Briefing paper on Older People's Mental Health Services in Barnet and the closure of Dolphin Ward in the Springwell Unit, Barnet Hospital.

1.0 Introduction

This briefing paper outlines the existing inpatient and community mental health care pathways for older people in Barnet and provides an update to the Overview and Scrutiny Committee since the last update provided in May 2012. It also makes the proposal to formally close Dolphin Ward which has been temporarily closed since 2011.

The existing model for older people's mental health services in Barnet is described below. All community and outpatient services are based at the Springwell Building at Barnet Hospital and inpatient services are based on the Chase Farm Hospital site.

Barnet Older People's Mental Health Services consists of:

- Community Mental Health Teams: supporting patients in the community with functional mental illness or dementia who are subject to CPA
- Day Hospital Provision: functional (sessional only) and dementia (full-day attendance)
- Memory Treatment Clinics: a nurse-led service monitoring patients on anti-dementia medication
- Acute In-patient Care: patients with a functional mental illness are admitted to The Oaks Ward; people with dementia are admitted to Silver Birches Ward (applies to Barnet, Enfield and Haringey).
- Home Treatment Teams: providing acute care for adults of all ages in the community with a functional mental illness

1.1 Background

The last paper to the OSC on Barnet's older peoples mental health services in May 2012 outlined a review of the temporary changes that had occurred to the acute in-patient pathway for older people in 2011. On the 5th of July 2011, Dolphin Ward (Based in Springwell Unit, Barnet Hospital) was temporarily closed and all activity transferred to Cornwall Villa based at Chase Farm Hospital. This was an urgent service change in response to a safeguarding and disciplinary investigation on Cornwall Villa. Cornwall Villa was a 25 bed acute admission ward for older people with a functional illness e.g. depression, schizophrenia or dementia. At the time, there was a consistent number of vacant beds, that allowed the Trust to temporarily close Dolphin ward and move the in-patient activity to Cornwall Villa. As Dolphin Ward was only 12 beds, the Trust could not close Cornwall (25 beds) and only use the smaller unit as there would not have been sufficient capacity. Since this initial move, patients have been moved to the Oaks Unit on the Chase Farm Hospital site that provides a more appropriate environment.

Since then, the Trust has managed in-patient demand effectively with only one older patient (Enfield patient) admitted to the private sector due to bed pressures during the last two years. However, there have been concerns within the Trust about the complexity of managing acutely ill patients with functional mental illnesses and those with dementia within the same environment (The Oaks). The consolidation of acute provision and increasing complexity in demand has resulted in rising levels of mental health acuity on The Oaks unit. It is considered too large at 25 beds.

A compounding issue is the mixed pathology on the unit. More vulnerable and elderly patients with dementia can, on a fairly frequent basis, become involved in altercations and incidents with younger (e.g. age 65-70) patients with functional illness such as people in the manic stage of a bi-polar illness.

A compliance inspection of The Oaks by the CQC in March 2013 found areas of non-compliance related to care plans not being updated in a timely manner and also that patients were not always having their capacity to make significant decisions assessed under the Mental Capacity Act (2005). During the last year there were also several safeguarding alerts raised by The Oaks and an increase in the number of complaints from patients and their families about care on the ward. These various problems highlighted the increased operational pressure the service was under in trying to manage and care for patients with functional mental illness and severe dementia within the same environment. In response to the above concerns, a providers concern process for The Oaks was initiated and led by the London Borough of Enfield with a robust improvement plan developed by the Trust and its partners.

In June 2013, as an agreed way forward during the provider concern review, the Trust proposed to move all acute admissions for people with dementia to Silver Birches Ward on the Chase Farm Hospital site. This new pathway for Barnet, Enfield and Haringey older people was established in August 2013. The plan aims to reduce the bed numbers on The Oaks from 25 to 21 (currently 22 beds). These actions intend to reduce the size of the unit and the complexity of provision by separating functional and dementia care pathways which could not be achieved when units were geographically based and borough focussed. There will be no corresponding reduction in staff resources resulting in a further increase in the staff to patient ratio on The Oaks.

The improvement plan, which has almost been fully implemented, included the following key elements:

- Reduce the size of The Oaks from 25 to 21 beds
- Separate out functional and dementia patient pathways through utilising Silver Birches Ward as the main acute assessment ward for people with dementia
- Improve the structure and layout of The Oaks unit through improving reception and creating two smaller 6 bed and 15 bed units within the footprint of the standalone unit
- Enhance clinical leadership on the unit through the introduction of a new dedicated Consultant Psychiatrist for the unit and an additional charge nurse
- Further increase medical staffing through the introduction of a new specialty doctor
- Introduce a standard induction process for agency workers
- Review and implement revised clinical review processes
- Continue to deliver our inpatient staff development programme
- Increase our quality assurance processes around the care and treatment provided on the Oaks
- Review and enhance the therapeutic activity programme
- Improve working with informal carers
- Review the physical health care needs of patients on the Oaks and address any identified gaps
- Deliver additional safeguarding training to staff
- Closely monitor practice in relation to Trust policy and guidelines on restraint
- Improve falls screening, assessment and care planning

