

SCHEDULE 2
THE SERVICES

Schedule 2 Part 1: Service Specifications

SERVICE SPECIFICATION

Service Specification No.	05/MRFH/0019
Service/ Care pathway/ Cluster	OPMH Intermediate Care Service for Dementia (ICSD)
Commissioner Lead	CCP for Mental Health & Learning Disability
Provider Lead	Dorset Healthcare University NHS Foundation Trust
Period	2013/14
Date of Review	Year 1

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

1. Purpose

1.1 National Context

Nationally it is recognised that the mental health needs of the ageing population are set to increase, and it is predicted that the number of people living with dementia in the United Kingdom (currently 750,000) will double within thirty years.

The National Dementia Strategy (2009), Dementia Quality Standard (2010) and local strategies all identify the following aims for mental health services for older people:

- Early diagnosis and early interventions
- Better care for people at home and in care homes
- Better care in hospital
- Better support for carers

1.2 Local Context

The proportion of people aged over 65 in Dorset is higher than the national average, and by 2030 it is predicted that 40% of the population in Dorset will be aged 65 and over.

1.3 Local Needs

In partnership with stakeholders Dorset HealthCare University NHS Foundation Trust and the Bournemouth, Poole and Dorset Primary Care Trust Cluster have developed a proposed model of care to meet this growing need. The model aims to provide more intensive support in the community for people with dementia and their carers, enabling them to stay within their place of residence and enabling those involved in their care to better support them.

In order to achieve this aim the balance between mental health inpatient provision and community provision needs to be readdressed with the Trust needing to move resources from inpatient services to community services.

The Intensive support Care Service for Dementia will provide a vital role in delivering the reconfigured services; the service will work closely with inpatient services in order to support people already known to mental health services to both remain in their homes, and return to their homes when it is clinically appropriate for them to do so.

It is proposed that this service will form part of phase one of the transformation of services for Older People with Organic mental illness. The service and the way in which it meets demand will be reviewed after phase two and during phase three.

Access to the service and the way in which it works with physical health services will be reviewed in phase three.

