and Nottinghamshire however account for 27.7% of occupied bed days.

Some intermediate care services are provided by CityCare for the City CCG. The criteria for the service are different to that in IRIS and it is rare that patients from MHSOP services meet the service criteria and are accepted by the team. The team provides care for people with up to moderate dementia - it does not take people with moderate to severe functional mental health problems or complex dementia. This has a significant impact on avoiding a mental health admission or expediting a mental health discharge in the city locality, as reflected in the occupied bed days above.

It is crucial that this is resolved if the proposed bed reductions are to succeed, as with the beds closed it will be both impossible to maintain and treat people in their own homes or admit them. There are two possible options:

1. Align the existing service model to that in the county e.g. acceptance criteria and length of service intervention time (city is currently 6 weeks and county 12 weeks). This will require an increase in capacity to accommodate new activity or a reduction in services that are currently provided. It will additionally require significant and extensive skilling up of staff to deal with the complete range of complex mental health problems other than dementia and complex/challenging dementia.

2. Or; create a team based on the county model (NHT preferred option). Additional investment of £500k would be required to establish one team which replicates services provided to Nottingham North and East. This would be insufficient to fully cover the city area but would allow for up to 30 people (dependent on need) to be treated in their own homes.

However, until this issue is resolved the principle that City and Nottingham North and East currently access Daybrook and Bestwood the amount to be reinvested from the closure of the wards should match that of Nottingham North and East which is £241 000. City funding from the closure of A23 in 2013 also remains to be re-invested.

14. WAD investment

Over time the entry pathway into services for Working Age Dementia Diagnostics across all CCGs has been in need of review in order to continue to provide the commissioned level of service. Working Age Dementia services are consistently facing pressure given the historic under estimation of the number of referrals that the team would receive, and also increasing pressures to accept patients with substance misuse related cognitive symptoms such as Korsakoff's.

As part of the service re-design planning the directorate was asked by commissioners to review the existing WAD service provision and identify the additional resource required to meet the growing demand. This information is presented below and related only to the existing service; it does not incorporate costs for alcohol related memory impairment which would require additional financial investment.

There have been capacity issues in the WAD assessment and diagnostic service since its inception. Over the 4 years it has been running there have been on average 216 referrals for individuals who will require at least a first assessment and follow up appointment. The diagnostic service currently has available:

- 120 new assessment appointments.
- 288 follow up appointments.

However based on this the referral rate of 216/year the diagnostic service requires:

- 216 new assessment appointments.

- 353 follow up appointments (this includes 216 follow up appointments, 88 post diagnostic appointment (2nd follow up), 22 further follow ups to review due to poor tolerance of medication, 27 repeat assessment appointments).

This shortfall in the number of available appointments is demonstrated by the long waiting times to an initial assessment appointment. The current waiting time for an initial appointment is 14 weeks. In order to reduce waiting times and increase capacity to match the demand the recommendation is for further investment to recruit the following staff:

Role	Band	Wte
Advanced Practitioner	7	1.0
Psychology Assistant	4	1.0
Admin	2	0.5
Grand Total		**2.5**

The costing of this investment is **£95,177** based at top of scale and including non pay. The division of this cost between CCGs would need to be agreed as the service is Nottingham and Nottinghamshire wide.

WAD Occupational Therapy

The OT staffing level in county and Bassetlaw has been inadequate. The current model for each areas is 0.2 wte OT and 0.2 wte OT TI. All the OT posts have had extremely high turnover with difficulty in retaining staff who are working in a different locality each day. Due to this the posts have been regularly vacant. The recommendation is to therefore have 0.5 wte of each role in each locality (in this instance seeing Mansfield and Ashfield as two localities). This will both meet the demand, retain the specialism of WAD and also retain staff in these important roles. The recommended skill mix by team based on the city model rather than using population data is:

Role	Band	Wte
CPN	6	0.5
OT	6	0.5
Therapy TI	3	0.5

The investment needed to achieve this level of service and support MHSOP in retaining experienced OTs would be:

Locality	OT (band 6)	OTTI (band 3)
Bassetlaw	0.3	0.3
Mansfield and Ashfield	0.6	0.8
Broxtowe	0.3	0.3
Gedling and Hucknall	0.3	0.3
Rushcliffe	0.3	0.3
Newark and Sherwood	0.3	0.3

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The costing of this investment is **£161,396** based at top of scale and including non pay.

15. Key Performance Indicators

Key Performance Indicators would include:

- Positive service user feedback and satisfaction with services
- Positive carer/family feedback and satisfaction with services
- All services users to have a recovery focused and risk enablement care plan, crisis and contingency plans in place
- Reduced length of stay in MHSOP inpatient wards
- Reduced re-admissions to inpatient wards
- Increased number of patients being seen by MHSOP services

16. Proposed New Model of Activity

Based on 85% bed occupancy across all functional and organic wards (90 beds), the proposed annual occupied bed days is 27, 923 against a current plan of 39,115.

Service	**Cost £000**
Enhancement of Inpatient Wards to achieve higher intensity intervention and higher throughput	386
Rushcliffe	104
Nottingham City	500 *
Nottingham West (Broxtowe)	90
Nottingham North & East (Gedling & Hucknall)	241
Total:	**£1,321**

Activity differences:

Inpatient OBD reduction	11 192
Community activity increase	12 837 *

* Based on same level of reinvestment/activity in IRIS as in Nottingham North and East as served by Daybrook and Bestwood Wards)

A re-investment in the direct cost of 63% would generate an **increase in activity of at least 14%**.

By addressing the alternatives to admission in the city theoretically **16.4% of its occupied bed days could be saved**.

Since the EMPACT study was conducted IRIS services have been established in all county areas which are having an impact on preventing admission and reducing length of stay:

MHSOP Median LOS for 14 June 2012= 52 days
MHSOP Median LOS for 14 June 2013= 43 days
MHSOP Median LOS Jan – Mar 2014 = 38 days

All these factors are supportive of reducing the bed numbers. Further calculations can be seen in Appendix 2.

17. Summary

Recent experience clearly indicates that investment into community services for older people has been successful in helping people stay at home. Furthermore, it rates more highly on quality for patients and carers than inpatient care, and has improved patient outcomes.

This paper provides an outline for the initial changes in response to the ward closures and costs. It should be noted that continuing demographic changes will increase the demand for MHSOP services over time. Further investment will be required to continue to develop alternatives to inpatient admission (i.e. IRIS) and ensure the capacity to respond in a timely manner to referrals to prevent the escalation of the situation to a crisis and the need for a higher level of services in all localities

Over time the entry pathway into services i.e. Memory Assessment, Working Age Dementia Diagnostic and Community provision and CMHT will require ongoing review in order to provide this function. The details recommended for future community services can be found in the Community Development Plan.

Working Age Dementia (WAD) services are consistently facing pressure given the historic under estimation of the number of referrals that the team would receive, and also increasing pressure to accept patients with substance misuse related cognitive symptoms such as Korsakoff's. This paper has outlined the increase in capacity needed to maintain an appropriate level of service should the commissioners wish to invest new money into this service.

The directorate is conscious that the re-investment sums have not yet been agreed by commissioners and would recommend should further funding be available WAD is specifically supported as a priority for new community investment.

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With acknowledgement to Helen Smith and Satwant Kaur, Project Managers, as principal authors of the paper.

N.B. Redundancy costs from ward closures and start up costs for any newly created services are not included in this report