1.2 Brief commentary on what we want to achieve.

The following outlines the key areas of priority for Barnet Mental Health Services for Older People:

- To strengthen acute care and avoid unnecessary admissions to hospital
- To further integrate community provision to support a managed network of services across a wide spectrum of care for example, the new MDT elderly frail networks
- To continue to support residential and nursing homes by helping to maintain placements and avoid unnecessary admissions to acute general and mental health hospital care
- To support carers especially carers of people with dementia.
- To work with commissioners to develop a Barnet Memory Service that will form the central part of a Dementia Hub for Barnet
- To develop an enhanced Psychiatric Liaison service at Barnet Hospital based on the RAID model
- To integrate with community services in managing people with long-term conditions (LTC)

Trust Strategy

The BEH Trust's discussion document, 'Changing for Good', published in October, 2009 reflected key elements contained in the healthcare policy framework at that time and are further developed in the Trust's Clinical Strategy published in 2013. A key focus of the Strategy is:

- to maintain the majority of care in the community enabling people to live independently at home,
- to develop alternative options for acute care (e.g. Home Treatment Teams) and
- to reduce unnecessary admissions to hospital.

To achieve these, mental health services will work more closely with primary and social care services to manage the growing demand for healthcare in the local population.

Older People's Services Model

An effective older people's mental health service requires a managed network of services across a wide spectrum of care. The expertise of older people's mental health services lies in the care and treatment of people with complex psychological, cognitive, functional, behavioural, physical and social problems usually related to ageing. Older people benefit from an integrated approach with social care services as most patients in older age mental health services have complex social needs (Joint Commissioning Panel for Mental Health 2013)[1]. In addition to complex social needs, older people often have a combination of mental and physical health problems. Significantly more older people suffer from functional illnesses, depression and psychosis, than dementia and there is significant cross-over between the two categories of illnesses. This latter point means that if is often very difficult to completely separate out provision for functional illnesses and dementia. Provision

[1] Joint Commissioing Panel for Mental health (2013) Guidance for commissioners of older people's mental health services. Published May 2013

can be separated and this now forms a requirement from the Trust's Clinical Strategy with regards to our older people's in-patient care.

Community Mental Health Teams (CMHTs)

These services are integrated health and social care teams that manage older people with complex needs related to functional illness and dementia under the Care Programme Approach. Their purpose is the active treatment and management of patients in the community in order to improve the individual's mental health and maintain independence in the community. Treating people in their own homes to maintain independence and avoid unnecessary admission to hospital for treatment is a key function of these teams. Carer burden can be significant and particularly for carers of people with dementia. Specialist support is required to improve and maintain carer health and avoid the potential breakdown of a person with dementia's support network at home. In addition to this, CMHTs provide a critical role in supporting patients in residential and nursing homes and helping to prevent placement breakdown and avoid unnecessary hospital admission.

In-Patient Services

In-patient services are essential components of the care pathways, dementia and acute care, that help to manage clinical risk and placement breakdown. The purpose of in-patient care is to provide more intensive, safe support to the person who requires assessment or stabilising of their mental health before returning to community living or step-down care.

In BEH we have a clear plan in place to improve acute care for older people within **The Oaks and Silver Birches Wards**. The Trust has made significant investment in resources for these units and, with the recent changes to the overall model, has now applied for AIMS (Accreditation for In-patient Mental Health Services) accreditation with the Royal College of Psychiatrists to support our continuous improvement and achievement of a recognised standard for in-patient care.

Memory Services

The Trust is working closely with commissioners to develop a dedicated **Barnet Memory Service** that will form part of a Dementia Hub in Barnet working closely with the Alzheimer's Society and other agencies. Referrals to older people's services in Barnet increase by approximately 7.5% per annum and we have seen a marked increase in the number of people referred in the early stages of dementia requiring assessment, diagnosis and treatment. The Trust has already achieved accreditation for Memory Services in Enfield and Haringey.

2.0 Service Development

The consolidation of the sectorised acute care pathway has enabled re-investment to enhance staffing in Barnet community services and the remaining specialist in-patient units based on the Chase Farm Hospital site. Recent and future developments are outlined below including the development of an enhanced Psychiatric Liaison service for Barnet Hospital based on the successful RAID model of liaison.

