NHS North Durham Clinical Commissioning Group

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS Darlington Clinical Commissioning Group

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

Improving mental health rehabilitation services for adults – merger of Earlston House and Willow Ward, Darlington

1. Purpose

The paper sets out the Trust's proposal to permanently close Earlston House, Darlington. The unit, which was closed on a temporary basis in April 2016, provides rehabilitation inpatient support to patients with complex needs. The Trust continues to provide 15 rehabilitation inpatient beds in Willow Ward, West Park, Darlington, for patients with complex needs. The Trust also provides a 15 bed rehabilitation unit (Primrose Lodge in Chester-le-Street, County Durham) for people whose needs are not as complex.

Following evaluation of the impact of the temporary closure of Earlston House the Trust believes that it can meet the needs of individuals with complex needs who require rehabilitation within the 15 beds at West Park. The Trust wishes to engage with stakeholders to seek their views on the proposal during September and October, prior to final decision, which we would expect to make in November 2017.

2. Introduction

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provide specialist mental health rehabilitation services across County Durham and Darlington. Their focus is on the treatment and care of people with severe and complex mental health problems whose needs cannot be met by acute assessment and treatment inpatient services. Current service provision is:

Unit	Location	Number of Beds	Type of service
Primrose Lodge	Chester le Street	15 beds	Active rehabilitation unit Target length of stay: up to 9 months
Earlston House	Darlington	15 beds (temporarily closed April 2016)	Bespoke and specialist, slower stream rehabilitation for complex/challenging patients Target length of stay: 1-2 years
Willow Ward	West Park, Darlington	15 beds	Bespoke and specialist, slower stream rehabilitation for very complex/challenging patients Target length of stay: 1-3 years
Specialist Community Rehabilitation	County Durham wide	N/A	Bespoke and individualised 7 day community based intensive support for individuals with complex needs,

Team	(operational since May 2014)		significant levels of risks and significant reduced ability to function in their own home/community. Average duration of contact: 70 days

There are also two beds for County Durham and Darlington patients in TEWV's non-forensic low secure male unit in Middlesbrough.

Over the past decade the Trust has continued to develop and modernise its rehabilitation services in line with national guidance and best practice, including Royal College of Psychiatry guidelines, working with individual service users to maximize their quality of life. This makes sure people get the care they need in the most appropriate environment. This includes (when appropriate) supporting people to live as independently as possible in a community setting, away from NHS based care. In particular, the focus has been on providing the appropriate community support so that patients can move from being in hospital to living in the community and being able to access a range of community services.

Work to date has included:

- much greater focus on rehabilitation goals, outcomes, individual needs and recovery
- more effective discharge planning with patients, family and carers
- working with providers of nursing care, residential care and supported living accommodation to help them support patients with complex mental health needs (this means patients have more choice about where they live)
- working to maximise the independence of patients so that they can live as independently as possible
- being clear about the aims and purpose of admission to the rehabilitation service so that the right patients receive intensive rehabilitation support to maximise their independence
- a community rehabilitation and recovery (intensive support) service to provide an alternative to bed based care or support transition into the community. The service was introduced in 2014 and we have in the last few weeks received confirmation of recurrent funding of this service.

These developments mean that we have much more streamlined service from assessment and treatment wards into our rehabilitation wards. As people get the type of support when and where they need it this has resulted in less time spent in hospital. The community rehabilitation and recovery service team now responds to over 50% of referrals to the rehabilitation service and has been effective in reducing lengths of stay and admissions. As a result of these developments there is less reliance on inpatient beds.
During the period of the evaluation, the Trust separately undertook a Trustwide review of rehabilitation services to look at the type of provision we provide and its effectiveness. This highlighted that other areas within the Trust have similarly benefitted from community based services in reducing reliance on inpatient based rehabilitation.