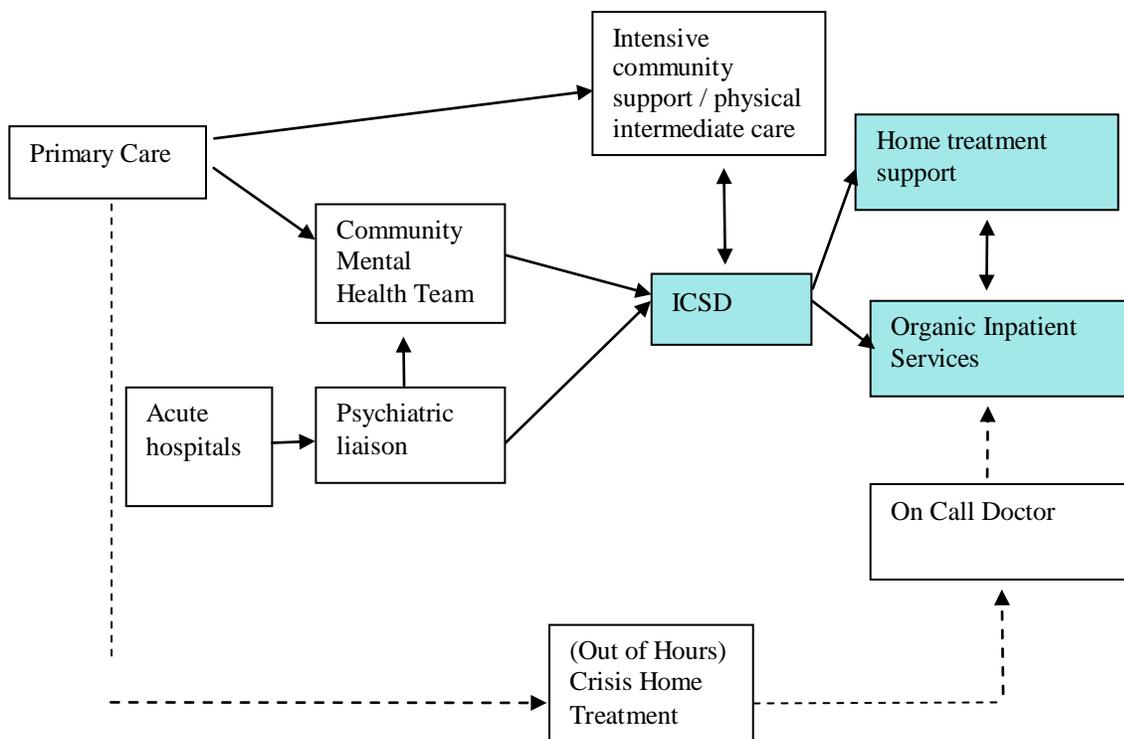


Diagram 1. Intermediate Care Service for Dementia (ICSD) care pathway

2.1 Aims and Objectives

The service will provide the provision of appropriate support and treatment for service users in East Dorset with a diagnosis of dementia who already access Dorset HealthCare University NHS Foundation Trust services. The Service will provide an urgent care response to needs arising in the community including residential and nursing homes, assess all referrals to determine the appropriate intervention to enable patients to receive care in their normal place of residence and will gate keep access to mental health inpatient care. The service will offer time limited contact with patients for up to six weeks, with the aim of providing the service until such time as the situation has been sufficiently stabilised for ongoing care to be delivered at a lower level of intensity. The service will also offer support to carers and ensure they are able to access a carers assessment if required

The aims of the service are:

- To ensure people who can be treated in their own home or place of residence are supported to do so, instead of being admitted to a mental health hospital;
- To support people to return home or to their normal place of residence earlier within their course of treatment;
- To support family members, carers and care home providers to maintain their caring role
- To provide quality, appropriate care and treatment for service users with dementia in the community;
- To prevent inappropriate hospital admission, and reduce the demand for mental health inpatient beds;
- To manage the increasingly ageing population with co-morbid dementia and physical health problems in the least restrictive settings.

The service will have the following functions:

- To supplement with intensive input the Community Mental Health service for people with dementia whose condition is such that inpatient admission is otherwise likely.
- To work collaboratively with the physical health Intermediate Care services to manage complex challenging co-morbidity.
- To work closely with the East Dorset Crisis and Home Treatment team ensuring that people access the service that is appropriate for their need and ensuring handovers and liaison take place between the two services
- To work across organic inpatient and community services to provide the most appropriate intensive service for patients with a diagnosis of dementia presenting with particularly challenging behaviours.
- To offer support and guidance to family carers and care home providers to enable their caring roles to be maintained
- To act in a gate keeping role and bed management capacity for the organic inpatient services for older people.

The service will be provided by a multi-disciplinary team with an appropriate level of skills and competencies appropriate to the needs of service users and within the objectives of care plans. This will include older person consultant psychiatrists, community psychiatric nurses, occupational therapists, and support workers. The team will also work closely with Social Workers, domiciliary care workers, Older Age Psychologists, physiotherapists and dieticians.

The service will ensure they are to direct service users and carers to resources and support such as the provision of telehealth, out of hours pharmacy and respite services.

The service will support individual care planning agreed with the multi-disciplinary team. The written care plan will be agreed and reviewed by the service users and appropriate family members/carers.

The service will provide effective support to appropriate family members/carers

Support and guidance will also be provided to care homes when an individual is at risk of an inpatient admission through the In-reach service.

Discharge from the service will be within six weeks. Discharge may be accompanied by ongoing advice and support to community based teams previously involved in the care of the individual.

2.2 Acceptance and Exclusion criteria

Acceptance: Current mental health service users with a diagnosis of dementia who need intensive support, assessment and/or treatment as an alternative to mental health hospital admission, this includes people with a diagnosis of Dementia Accessing services such as Psychiatric Liaison, Crisis and Home Treatment, OPMH CMHTs and the Memory Assessment Services.

Exclusion: Service users with a primary diagnosis of functional mental illness, direct GP referrals, Self referrals

The Acceptance and Exclusion criteria will be reviewed as part of Phase three.

2.3 Geographical population served

East Dorset (covering Bournemouth, Poole, Christchurch, East Dorset and Purbeck)

3. Service Delivery

3.1 Location of service

- The Intermediate Care Service for Dementia will be based with the reconfigured inpatient wards at Alderney Hospital;
- This location is key to the fluid working with the inpatient teams, to ensure collaborative working enabling timely discharge when patients are ready to return to the community
- The intensive support function of the team is likely to be based in the same location, but team members will have bases within other sites to enable flexible working

3.2 Days/hours of operation

- The service will operate 7 days a week, 52 weeks a year
- The service will work across a 12 hour period with core hours of 7.30 am – 7.30 pm but will be able to mobilise additional social care outside these hours when necessary.
- If emergency support, assessment or admission is required outside these hours the current crisis pathway will continue to apply; ie patients/staff will access the East Dorset crisis team.

