

NHS Wirral and Wirral Department of Adult Social Services

A Strategy for Services for Older People with Mental Health Needs 2009 and Beyond

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INTRODUCTION

1.0 This document sets out the strategic direction and investment priorities for mental health services for older people in Wirral from 2009 and beyond. It has been developed as a consequence of and is linked with:

- The NHS Wirral Strategic Plan 2008
- The Mental Health and Wellbeing Commissioning Strategy 2008-2013.
- The National Dementia Strategy
- Local initiatives arising from the Care Services Efficiency Delivery project (CSED).
- The recommendations of the Older Persons Review (Gott Review)

1.1 The strategy covers services for older people aged 65 and over and includes primary and secondary care mental health services. It is a joint strategy between NHS Wirral and the Wirral Department of Adult Social Services (DASS) and recognises the important role of the Third Sector.

1.2 The strategy is based on the underlying philosophy of the prevention of mental ill health and the promotion of positive mental health.

1.3 In Wirral people with mental health problems will be able to expect services that will:

- Involve service users and carers
- Deliver high quality treatment and care
- Be person centred and based on need not age and be accessible
- Promote safety for carers, staff and the wider public
- Have a philosophy and focus of rehabilitation and recovery
- Be well co-ordinated and deliver continuity of care
- Empower and support service providers
- Be accountable to the public, service users and carers
- Be informed by public health assessments of need
- Be provided in the community and as close to people's homes as possible when possible.

1.4 Commissioning is a real opportunity to involve service users and carers. We recognise the need to respect, acknowledge and address the views of different people involved in the care of a person with mental health problems, including the person themselves. We believe that the involvement of service users and carers in all aspects of the development, commissioning and management (as appropriate) of mental health services is essential.

1.5 A fundamental approach will be to continue to support services that seek to empower service users or carers. This will include supporting the development of user-run services and user-led service monitoring. Supporting organisations that promote the service user voice; and supporting the employment of people with mental health difficulties within mental health services. Support will include access to training and development opportunities and to at least some dedicated financial resources, as well as access to staff time.

1.6 This strategy has been developed in anticipation of the National Dementia Strategy over a period of 2-3 years of active engagement with carers, patient representative groups and patients where possible. It reflects the National Dementia Strategy recommendations.

1.7 The intention is to actively engage with patient representatives and carers in an active way in implementing the recommendations of the strategy.

VISION AND AIMS FOR THE FUTURE

Our vision and aim is to improve the mental health of Wirral residents and for the services available to be effective and of the highest quality¹.

2.0 If you live in the Wirral as an older person we believe you should have:

- A positive image of ageing
- Live as independently as possible in a safe environment of your choice
- Access to mental health services, if you need them, based on need not age
- High quality general health care according to your needs

2.1 To achieve this vision we recognise that there is a need to:

- Focus on promotion, prevention and early intervention
- Deliver high quality care and support on a locality basis
- Improve awareness of mental health issues in older people
- Offer personalised self-determined support

2.2 This will require people and facilities to provide high quality care through:

- A skilled workforce at locality level
- Integrated commissioning and
- Leadership to deliver comprehensive services and continuous service improvement.

2.3 Statutory services will need to be complemented by:

- Service users, carers and professionals who are fully informed about the mental health issues faced by older people.
- Staff, carers and service users who have a heightened awareness of early signs and symptoms of mental health problems.
- Clear public health messages which inform public views and address stigma and fear.

2.4 Partnership working to develop a range of services which support older people with mental health needs to remain at home for as long as possible will be implicit in all aspects of service provision.

2.5 Our intention is to continue to engage with patient representatives and carers to continuously review our vision and aims, to develop investment proposals and to evaluate service provision.

OLDER PEOPLE'S MENTAL HEALTH NEEDS

The details below provide a synopsis of the more detailed work undertaken as part of the Joint Strategic Needs Assessment for Older People (JSNA). This is available at:

http://www.wirral.nhs.uk/Wirral_Joint_Strategic_Needs_Assessment/Wirral_Joint_Strategic_Needs_Assessment.html

3.0 Wirral NHS and the Department of Adult Social services (DASS) are responsible for commissioning services for a GP registered population of circa 334,000 residents (164,000 males and 170,000 females). This is the current population number and follows a period of steady decline in total population numbers. However, compared to England and Wales, Wirral has a relatively high ageing population and a low proportion of people in their twenties and thirties. These demographics become increasingly important when looking at issues such as caring for Wirral's older people in the future².

3.1 The term older people applies to people who are 65+ years of age. There were 58,300 people over 65 as at December 2008 in Wirral. These people make up 17.5% of the total population (according to the GP registered population). This is higher than the national average. Population projections produced by the Office of National Statistics (ONS) estimate that this population group will increase to make up 26% of the Wirral population by 2031. DH statistics indicate that there will be 76,000 people over 65 in Wirral by 2025. **The statistics, from whatever source, demonstrate that there is currently significant pressure on services and that there will be an increasing demand on services. Additional investment and re-profiling of existing investments will be required as a minimum to maintain current service levels.**

3.2 Healthy life expectancy is the number of years a person can expect to live in good health. It is apparent from Table 1 that both men and women in Wirral are significantly more likely to have a poorer healthy life expectancy than the national average.

Table 1

Healthy life expectancy at age 65 years	Males	Females
Wirral	11.9*	14.1*
North West	11.4	13.3
England	12.5	14.5