Evaluation

The Trust made the decision to temporarily close Earlston House in April 2016. At that time most patients were working towards a planned discharge. The temporary closure gave the Trust the opportunity to assess whether the improvements made would, as expected, reduce

the need for inpatient beds The service completed an evaluation (June 2017) which considered a range of information using the following indicators and qualitative information:

Quantitative:

- The number of admissions and bed occupancy across the rehabilitation pathway
- Number of readmissions – linked to placement outcome (those patients who were transferred to a placement in line with their care plan before end March 16)
- Referrals and activity undertaken by the community rehabilitation and recovery team (County Durham only due to commissioning arrangements)

Qualitative:

- Feedback from care coordinators of patients who are in a placement on the effectiveness/suitability of this
- Comments from patients and their families on how the placement is working for them
- Staff comments – indirectly via team away day events and with clinical and management leaders, along with feedback from staff via supervision.
- Feedback from regulators (CQC) and accreditation bodies (AIMS)

The table below provides details of the evaluation.

Criteria	How have we measured the impact	Comments on the impact of the change
Maintenance of placements	Readmissions to mental health inpatient service	Of the 14 people who were discharged from inpatient rehabilitation services either to their family home or to a community placement in the lead up to the temporary closure of Earlston House in April 2016, three have been re-admitted to TEWV inpatient services: • One patient who had been living with a family member had deteriorated and was unable to remain safely with family (readmitted to West Park Hospital). A placement suitable to the patient's needs was identified and transfer completed. • The second readmission was a patient who was in a supported housing placement, Due to deterioration in the individual's mental health this individual was readmitted and remains in Primrose Lodge. Work is ongoing to identify a placement which allows own tenancy with more supervision. • The third patient was readmitted to an acute ward at West Park Hospital from a care home and remains there. Work continues to identify a placement that meets the required level of support. Two people were admitted to acute hospital for physical symptoms (which had also occurred when they were at Earlston House). Sadly one person has died (linked to physical issues). The second patient is now back in their placement.
Quality of individual placement	Feedback from care coordinator, family and/or patient to determine if the placement is meeting their needs	Examples of feedback about three individuals indicates that they are settled in their placement and examples are given of established trips to the leisure centre for football, regular contact with siblings, and one individual who is attending college. There are a number of people who had been in hospital beds for many years with no realistic discharge plan, or only discharge options being 24 hour care, who are now living enjoyable, productive lives. For example, some older former patients with more chronic needs continue to receive appropriate packages of care in their new homes, and recent reviews have found them to be doing well and satisfied with the care they are receiving.
Fit for purpose rehabilitation service	Number of referrals to the rehab service, Number of admissions, Number managed by	A streamlined referral process has been introduced to ensure that all referrals are assessed by experienced clinicians within a week. This enables us to accurately match an individual's needs to the appropriate service. In 2016/17 there were 85 accepted referrals to the rehab service with 46 managed via the community rehabilitation and recovery team, 36 patients

	the community rehab and recovery service (County Durham only)	were admitted to a rehab bed (3 assessments pending at year end). 54% of people referred were able to be supported by the community rehab and recovery team in a community setting who may previously have had either a longer length of stay in acute wards or been admitted to a rehab bed. Following the introduction of the community rehabilitation and recovery team an evaluation of its impact and effectiveness was completed in January 2016. This outlined a range of benefits that this team provides using intensive community input to maximise service user independence. The evaluation included comments from staff who commented positively on the service impact, for example:
	Staff comments on the Impact of the community rehab and recovery service	"*The introduction of the community rehabilitation team has allowed the essential levels of additional support for complex patients after discharge from acute admission wards and avoided the need for referrals to inpatient rehabilitation services and the associated lengthy waiting times. This has positively reduced stay in acute admission wards and freed up availability of beds for those in essential need. Furthermore this has promoted patient choice and allowed recovery within the home environment".* *"The community rehabilitation and recovery team have filled a gap of transition where community teams are unable to provide intensive home care for patients but require support after leaving hospital working effectively with a patient post discharge. They have been effective in assessing level of needs and initiating community activity the patient would otherwise have struggled to access."*
	Bed occupancy : Willow & Primrose Lodge	We continue to monitor bed occupancy to ensure that we can meet need for admission. Following the temporary closure of Earlston House in April 2016 the occupancy level in Willow ward was 95% and in Primrose Lodge was 83%, for the 12 months ending March 2017. This compared to 84% at Willow and 77% at Primrose Lodge in 2015/16. Even with the slight increase in occupancy, bed capacity has remained manageable, assessments are completed within required timescales and the service has been able to facilitate new admissions in a timely way. The service has identified that there remains a small number of complex high risk individuals who are on Willow ward and do not meet the rehab profile, will not achieve independent living and will continue to need long term intensive support. We are currently working with identified agencies e.g.: housing, nursing care to ensure each individual's ongoing care