3.3 Operational Model

- The team will be multi-disciplinary and will include consultant psychiatrists, community psychiatric nurses, occupational therapists, and support workers. The team will also work closely with Social Workers, domiciliary care workers, Older Age Psychologists, physiotherapists and dieticians
- There will be an appropriate mix of staff at any one time during the operational hours. This will include staff who will work closely with the wards regarding admissions and discharges as well as staff who will support people in the community.

3.4 Function

- Rapid response within 4 hours
- Assessment of health needs and liaison with social care workers to ensure social care needs are reassessed when required
- Crisis treatment and support to prevent hospital admission;
- Comprehensive risk assessment and management to enable ongoing care in patients normal place of residence. Operating under principles of positive risk taking
- Provision of a clear care plan for service user and family carer
- Discharge planning to start on referral
- Interventions such as assessment, medicines management, , therapy, support and education for carers;
- Ensuring intermediate social care is available for those who require it – either through using domiciliary care staff employed on a bank basis or through contracting with social care agencies.
- Supporting discharge from an inpatient bed when intensive support is required.
- Direct people to useful resources such as the provision of telehealth and respite
- Links with existing services to ensure continuity of care and ensure people are aware of what is available to them and appropriate steps are taken to support them.
- Supportive discharge to lower intensity services
- Withdrawal from case management within six weeks
- The service will work with CMHT's, the AMHP service and crisis service to facilitate mental health act assessments and ensure DOLS assessments, safeguarding alerts, Best Interest assessments and so on are undertaken as and when necessary
- Liaising with End of Life services

3.5 Capacity

- Predicted caseload based on retrospective analysis of inpatients who might otherwise have been supported in the community is 100 - 120 people per year, this will be reviewed as part of phase three of the OPMH reform
- Staff capacity and skill mix is that required to manage the predicted caseload of 100 – 120 people per year, initially..
- The existing Care Homes In-reach team will be managed by the Team Leader for this service and the teams will work collaboratively. The function of the In-Reach service will be protected, whilst being integrated with the ICSD.
- It is important to note these figures are a prediction and the service demand will depend on the assessed need of each individual.

Staff competencies

It would be expected that all qualified staff reach level 3 of the competency framework and unqualified level 2. Web link: <http://dementia.dh.gov.uk/dementia-competency-framework/>

Experience

All staff working within the service should have recent experience of working in mental health services for older people. All qualified staff should have at least three years experience.

3.7 Interdependencies with other agencies

- The service will work closely with other internal Dorset HealthCare services, such as Community Mental Health Teams for Older People, organic inpatient services the Crisis team and the Psychiatric Liaison services, as well as physical health services.
- The service will work closely with the relevant local authority, specifically in relation to mental health act assessments, and social care provision;
- The service will work closely with the third sector in order to signpost patients to appropriate supportive services from which they might gain benefit.
- The service will work closely with palliative care teams, hospices
- DoLS Team Safeguarding
- The service will work closely with care homes and Nursing homes

3.8 Education, Training and Research activities

The service model will comply with best practice and it is the responsibility of the provider to ensure implementation of any best practice evidence based guidance. Services will be assessed against National Clinical Strategies, National Institute for Health & Clinical Excellence (NICE) Guidance, and agreed best practice. Where there is a resource implication a contract variation may be required. The Provider must be registered with and meet approved quality services in line with The Care Quality Commission's regulations and standards (2009).

The provider will be expected to comply with the clinical governance framework for the NHS Dorset Cluster and to function under agreed operational and clinical policies.