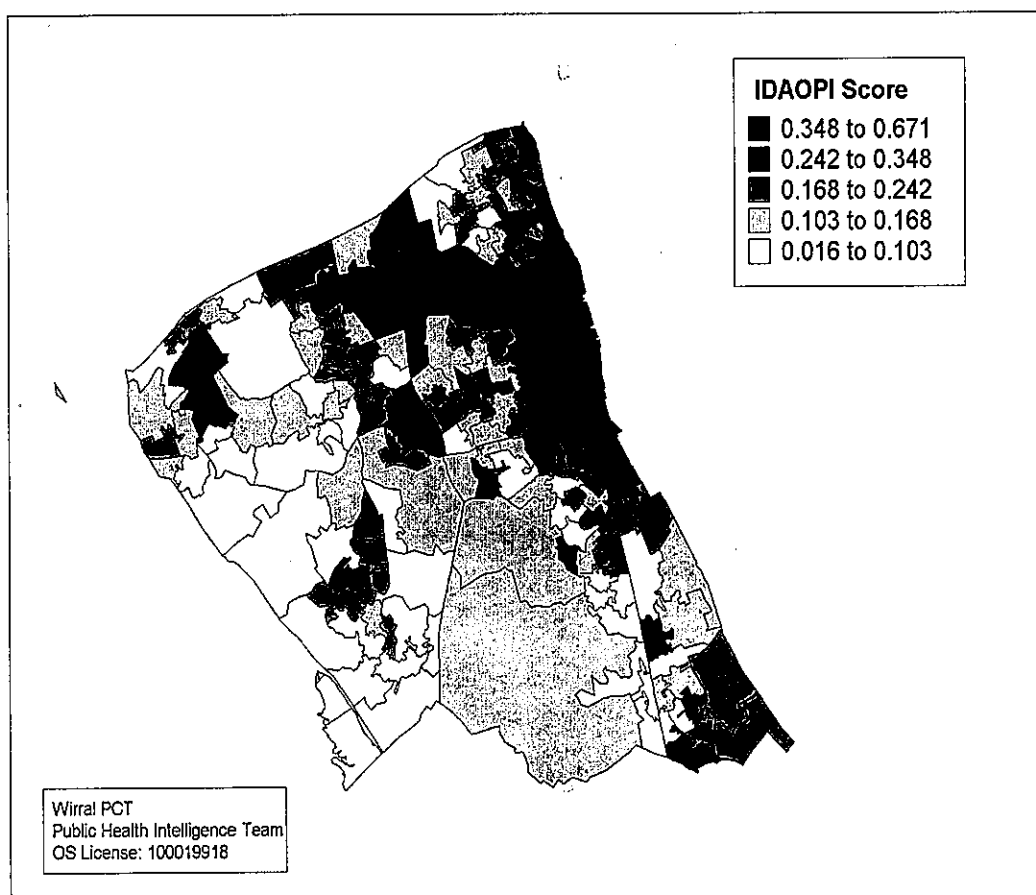
Source: ONS, 2008

* Significantly below the national average

3.3 Health inequalities in Wirral exist between and within geographical communities. There are many specific population groups that have needs requiring a targeted approach for an intervention or service development³. The ageing population will need particular attention, as a higher number of people living longer will mean an increase in the number of people with long term conditions, higher risk of falls leading to injury, depression and dementia, cancer and cardiovascular disease, amongst others. This is likely to present significant challenges in relation to an increased demand for care.

3.4 To highlight this position further, in 2007/08, a total of 451 hip replacement procedures were carried out on Wirral residents aged 65 years and above. This was significantly higher than comparable data for England. Similarly, in 2007/08 a total of 449 knee replacement procedures were carried out on Wirral residents aged 65 years and above, again giving a higher than expected rate compared to national figures. As there is evidence that mental health problems such as anxiety and depression can be linked to physical health we can predict that as the population ages, and their physical health demands increase, so mental health problems will be linked to this increase.

3.5 The Index of Multiple Deprivation 2007 includes a measure of Income Deprivation Affecting Older People (IDAOP). It measures the number of adults aged 60 years and over living in pension credit households, as a proportion of all those in this population group. Pension credit is a benefit for people aged 60 or over that guarantees a minimum income; entitlement is, therefore, a good indicator of income deprivation.



Source IDSOP, 2007

3.6 In total 17,970 older people in Wirral are in receipt of pension credit (Department for Work and Pensions 2007). There are a greater proportion of older people on pension credit in areas in the East of Wirral, particularly areas of Birkenhead and Tranmere, Bidston and St James and Seacombe and Rock Ferry. It is, however, important to note the pockets of deprivation in other areas of the borough⁴.

3.7 The ageing population means that the number of people with dementia and other mental health conditions will rise considerably over the next few years. Whilst dementia is the predominant problem account must be taken of other conditions and co-morbidity factors (e.g. depression associated with acute conditions (diabetes, COPD)). It will be important that these conditions are not ignored in planning future service provision.

3.8 The projections for the number of people in Wirral over 65 years that will have dementia, between 2008 and 2025, are outlined in table 2

Table 2:

	2008	2010	2015	2020	2025
Total males	1,398	1,483	1,717	1,942	2,217
Total females	3,118	3,132	3,298	3,537	3,930
Total population aged 65 and over	4,516	4,615	5,016	5,479	6,147

Source: CSIP, 2006 (*Projecting Older People Population Information System*)

These estimates suggest that rates of dementia in older people will increase by 11% between 2008 and 2015, and 36% by 2025.

A report by Dementia Care UK (published February 2007) reported the number of people with dementia in Wirral as 4,294. They estimated a rise of 28% in numbers of people with dementia by the year 2020.

3.9 Research published by the Alzheimer's Society suggests that Wirral is in the top 11% of local authorities with the highest whole population prevalence of dementia (16th of 150) with a prevalence rate of 1.37%. Local authorities with larger populations of older people, and with more institutional places, will tend to have a higher whole population prevalence of dementia. The definition of dementia adopted is that it is "a progressive global loss of mental function (concentration, memory and orientation) occurring in clear consciousness. Most cases are due to the degenerative process of Alzheimer's disease (loss of brain cells generally, especially those containing acetylcholine) or to cerebro-vascular disease (multi infarct dementia)" (Bandolier).

3.10 As part of the Quality Outcomes Framework (QoF) GP Practices are expected to produce a register of patients with dementia. In Wirral, a total of 1,696 people were recorded on the registers between April 2006 and March 2007, which gives an unadjusted prevalence rate of 0.5%. This is slightly higher than the North West and England GP practice prevalence rates which are both recorded as 0.4%. This information has been derived from the Joint Strategic Needs Assessment. However nationally and locally there is some concern about the accuracy of this data. This is due to a number of factors including:

- the late presentation and/or diagnosis of the condition within primary care
- the differential application of the definition of dementia within primary care
- the robustness of data collection
- the none application of a clinical diagnosis at first contact with statutory organisations

3.11 The gap between current and future demand is demonstrated. Anecdotal evidence also suggests that there is a current level of unmet need supported by "hidden carers" where services have not yet been accessed.

Taking these issues into account it is highly likely that the extent of the current problem is significantly understated.

3.12 Admissions to acute hospital care (Wirral University Hospital Trust only) for dementia with associated conditions in Wirral are considerable. The admission rate in 2005/6 for Wirral was 3.2 per 1,000, which is above the national average of 2.1 per 1,000 and dementia contributed to 5,443 emergency bed days, with the average length of stay being 46 days.

3.13 People with dementia are more likely to be admitted to care homes than older people in general. In Wirral in 2007, approximately 1,166 people with dementia were in care. This suggests, based on incidence projections (see Para 3.8) that in excess of 3,000 people with dementia are living in their own homes in the community. This calls into question the robustness of the GP registered figures (see 3.11).

3.14 In January, 2007, Wirral launched a consultation on the future of older people's mental health services. In terms of early intervention, prevention and awareness 70% of carers experience major barriers to initial diagnosis. This tends to support the need for enhanced awareness and training within the general community and in primary care services. Issues relating to patient confidentiality may also exacerbate early identification of this problem. Service users and their carers were left to find information and support for themselves. It was found 50% of people waited until a crisis point before seeking help or support.

3.15 The consultation found that people thought an increased awareness by staff is required in relation to the care of people with dementia. In addition there is a need for a smoother transition from general to specialist consultant support. There were also concerns about access to information and choices for accessing community services as opposed to institutional options.

3.16 People consulted also thought the local picture reflects a lack of access to crisis home support where more choice and flexibility is needed. There needs to be more information about services available at home, and more understanding of the impact the environment has on a person's care. Carers and staff need to be more aware of specific conditions when working with people who have dementia. Families need support with younger people who have dementia and there is a need to review End of Life Support.

CURRENT INVESTMENT

4.0 In terms of an overall picture for NHS Wirral, the number and types of provider who provide specific services to people with a mental health problem are listed below.