		needs can be met. Once each individual's transfer has been successfully completed this will increase the capacity within Willow Ward.
Greater multi-disciplinary working and recovery focus	Via feedback from staff, regulators (CQC), other accreditation bodies	The benefits from the introduction of improved ways of working within the service, along with innovative developments such as the non-medical approved clinician (AC) role are now being seen. The psychologist (AC role) is able to support five patients at each unit (Willow ward and Primrose Lodge) and the consultant psychiatrist supports 10 patients at each. This means patients receive more intensive input particularly those who benefit from having a psychologist lead their care. With fewer units there is increased input from consultant, occupational therapy and psychology staff. All staff report that this improves multidisciplinary team working. There is a training programme in place for staff which includes positive behaviour support (PBS), harm minimisation and observation and engagement training, along with sessions on intervention planning. Staff report that the PBS and harm minimisation training have had a positive impact across the team. Staff from the PBS team have attended formulation meetings when intervention plans are being developed. Staff report feeling more confident in the team's approach to support patients with challenging behaviours and complex needs (articulated via supervision). Students have reported that they have found the ward a useful learning experience and receive good mentoring. The CQC inspection from earlier in 2017 confirmed an overall rating of Good and the report recognised the improvement methodologies used by the ward and highlighted the example of improvements to the ward layout The ward has also retained its AIMS accreditation in 2017.
Impact of new service models	Patient feedback	Specific feedback from patients and their families on the range of services currently available, and the impact on their mental health and recovery, has been sought. Some examples are included below: *"Before the valuable on going assistance given to both my wife and myself by the Rehab and Recovery team we had been left to fend for ourselves with sporadic support and guidance*

		from the community health teams. I can only say that their dedication and experience have enabled my wife to begin to see a life beyond her illness and I dread to think what progress could have been made without their assistance" **Carer** *"The services the mental rehab team provided for me were second to none and went way over what I expected of them- they were excellent in boosting my self-confidence and self-esteem and motivating to do things to get me out of myself- get me better"* **Patient** "*The rehab team were on board with my sister for a 12 week period and throughout this time they gave her a lot of support, time and help to encourage her to be independent and motivated her to partake in various social events and activities. This extra input was very valuable both to her and myself as I could have a small break and see her improve and therefore she was able to attend the recovery college too and gain confidence in herself*" **Carer** *"The rehab team have been very helpful in supporting me while on leave and getting me ready for discharge. They are great, friendly and very professional at their job. The team are making it a lot easier for me to do the next step from hospital to the community and have been very understanding when I need more help too. If it wasn't for the team I think I would find the transition much harder"* **Patient** *"Just a note to say I find it useful that the team visits me, helping socially and hope the service can continue"* **Patient** *"My family wish to express our heartfelt appreciation for your kindness and excellent support you give to our mother. Your daily input let us feel reassured knowing mum is not on her own. This also gives me some free time which has been difficult over the last year, I feel support and I think this service is invaluable to service users and their carer's. Thank you very much"* **Carer** *"I would like to thank you all, I know this is a long process, and some days feel better than*