Clinical Obligations:

- If Statutory/Professional Registration is required it must be maintained at all times.
- The provider must ensure that each practitioner takes responsibility for maintaining continuous professional development in order to meet requirements of professional registration
- All practitioners must work within the boundaries of professional registration and relevant professional Code of Conduct.
- The provider must demonstrate that systems are in place to ensure that competencies are maintained and skills are up to date. The provider must ensure that sufficient numbers and grades of staff are employed in order to provide an appropriate skill mix and to ensure the service can be consistently delivered in accordance with the service specification.
- All staff will ensure compliance to statutory and legal frameworks implementing service

developments in a timely manner as new directives are published

4. Referral, Access and Acceptance Criteria

4.1 Referrals

- Referrals can be made from any existing Dorset HealthCare mental health service if the person being referred has a primary diagnosis of Organic mental illness. This includes the Organic Inpatient services, Crisis and home treatment services, psychiatric liaison services, OP CMHT's and the Memory Assessment Services
- Other services such as Primary Care services and Acute services will need to refer to the OP CMHT, Crisis service or Psychiatric Liaison Service
- The service will also accept referrals from the Dorset HealthCare Physical Intermediate Care Services (Such as CART)

4.2 Criteria for referral

- Primary Diagnosis of Organic Mental illness
- Accessing Dorset HealthCare services

4.3 Acceptance

- The ICSD will undertake an assessment to understand if they are able to meet the needs of the individual

4.4 Exclusion criteria

- People without a primary diagnosis of organic mental illness
- People who are not accessing secondary care services with Dorset HealthCare

4.5 How to refer

The following staff can refer East Dorset patients directly to the team, via telephone referral or e-mail referral:

- Community Mental Health Team staff
- Crisis response and home treatment staff
- Mental health Liaison staff
- Physical intermediate care services staff

The following staff should refer patients either to the Community Mental Health Team, Memory Assessment service or Crisis response and home treatment team initially:

- GPs

- Primary care nursing staff
- Consultants from Acute hospitals

5. Key Service Outcomes

5.1 Intended Outcomes

- Increased capacity within the community to manage increasing demand arising from increased prevalence of dementia
 - Reduction in the number of delayed discharges from mental health inpatient services
 - Reduced dependency on inpatient beds thus maintaining functional skills of patients in own place of residence
- Increased patient and carer satisfaction

6. Applicable Standards

6.1 NICE Clinical Guidance

NICE Clinical Guidance 42 – Dementia (2006) states people with dementia should not be excluded from any services because of their diagnosis, age or co-existing disabilities, such as learning disabilities.

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour.

The National Dementia Strategy (2009) highlights the need for better care for people in their homes. Objective 6: *Improved Community personal support services* identifies the need for a comprehensive community personal support service that includes responsiveness to crisis services, and home support.

7. Baseline Performance Targets – Quality, Performance & Productivity

Indicator	(Baseline establishment)	Method of Measurement	Frequency of monitoring
ACTIVITY AND PERFORMANCE			

Number of referrals	104 (annual)	DHFT monthly service performance report	Monthly
Time of day referral was made, to be reported as percentage within/outside of core hours		DHFT monthly service performance report	Monthly
Number of referrals split by source of referral		DHFT six monthly audit report	Bi-annual
Number of open referrals to the team		DHFT monthly service performance report	Monthly
Percentage of response to referral time within 4 hours		audit six monthly	6 Monthly
Number of people discharged from caseload	100 (annual)	DHFT monthly service performance report	Monthly
Percentage of patients with referral to discharge length under 6 weeks	6 weeks max	DHFT monthly service performance report & exception report for breaches of target	Monthly
Enhanced social care expenditure	£254k max	DHFT monthly service performance report	Quarterly
No of social care clients		DHFT monthly service performance report	Quarterly
Length of social care packages		DHFT monthly service performance report	Quarterly
QUALITY			
Survey of patient and carer satisfaction with the services		(via Trust Quality Report)	Annual
Review of team capacity and capability in relation to demand for service			Quality report 12 months after service becomes operational.
Documentation audit to ensure care planning and records are complete and have involved the client		Trust Quality Report	Monthly

carer in the development of plans.			
% staff trained in caring for people with dementia		Trust Quality Report	Monthly
Percentage of admissions gate-kept		DHFT monthly service performance report	monthly
Numbers of admissions prevented		DHFT monthly service performance report	monthly

7. Prices

Area of Spend	Expected Maximum Annual Cost
Intermediate Care Service for Dementia Staffing & Non Pay: Intermediate Care Service for Dementia Team (incl non pay): Existing In Reach Team Budget: Therapy Support Team Requirement (to support Inpatient & Community functions):	£ 1,093,414 £132,095 £86,680
Allocated Social Care spending budget Discrete budget for purchase of enhanced social care in advance or alternative to Social Services provision to enable maintenance of care in the patient's normal place of residence. The operational use of this budget will be monitored and reviewed formally to ensure effective delivery of the aims of the service.	£254,210
Total Cost	£1,566,399