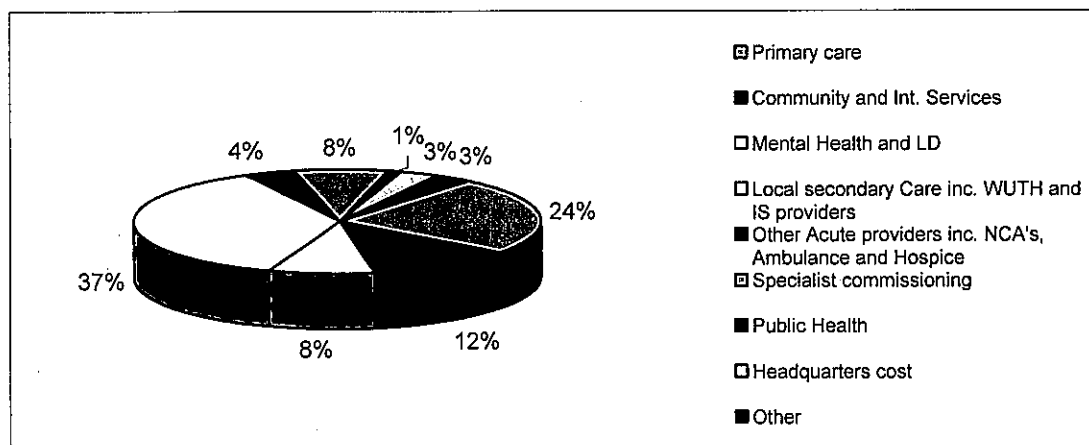


Table 2: Key Providers

4.1 In Autumn 2008 a financial mapping exercise for the Wirral based on information from the Local Implementation Team (LIT)²⁴ was produced. The financial mapping covers all reported investment by the PCTs and Local Authority in adult and older adult mental health services, including delivery of services from all providers to, and all commissioners for the Local Implementation Team, not just NHS organisations.

This report is an analysis of the financial mapping for the Local Implementation Team as at November 2008. The overall picture of investment in adult and older people's mental health is outlined including the delivery of all services from all providers to the Local Implementation Team and all commissioners for the Local Implementation Team - not just the NHS. The data has been validated at local level and has been submitted to the Department of Health for review.

4.2 It must be noted that this is only the third year for the Local Authority to collect Older People Mental Health (OPMH) financial mapping information and data quality will improve with future years.

4.3 The population data has been weighted for both mental health need and financial factors and therefore also takes into account the varying staff costs around the country. Therefore, the

data can be seen as a good picture of the present comparable financial picture of Wirral's mental health investment compared to the rest of the Strategic Health Authority, other organisations that are comparable as a cluster, using Office of National Statistics (ONS) data, and LITs in England as a whole. An ONS cluster is the latest classification by the ONS which allocates all HAs and LAs on one of 12 "family groups" or areas with broadly similar characteristics – Wirral is within the industrial hinterlands group.

4.4 In terms of older people with a mental health problem the total annual investment for older people in Wirral LIT is £19,846,000. Comparative figures across the SHA and related clusters are not yet available.

4.5 Using 2007 figures, when weighted per head of population comparative expenditures were:

- £290 per head for Wirral Local Implementation Team
- £267 per head for Strategic Health Authority
- £283 per head for Office of National Statistics
- £273 per head for England Local Implementation Teams

However, when you compare this in terms of the investment directly on services rather than overheads or other indirect costs the picture is Wirral LIT spends 84%, SHA 83%, ONS 83% and England LITs 81%. NHS Wirral has invested an additional 8.2% on all mental health services over the last 12 months and therefore the comparative analysis in paragraph 6.5 should be treated with caution.

4.6 In addition NHS Trusts are required to make cash releasing efficiency savings which will be reinvested in services. This will not necessarily be with the organisation generating the savings. Out of the total £19.8m spend approximately £7.5m is spent with secondary care providers for older people's mental health services. This means that an additional annual investment of £75k over and above inflation will be immediately available. This is clearly insufficient to develop services at the required pace. **The PCT will therefore finalise a strategic investment plan for older people's mental health services. This will:**

- **Be based on additional recurrent investment of £500k in 2009-10 and a further recurrent investment of £250k from 2010-11.**

- **Require a significant reengineering of current investment with a major shift from residential care (DASS funded) to primary and community care (DASS and PCT funded).**

CURRENT SERVICES

5.0 For older people with mental health problems in Wirral there are a range of services provided across health, social care and the independent and voluntary sector. The intention is to continue to develop, redesign and improve these services and where needed increase provision. Some of the services that are delivered within general health services have an immense effect on people with mental health problems, as there is evidence that physical and mental health are intertwined. This section gives a picture of the services and areas of care currently provided. Whilst this concentrates on mental health, the impact of associated initiatives which relate to general health are recognised.

5.1 Older people in the Wirral, who have long term conditions, use secondary care services. There is an ongoing process to develop alternatives in primary care and utilise the experience and knowledge of primary care staff. Older people with mental health problems also have a range of chronic conditions, so it is vital that general health and social care services ensure access to these services is as effective as possible. Staff in these general services must have the appropriate training in order to care for people who have mental health problems with chronic conditions.

5.2 There are a number of **general services** provided to which older people with mental health problems require equal access and which need to be capable of responding to their specific needs. These include:

- Wirral Case Management Project Team (Community Matrons). We will need to ensure that older people with mental health problems are able to access such schemes and benefit from the valuable services they offer ¹².
- Wirral Falls Prevention Service. Older people with a mental health problem are encouraged to make full use of this service and access will be improved as needs are further identified.
- Wirral Homecare Assessment and Rehabilitation Team (HART) which provides rehabilitation and reablement services within the community.
- Primary Care and Community services including dietetics, community nursing and community equipment services etc.

- Older People Independence Network (popin). This provides a low level preventative service working with older people within the local community (including a dementia café for older people and their carers to access advice and support in coping with dementia).
- Assistive Technology Team. Assistive Technology has the potential to support many more older people with mental health needs in relation to providing memory prompts, maintaining safety inside and outside of the home and enabling independence and positive risk taking. It could support the transformation of the quality of dementia care. It has potential within residential/nursing home, day care and community settings to promote choice, dignity and well being.
- A range of Local Authority services which aim to help older people remain active and independent. These services focus on promoting independence, ensuring safety and protecting vulnerable adults.

5.3 Specialist Community and Primary Mental Health Services Older People

These services include:

- Psychological therapies for older people. Talking Changes (New PCMHS) will incorporate psychological therapists for older people and access is expected to improve in 2009.
- Integrated Community Mental Health Teams
- Crisis Resolution Home Treatment Team for people with a functional mental illness
- Early Onset Dementia Team
- Extra Care Housing

All these services need to be reviewed in association with other planned service developments and redesign projects.

5.4 Secondary Care

As part of the improvements to Older People's Mental Health Service the current number of older people's beds will be reconfigured by October 2009 to reflect the level of need for inpatient services. There will be 33 beds (20 functional and 13 organic). Mental illness such as dementia is a result of brain impairment and is usually described as 'organic'; whereas non-organic mental illness such as schizophrenia is usually described as 'functional'.

The bed reconfiguration will require a reduction of 18 functional beds and the closure of Balmoral ward; this will be supported by expansion of the Older People's Crisis Resolution and Home Treatment team. The reduction in organic inpatient beds will require the loss of 2 beds from Church ward. This will take place once the functional beds have been reorganised. The reduction in beds will be achieved in a safe and clinically appropriate manner and any risks identified will be managed.

From October 2009 all the in patient beds will be in the Springview Unit on the Clatterbridge Hospital site. The beds currently at St Catherine's Hospital will be relocated to Clatterbridge.

Current investments in secondary care services will be reviewed in the context of national recommendations and the National Dementia Strategy.

5.5 Service Redesign

Wirral has a specific Local Area Agreement (LAA) Local Improvement Target relating to dementia. The target relates to a planned reduction in the numbers of people with dementia admitted to residential and nursing home care.

Wirral DASS and NHS Wirral are participating with key partners in a national pilot project on dementia with Care Services Efficiency Delivery team, DH. This project was completed in September 08 and involved care pathway development and the use of Systems Dynamic Modelling to analyze and test out the use of resources, related to activity, capacity and demand. The work is further described in section 7.

5.6 Service Gaps.

It is recognised that **intermediate care** for older people with mental health problems is a gap within services in Wirral. This strategy highlights this area. The commissioning intentions indicate how this will be addressed. In developing intermediate care services for the future we will ensure that we develop services that are locality based and demonstrate cost effectiveness. The services will be flexible and provide person centred services responding to need.