		others, but knowing I have you calling and giving me support really does help, you take me to coffee afternoons, and support groups which I do appreciate, you are a team which I know are there to help me and support me. Thank you" **Patient** *"With the support of the rehab and recovery team, who have worked with my son intensively and assertively in addressing his motivation whilst improving his social inclusion by supporting him attending the gym twice weekly and hobbies of interest such as fishing activities, thus building his confidence and self-esteem which in turn promotes independence and reduce the burden and stress on ourselves as carers. The team have been excellent in liaising with ourselves as carers/family, keeping us involved and well informed in his care and recovery goals, recognising and highlighting the role we play in his recovery and the ongoing stress associated with same. Staff involved have been most professional and understanding and have demonstrated the utmost compassion throughout. They evidently understand the importance of developing a therapeutic relationship with both patient and families! I cannot thank the team enough, and I hope this service continues to be commissioned and funded, keep up the good work guys".* **Carer** *"The community staff team have been fantastic. They have explained everything to tenants in plain English, they had done a rota for one tenant, the community team would support tenants any time of the day, one tenant is now accessing the community independently." how marvellous is that" without the community team it would have taken us much longer to develop her skills in the community, they are very approachable and friendly and gave good advice. Thank you so much for their support."* **Manager of Supported Living Scheme**

Conclusion

The information demonstrates that:

- The development of the community rehabilitation service has had a positive impact on the ability to offer an alternative to admission or reduce the length of time individuals remain as inpatients and has significantly increased the number of people who are supported in the community. Recent agreement of recurrent funding secures its future and provides a key element of the community infrastructure toi support the proposal re Earlston House
- Current throughput and occupancy levels confirm that 15 beds is sufficient to meet the demand for rehab beds for people needing inpatient care for up to 2 years with complex and challenging needs. Occupancy levels at Primrose Lodge demonstrate that the service has the ability to transfer people once they are ready for this element of the pathway.
- There have been 3 readmissions to mental health inpatient services of those people who were discharged from Earlston prior to its temporary closure. The readmissions were as a result of a relapse in their mental health, which would not be unexpected given the chronicity of their problems.
- We recognise that we have lost a community based facility through the temporary closure of Earlston. Neither Earlston House nor Willow ward are purpose built rehabilitation environments. The environment at West Park has a number of benefits however for patients in Willow ward, such as access to PICU and some local amenities.
- There are a number of patients whose needs cannot be met within the current Willow ward. These include patients who need to be managed within a single sex rehabilitation environment, and those individuals who remain in the unit beyond the agreed rehabilitation timescale, need intensive support and will be unable to live independently. However, staff across rehabilitation and community services have been working proactively with local authority and other agencies to identify appropriate homes for them with positive results in that some of these individuals are now moving towards discharge. (some discharge dates now confirmed).

The Trust has been able to successfully manage demand since the temporary closure of Earlston House within the scope of the commissioned service on Willow Ward, West Park Darlington and support from the community rehabilitation and recovery team. We will however need to continue to monitor this to ensure that patients are receiving the care and support they need when and where they need it.

3. Recommendations

The paper outlines the continued development of the rehabilitation service to provide more responsive, needs led and recovery focused options for patients. This means that we have been able to reduce 15 beds with no adverse impact on the ability of the rehabilitation service to offer inpatient support when this is required.

The Trust recommends that Earlston House, Darlington is closed on a permanent basis in light of the changing needs of the service and patient group, and development of more recovery focused alternatives to specialist inpatient rehabilitation and recovery care.

We are seeking to engage with stakeholders during September and October 2017 to share this proposal and discuss any issues or concerns prior to making a final decision in November 2017.

Patrick Scott
Locality Director
County Durham and Darlington

Appendix 1

Proposed Engagement Process

ACTION	**BY WHEN**	**LEAD**
Initial discussion with Durham and Darlington OSCs to agree process	End June 2017	Director of Operations
To discuss at AMH QUAG	August 2017	Head of Service
Share focussed engagement paper with CCGs	September 2017	Director of Operations
Share paper with OSCs	October 2017	Director of Operations/ Head of Service
Respond to engagement with follow up meetings with stakeholders as required	1 October 2017 – 31 October 2017	Director of Operations/ Head of Service
Submit proposal to CCGs following engagement recommending preferred outcome for Earlston	November 2017	Director of Operations