Initially we will need to provide a range of community bed and home based services to provide "bridging" support in the community. The implementation of robust community services will impact on the number of intermediate care beds needed in the future and therefore must be recognised as part of an integrated health and social care approach to provision.

STRATEGIC DIRECTION

6.0 The need to address the requirements of an increasingly ageing population by working across agencies (including health, social care, housing, the Third Sector, service users and carers) is acknowledged. Following the completion of the Older Peoples Services Review (Gott), participation in the National Care Services Efficiency Delivery Pilot Project on Dementia (CSED) and the launch of the National Dementia Strategy, it is evident there is a real need for direction built upon integrated commissioning and a joint approach for older people's mental health services.

6.1 The aims of the Wirral integrated older people's mental health strategy will be to commission services based on:

- Increased public and professional awareness of mental health needs of older people
- Good quality early diagnosis, prevention and intervention for all within a clear pathway
- Good quality timely information for older people and their carers
- The 'Wellbeing approach' to service development and provision
- Improved quality of care in institutional settings and community settings

6.2 **Significant additional investment and service redesign** will be planned to sustain existing service levels and to develop new services.

6.3 The intention will be to commission innovative joint schemes that address the issues of employment, environment, housing, education and other factors that influence wellbeing.

6.4 The intention is that health, social care and independent sector and voluntary sector services develop an approach where the person directs, as far as possible, the services they receive.

6.5 We will develop services which help people to stay healthy and independent, focusing on prevention, improving health as well as treating sickness. The local health and social services economy will commission, in partnership, comprehensive well being and prevention services which are personalised and meet the specific needs of the local population.

6.6 For people with long term mental health conditions personalised care plans will be the focus. Plans will be agreed by the patient and a named professional and provide a basis, for the NHS and its partners, to organise services around the needs of the individual.

DEMENTIA SERVICES

7.0 Dementia is one of the biggest health and social challenges facing the country: in less than 20 years time, there will be over one million people living with a form of dementia.

7.1 The term 'dementia' describes a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as the result of physical diseases such as Alzheimer's disease

7.2 Dementia can affect people of any age, but is most common in older people. One in six people over 80 have a form of dementia and one in 14 people over 65 have a form of dementia. Dementia is a progressive condition, with the symptoms becoming more severe over time. Understanding how this progression happens can be useful in helping someone with dementia anticipate and plan for change.

7.3 As well as the person with dementia, there is a need to consider the invisible burden of their carers. Of older people who have dementia, it is estimated that 63.5% live at home and are cared for by their families, friends and close relatives.

7.4 The Government has made a commitment to making dementia a national health and social care priority, through the development of a National Strategy for England. The strategy focuses on three key areas:

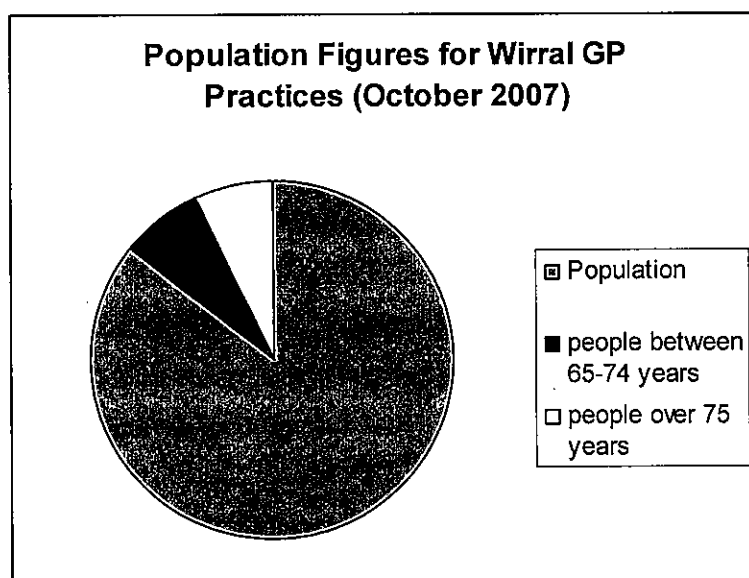
- Improving awareness of dementia
- Early diagnosis and intervention
- Improving quality of care

7.5 Locally NHS Wirral and DASS have accessed a national systems modelling programme (CSED) to support a review of current service delivery and to inform future service provision.

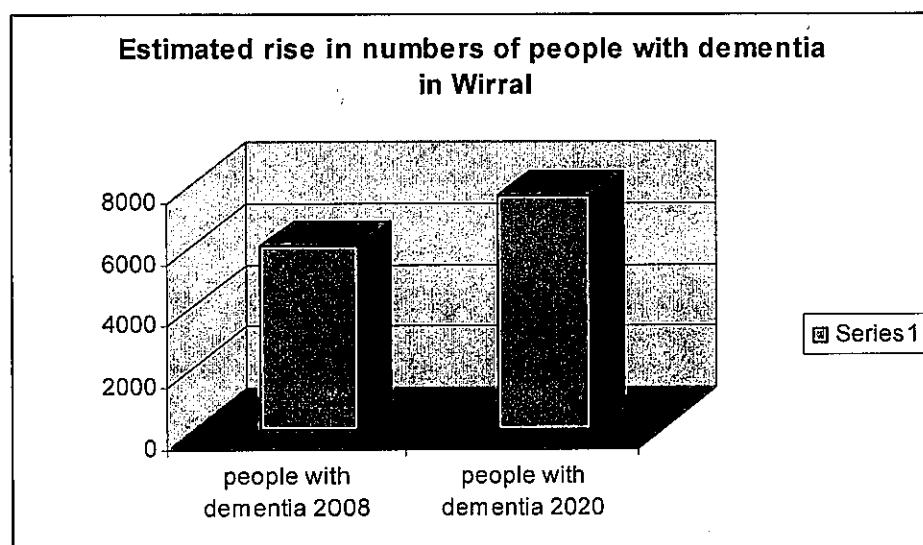
7.6 The Dementia UK report of February 2007 reports numbers of people over 65 years with dementia in Wirral as 4,294. Current alternative data suggest this has risen to 4,516. This figure is estimated to increase by 28% by 2020.

NHS Wirral figures for Wirral GP practices in October 2007 show an approximate patient population figure of 359,209 in total. 60 practices report 30,015 people between 65-74 years and 29,064 over 75 years (five practices gave overall figures only).

Wirral Older Peoples Community Mental Health Teams showed a caseload figure of 1,217 patients for the four teams, for the month of May 2008. This figure is a snapshot figure, including dementia and functional mental health, as an indication of the level of activity. This is significantly less than the GP dementia register figure. This is explained by the fact that the Cheshire and Wirral Partnership Trust Community teams provide care to the most severely ill people with mental health issues (dementia, psychosis, depression). A significant number of patients are "managed" at primary care level.



The Dementia UK report shows figures in Wirral rising by 28% by the year 2020.



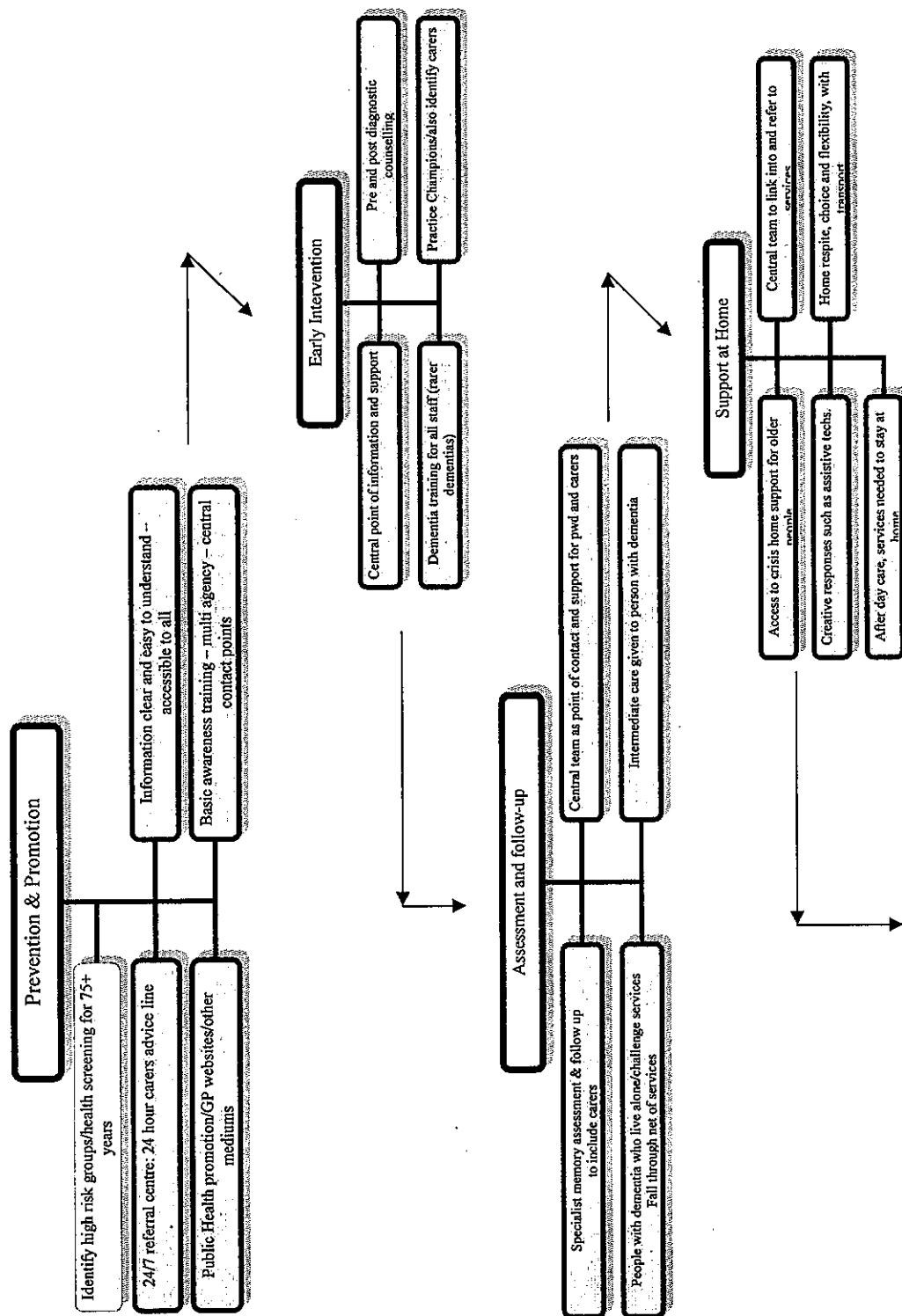
Care Services Efficiency Delivery (CSED)

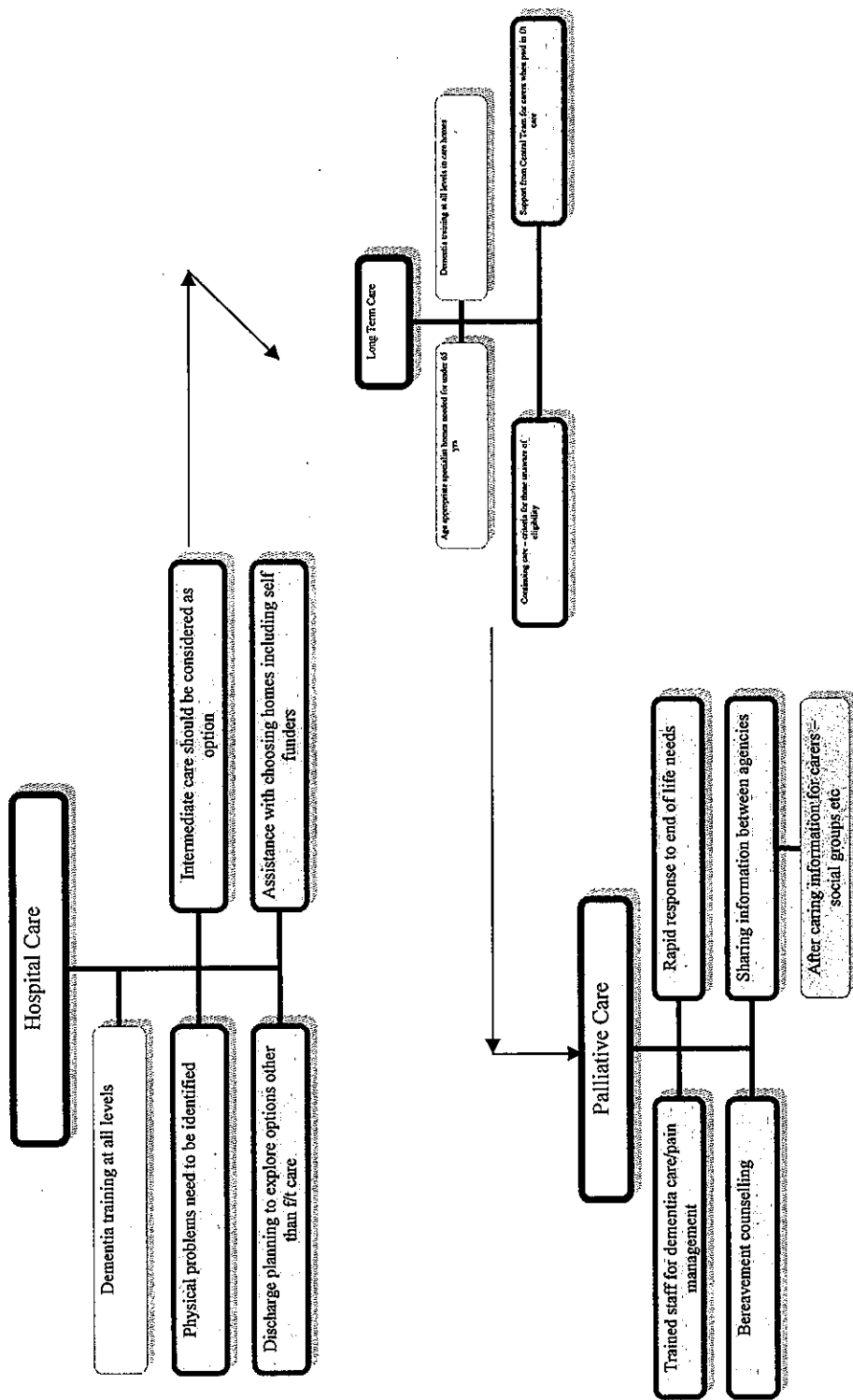
Wirral DASS and NHS Wirral have participated in a national Pilot Project on dementia, in partnership with the care Services Efficiency Delivery Unit (DH). The project supported pathway development building on work already undertaken within the local health and social care economy and gave access to Systems Dynamic Modelling. Specific commissioning intentions have emerged from this project which have been included in this strategy. CSED has enabled the testing out of a range of hypotheses, based on inputted local data, relating to current investment, resources and activity.

Development of a Dementia Care Pathway

The table below provides detail about the proposed local dementia care pathway which has been developed as a consequence of detailed consultation with all appropriate parties.

DEMENTIA PATHWAY MAPPING EXERCISE





As indicated Pathway development has involved all key stakeholders and within the separate report key findings and recommendations are set out. The details below provide a synopsis of that more detailed work.

7.7 The need to develop a 'gold' standard dementia care pathway from pre-diagnosis for preventative measures, support at point of diagnosis and at all points along the dementia journey to include end of life care, is vitally important.

7.8 The process for developing a pathway began with a series of small workshops and interviews with stakeholders from primary/secondary health, DASS, the Third Sector and various other agencies. Carers and people with dementia were also involved and the events reviewed current services, identified gaps and mapped emerging issues.

7.9 To ensure that NHS Wirral is able to manage the future demand of people with dementia a dementia service review project was commissioned in November 2007. The project involved a detailed analysis of current services and understanding of some of the bottlenecks within the system. A multi agency team was involved in this process and has developed an 'ideal' pathway for dementia care in Wirral.

7.10 The carer and service user perspective was crucial to the review process. The carers took part, initially in focus groups, considering the present services from their experiences, from diagnosis throughout the course of the illness. A small group also considered end of life issues.

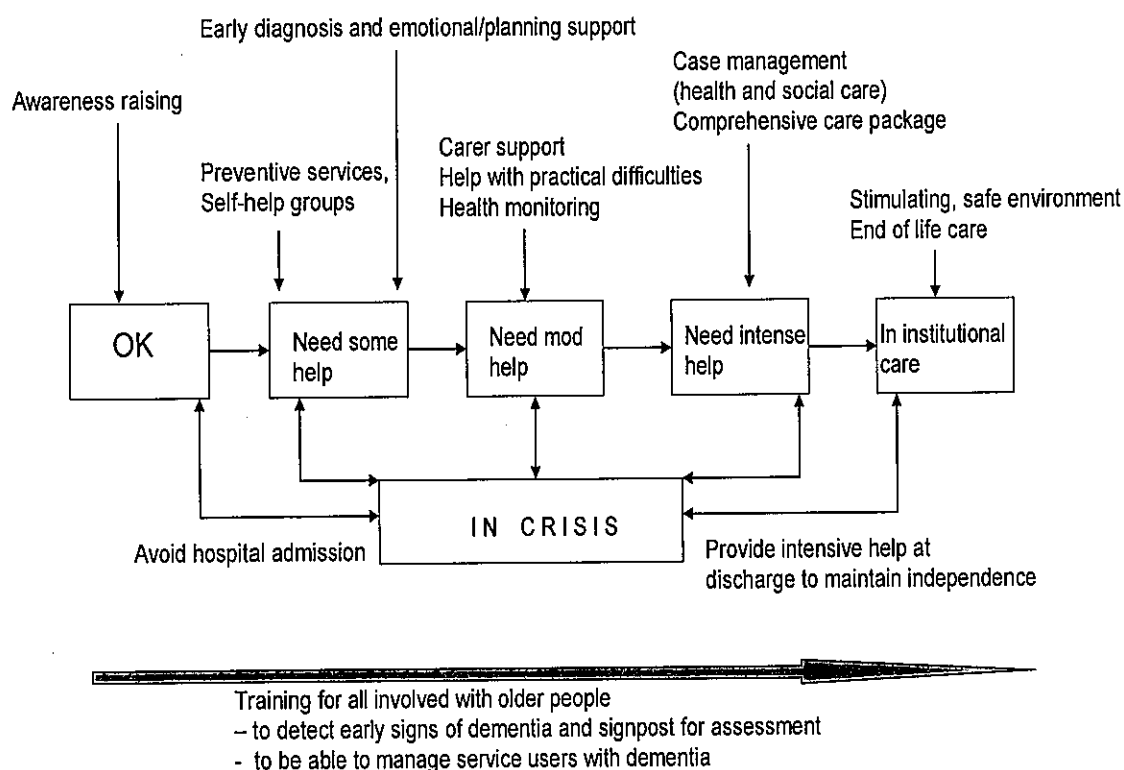
7.11 The Vision and objectives for the dementia work were established at the beginning of the process and they were to:

- Enable people with dementia to remain in their environment of choice
- Reduce use of residential and nursing care homes
- Reduce admissions to the local acute hospital
- Earlier intervention and detection to reduce the "unknown" cohort (people who turn up in an advanced stage of dementia, where a care home may be the only option)

7.12 As a consequence a high level pathway has now been defined. Once finalised and in the light of the National Dementia Strategy, this will be commissioned for the future. It is described in the diagram below. It takes a patient through a four level process from needing a small amount

of care, to a moderate level of care to intense care and then to care within an institutional environment.

Critical elements of a high-level care pathway



Recommendations

7.13 The key to the whole pathway will be the establishment of a central multi disciplinary older person's resource/team to act as the focal point for dementia information and support. This resource/team will complement the three community mental health teams for the elderly which will be established in each locality. There are currently four teams and these will be reorganised on a locality basis. The central resource will co ordinate an operating model that:

- Focuses on preventative services
- Increases public and professional awareness of dementia to enable their earlier identification of people who need support

- Ensures that once identified people are pro actively monitored and helped to obtain an integrated support package
- Is geared towards minimising admissions to hospital time in hospital and discharges from hospital straight into a residential setting and is flexible in how it supports people to stay at home where this is their choice
- Helps carers to be confident for longer to delay consideration of residential options
- Ensures dignity and choice and control to the end of their life
- Allows development of Intermediate Care Services for this client group.

7.14 In order to improve the pathway there needs to be a healthy active population with a lower probability of memory loss/dementia. To do this we will make services equally accessible to people with dementia and train the workforce.

7.15 The need to raise public and staff awareness of memory loss and dementia, how to spot early signs and common causes of symptoms and have a willingness to talk about it is recognised. This will need public education and awareness campaigns and staff training for the workforce in Wirral likely to encounter people with memory loss or dementia.

7.16 The need to have easy access to information, advice and support 24/7 when aware that self or loved ones may have memory issues or dementia is evident. This will enable early intervention to have the maximum impact. A single access and information service which would maintain a register accessible to appropriate professionals and offer advice arranging crisis response and interventions will be considered.

7.17 Access to support services early in the disease will improve the individuals and carers quality of life and prolong time in the mild stages of the disease. This would be done by incorporating access to medical advice (GPs, improved memory clinic) support to carers and suitable housing and transport.

7.18 We need to help to arrange person specific care (where possible) so that choice and control is retained over time. We will do this by new brokerage and advocacy services that the information service would direct people to.

7.19 We need to enable a wide range of flexible respite care and support services that are integrated where appropriate and a real alternative to residential or hospital care. We will also develop an integrated therapy service and prompt the market to offer flexible support services

7.20 We need to retain dignity and choice and control at the end of life as well as throughout the disease. We would do this by initiating the planning process early in the disease via the access and information service, facilitating choice at the end of life (e.g. to die at home with dignity) and develop end of life services for this client group. We will ensure that the needs of older people with mental health problems will be addressed in the End of Life Care Strategy.

7.21 Wirral's ageing population and the increasing likelihood of age related mental health issues, like dementia also has implications for the local housing, care and support agendas and highlights the need for a more joined up approach to the planning and delivery of services. In the Mental Health and Wellbeing Commissioning Strategy we have outlined the housing situation in the current services section and our recommendations in the commissioning intentions section. This will include the development of tailored housing for clients with dementia.

7.22 The recovery model as outlined in the Mental Health and Well Being Integrated Commissioning Strategy is a positive approach which has been generated expressly from service users themselves. In summary, the emphasis of the recovery approach is on using what works for each individual in a planned and structured way, by promoting a self-help approach to maintaining wellness, identifying and monitoring illness triggers and the development of a personal crisis plan. The recovery approach utilises key individuals whether they are family members, friends or professionals to support the person with mental health problems. It enables people to take back control over their 'treatment' and encourages people to develop their own 'wellness' tools to compliment mainstream health care approaches.

7.23 This approach could be used to explore models with older people who are in the early onset of dementia, to build up the recovery principles and a picture of what is key to the patient. As a progressive illness takes hold carers are still able to communicate with the patient about their likes and wants. They would have a wellness recovery plan which is an individual and personalised approach – this could not only make a difference to the service user but to carers as well.

7.24 Specifically Memory Services will be expanded and developed.

7.25 Crisis support services will be provided.

7.26 This overall direction will need to be supported by the identification and increase of senior medical support with special responsibility for dementia. Additional investment will address the issue of Wirral's comparative position in relation to other PCTs. The recommendations of Royal Colleges, the need to improve care for older people with mental health problems in acute hospital settings, the need to support patients, carers and staff in education and awareness programs will all need to be considered.

INTEGRATED COMMISSIONING

8.0 The local health and social services economy has identified mental health as one of its key priorities in the development of its Strategic Plan, in line with the World Class Commissioning Framework.

8.1 For these services the aim will be to undertake the process of commissioning jointly between the NHS and the Local Authority where appropriate.

8.2 Joint commissioning may mean we will have to change the way in which we deliver services. Some services may no longer meet our priorities or deliver the outcomes that we wish to achieve. Some services may not offer value for money or not deliver to contract specifications. In such circumstances services will need to be de-commissioned and monies disinvested.

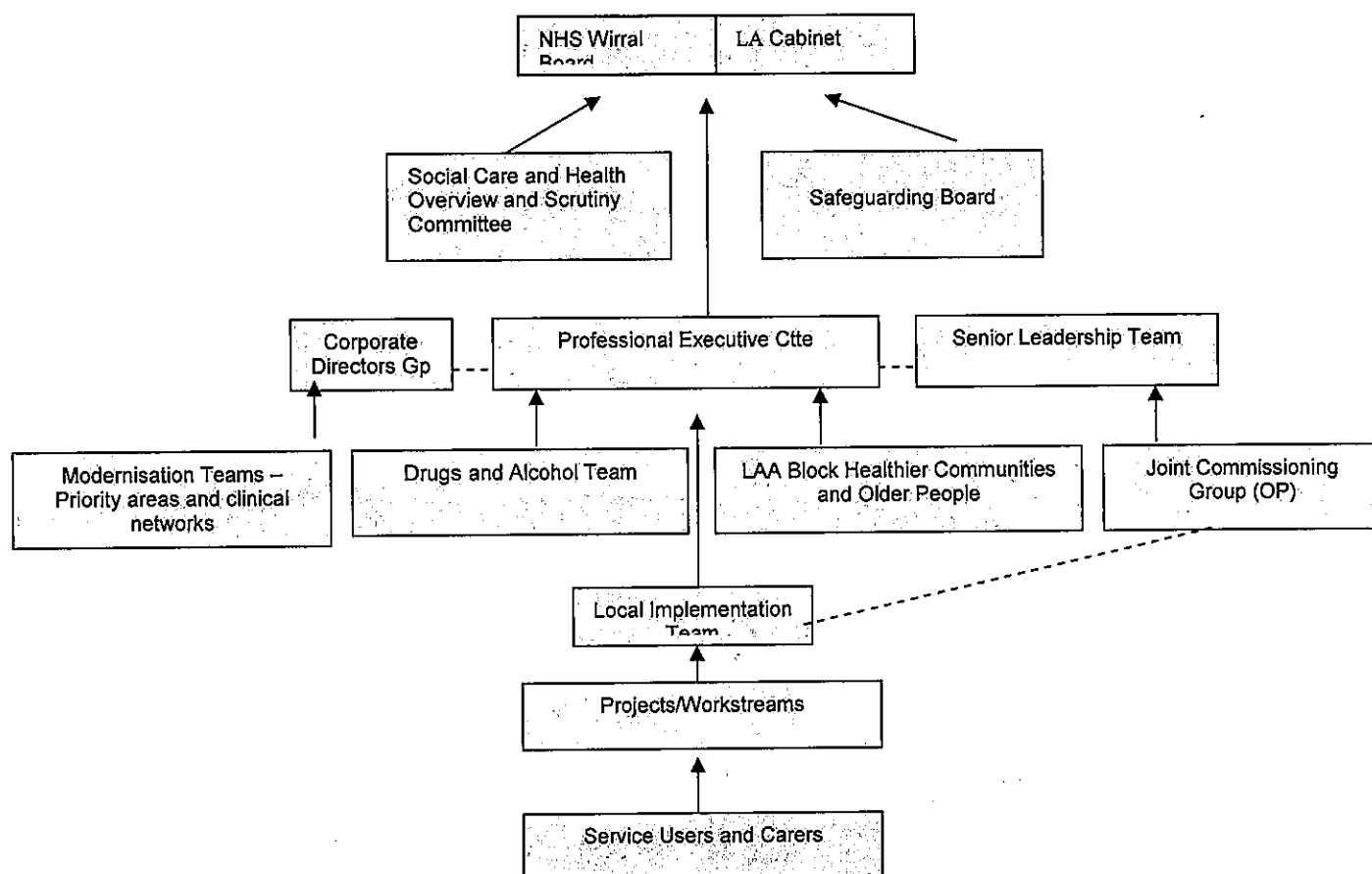
8.3 Secure mental health services for Wirral residents are commissioned on behalf of NHS Wirral by the North West Specialised Services Commissioning Team. The establishment of Specialised Commissioning Groups (SCGs), coterminous with the SHA footprints, and supported by dedicated teams of specialised service commissioners, will facilitate a more integrated and cohesive approach to the commissioning of these specialist services.

8.4 The Local Implementation Team (LIT) for Wirral currently acts as the key commissioning forum to bring together stakeholders involved in the planning and development of mental health services in Wirral⁷. Its place in the joint planning process is illustrated below. Stakeholders include representatives from NHS Wirral, Wirral DASS, Cheshire and Wirral Partnership NHS Foundation Trust, service user and carer representatives, and representation from the Third Sector.

8.5 Wirral LIT has commissioned a service user led organisation, Disability Consultancy Service (DCS), to undertake a rolling programme of reviews of mental health services, the outcomes of which are reported back to the LIT on a regular basis. All of the recently undertaken reviews of service have involved key stakeholders in a number of process mapping workshops, and DCS have been commissioned to involve service users and carers in these processes. The advice and recommendations of DCS have and will directly influence the design of services.

8.6 Service users and carers will be invited to attend and actively take part in all relevant meetings concerning the development and commissioning of mental health services. Adequate training and support will be provided for service users and carers to enable them to take a full and equal part in the meetings they attend⁸.

GOVERNANCE STRUCTURE PARTNERSHIP ARRANGEMENTS



8.7 The governance arrangements will be the subject of early and urgent review to ensure that appropriate arrangements are in place to develop services in a timely way.

8.8 The Joint Commissioning Group (Older People) includes representatives from The Cheshire and Wirral Partnership Trust, the Alzheimer's Disease Society and carers.

8.9 The governance arrangements are subject to current review to ensure that they are responsive to current priorities and timetables and that they are based on an inclusive approach.

SERVICE USERS AND CARERS

9.0 As already stated the engagement of service users and carers in the planning, development, commissioning and provision of services is recognised as crucial.

9.1 A Commissioning Strategy for Carers has been drawn up to refresh the last Carers Strategy that was approved in 2006 and to take account of changes in legislation and guidance. It is intended as a statement of how services will be developed and delivered for carers in Wirral over the next three years.

9.2 There are many reasons why carers should be supported: In summary:

- The number of people needing carer support is increasing.
- Carers are a valuable resource and make a vital and meaningful contribution to care.
- If appropriate support is not provided, the result is that the caring role becomes unsustainable, or carers themselves become ill

In recognition of this it will be more important than ever to make sure that available resources are targeted appropriately and used to support carers in the way that they themselves perceive to be the most beneficial.

9.3 The vision for carers in Wirral is one of a consistent and accessible programme of support. The pathway into the system should be straightforward: anybody who becomes a carer should be able to find accurate and up-to-date information quickly and easily and they should have access to the level of support they want from the outset.

9.4 Each carer should be able to talk to a specialised worker if they want to, who can point them in the direction of support agencies specific to their individual circumstances. All of the agencies in Wirral should work in harmony, and the crossover between DASS, NHS Wirral and the Third Sector should be as seamless as possible. Agencies should have enough information to feel comfortable in cross-referring carers to other agencies where this is appropriate.

9.5 The vision for carers in Wirral is also one in which carers are actively encouraged to participate at all levels in the decision making processes, in respect of issues that affect them or the person they care for.

9.6 Locally information from the last census (2001) shows that in Wirral there are 22.52% of the population who have a limiting long term illness, compared to 17.93% nationally. As a result, there are also proportionately more carers in Wirral than there are nationally, with 23.75% of carers in Wirral providing care for 50 hours or more per week, compared to 20.48% of carers nationally, who are providing care at that level.

9.7 During Carers Week in June 2007, partners from the Carers Development Committee hosted advice and information stands throughout Wirral. These events provided an opportunity to gather anecdotal evidence from carers about the services that they felt would be most helpful. Comments received related to, lack of information, the feeling of isolation as a carer, confusion and poor communication about carers assessments, the need for a counselling service, information about holidays, support groups, financial advice, advice about employment issues and information about specific illnesses.

9.8 A survey was undertaken in September 2007 of 670 carers in Wirral aimed to establish basic information and to identify their priorities for the provision of support services. In the main, the results of the local survey confirmed findings from national surveys. For example, accessible information was needed, practical help around the home, training in connection with their caring role, recreation and relaxation classes, employment and breaks in order to sustain the caring role. In summary the findings were; make the system accessible, give carers peace of mind, co ordinate the current services, improve facilities and value carers contribution.

9.9 Within Wirral a Carers for Dementia project was launched in September 07. The objectives of the project were to:

- Identify and seek out carers of older people with dementia who are not currently receiving services and may not be aware of the support available
- Help prevent later carer breakdown that would otherwise be likely to result in an emergency admission to hospital or institutional care
- Work to have this service established within the care pathway for first diagnosis of dementia, whether in primary care or elsewhere
- Demonstrate that project objectives have been achieved through formal evaluation that is robust and valid

9.10 All carers contacting the project are offered timely information. Carers accessing the project, after the initial visit are put in touch with appropriate services and follow up visits

arranged as required. Carers also feel able to contact the worker for ongoing support as and when issues arise¹¹.

9.11 Carers are one of the key resources in service provision and we see them as part of the service that needs support, training and above all to be valued.

Annex 1

DH National Dementia Strategy (Objectives and Outcomes).
 (See www.dh.gov.uk/dementia)

Objectives	Outcomes
What we want the Strategy to achieve	What the Strategy will mean for people with dementia and their carers
1. Raise awareness of dementia and encourage people to seek help	<p>The public and professionals will be more aware of dementia and will understand dementia better. This will:</p> <ul style="list-style-type: none"> • help remove the stigma of dementia • help people understand the benefits of early diagnosis and care • encourage the prevention of dementia • reduce other people's fear and misunderstanding of people with dementia.
2. Good-quality, early diagnosis, support and treatment for people with dementia and their carers, explained in a sensitive way	<p>All people with dementia will have access to care that gives them:</p> <ul style="list-style-type: none"> • an early, high-quality specialist assessment • an accurate diagnosis which is explained in a sensitive way to the person with dementia and their carers • treatment, care and support as needed after the diagnosis. <p>Local services must be able to see all new cases of people who may have dementia in their area promptly.</p>
3. Good-quality information for people with dementia and their carers	<p>People with dementia and their carers will be given good-quality information about dementia and services:</p> <ul style="list-style-type: none"> • at diagnosis • during their care.
4. Easy access to care, support and advice after diagnosis	<p>People with dementia and their carers will be able to see a dementia adviser who will help them throughout their care to find the right:</p> <ul style="list-style-type: none"> • information • care • support • advice
5. Develop structured peer support and	

learning networks	<p>People with dementia and their carers will be able to:</p> <ul style="list-style-type: none"> • get support from local people with experience of dementia • take an active role in developing local services.
6. Improve community personal support services for people living at home	<p>There will be a range of flexible services to support people with dementia living at home and their carers.</p> <p>Services will consider the needs and wishes of people with dementia and their carers.</p>
7. Implement the New Deal for Carers	<p>Carers will:</p> <ul style="list-style-type: none"> • have an assessment of their needs • get better support • be able to have good-quality short breaks from caring.
8. Improve the quality of care for people with dementia in general hospitals	<p>This way people with dementia will get better care in hospital:</p> <ul style="list-style-type: none"> • it will be clear who is responsible for dementia in general hospitals and what their responsibilities are • they will work closely with specialist older people's mental health teams.
9. Improve intermediate care for people with dementia	<p>There will be more care for people with dementia who need help to stay at home</p>
10. Consider how housing support, housing-related services, technology and telecare can help support people with dementia and their carers	<p>Services will:</p> <ul style="list-style-type: none"> • consider the needs of people with dementia and their carers when planning housing and housing services • try to help people to live in their own homes for longer.
11. Improve the quality of care for people with dementia in care homes	<p>Services will work to ensure:</p> <ul style="list-style-type: none"> • better care for people with dementia in care homes • clear responsibility for dementia in care

	<p>homes</p> <ul style="list-style-type: none"> • a clear description of how people will be cared for • visits from specialist mental health teams • better checking of care homes
12. Improve end of life care for people with dementia	<p>People with dementia and their carers will be involved in planning end of life care.</p> <p>Services will consider people with dementia when planning local end of life services.</p>
13. An informed and effective workforce for people with dementia	<p>All health and social care staff who work with people with dementia will:</p> <ul style="list-style-type: none"> • have the right skills to give the best care • get the right training • get support to keep learning more about dementia.
14. A joint commissioning strategy for dementia	<p>Health and social care services will work together to develop systems to:</p> <ul style="list-style-type: none"> • identify the needs of people with dementia and their carers • best meet these needs. <p>There is guidance in the Strategy to help services to do this.</p>
15. Improve assessment and regulation of health and care services and of how systems are working	<p>There will be better checks on care homes and other services to make sure people with dementia get the best possible care.</p>
16. Provide a clear picture of research about the causes and possible future treatments of dementia	<p>People will be able to get information from research about dementia.</p> <p>We will do lots of things to identify gaps in the research information and do more research to fill the gaps.</p>
17. Effective national and regional support for local services to help them develop and carry out the Strategy	<p>The Government will give advice and support to local services to help them carry out the Strategy.</p> <p>There will be more good-quality information to help develop better services for people with dementia.</p>

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