The main changes include:

- The move from geographically-based sectorised wards with mixed pathology (functional illness and dementia) to centralised and better resourced units separately focussed on a primary pathology (e.g. functional illness or dementia) and based on the Chase Farm Hospital site.
- Increased staff enhancements to community services including Consultant Old Age Psychiatry, Therapy staff and the introduction of Admiral Nurse provision (trained mental health nurses whose clients are the family carers of people with dementia)
- New service developments including a new Memory Service team for Barnet and a new Psychiatric Liaison team for Barnet Hospital
- The intention to develop a proposal for a rapid assessment service for people with dementia aimed at preventing unnecessary hospital admissions

Triage, Crisis and Home Treatment Services

The Trust is transforming the way it responds to both routine and urgent care referrals. The service transformation and re-design proposals set out an organizational structure that allows for the services to be delivered through three borough teams with an overarching streamlined management and clinical structure for both the new Triage Service and the Crisis Resolution & Home Treatment Team (CRHT). These changes will create three new integrated Triage services and CRHT's in Barnet, Enfield and Haringey based locally to provide mental health assessments and advice. The service recognises a need to manage risk effectively but also engage in positive risk taking to ensure that the care offered is designed around service user need rather than service need.

Response targets are guided by NICE guidelines: 2 hour response for urgent and crisis referrals, 3 working weeks for routine and non-urgent referrals. These services are for all adults including older people. Senior clinical staff will lead at the front of the pathway through undertaking all initial assessments. This will support better decision making, signposting and appropriateness of onward referrals and also help to avoid unnecessary admissions.

Anticipated advantages of the changes include

- Improved quality of care and patient experience
- Equitable and fair access to services
- A modernised approach to care emphasising the need for a timely and clinically appropriate response and assessment.
- Integrated bed management structure for all services.

- Changes to the way staff work to ensure the right skills are in the right place with skilled staff available to provide supervision and support as needed.
- Increased flexibility
- Ability to respond more effectively to the challenging economic climate.

Carers Strategy

The Trust recognise and value the crucial role that carers play. Over the past two decades there has been a progressive shift in the provision of care for people with health problems from hospital based services to more community focused care and whilst this brings many positive outcomes, the provision of day to day care frequently lies with their carers, who take on the task of caring alongside other responsibilities. The Trust are currently consulting on a new Carers Strategy that outlines the expectations placed on the Trust in recognising and supporting carers to stay healthy. The strategy provides a framework for carer engagement at individual, team and service development levels, in line with Trust objectives.

Amongst all carers, the carers of people with dementia are one of the most vulnerable, suffering from high levels of burden and mental distress, depression, guilt and psychological problems[2]. The behavioural and psychological symptoms of dementia patients, such as aggression, agitation and anxiety, are particularly difficult for carers and are a common cause for institutionalisation of dementia patients in care homes. The roll out of Admiral Nurses across the three boroughs has been a welcome addition to the existing service model. During the last year, two new Admiral Nurse posts have been established to work with carers from Barnet. A senior band 7 Admiral Nurse has been appointed to support the Oaks, Silver Birches and Cornwall Villa and the new Admiral Nurse position (Band 6) within Barnet's community services for older people.

2.1 In-patient Provision

Mental Health in-patient care is highly specialised, focussed on the most vulnerable, those with the greatest need and complexity. It requires specialist expertise, with intensive levels of assessment, monitoring and treatment that is not possible in other settings. Inclusion of a wide range of disciplines as part of the multi-disciplinary clinical and management team is essential. The Royal College of Psychiatrists (2011)[3] recognises that practically, in order to deliver such high-quality specialist units, people may have to travel further to more centralised and well-resourced in-patient areas although it recognises that this may be potentially problematic for some older people.

Since the temporary closure of Dolphin Ward in 2011, the Trust has made significant re-investment in the acute care pathway. This has included:

- Increasing nursing staff on The Oaks shift plan to 6 during daylight hours and 4 at night (Previously 4:3). In addition to this there is a full time supernumerary ward manager.
- Creation of a full time Nurse Consultant post for The Oaks since December 2011 (in addition to the above shift plan)

[2] University of Oxford (2010) Dementia 2010: The economic burden of dementia and associated research findings in the United Kingdom. Health Economics Research Centre, University of Oxford.
[3] Royal College of Psychiatrists (2011) In-patient care for older peple within mental health services. April 2011

- Creation of a senior inpatient Admiral Nurse post (Band 7) to support carers of people with dementia
- Creation of an additional full time OT post to support rehabilitation and facilitate discharge
- Increased medical consultant time by 0.4wte to 1.0 dedicated full-time Consultant Psychiatrist for The Oaks
- Further increase of medical support with a full-time specialty grade doctor for The Oaks.

Table 1 below outlines the number of Barnet admissions since April 2010 to the acute care pathway. This shows a range of between 2 and 11 admissions per month with an average of 6.3 admissions per month and a small rise in trend during the last 12 months. On average, Barnet accounts for almost 50% of all admissions with 28% from Enfield and 19% from Haringey (3% from other boroughs). Barnet incurs more admissions proportionally than would be expected based on its population but the high number of residential and nursing home facilities in Barnet increases the number of older people with significant morbidity and this is likely to be a factor. During the last year, 39% of Barnet admissions were for people with dementia.

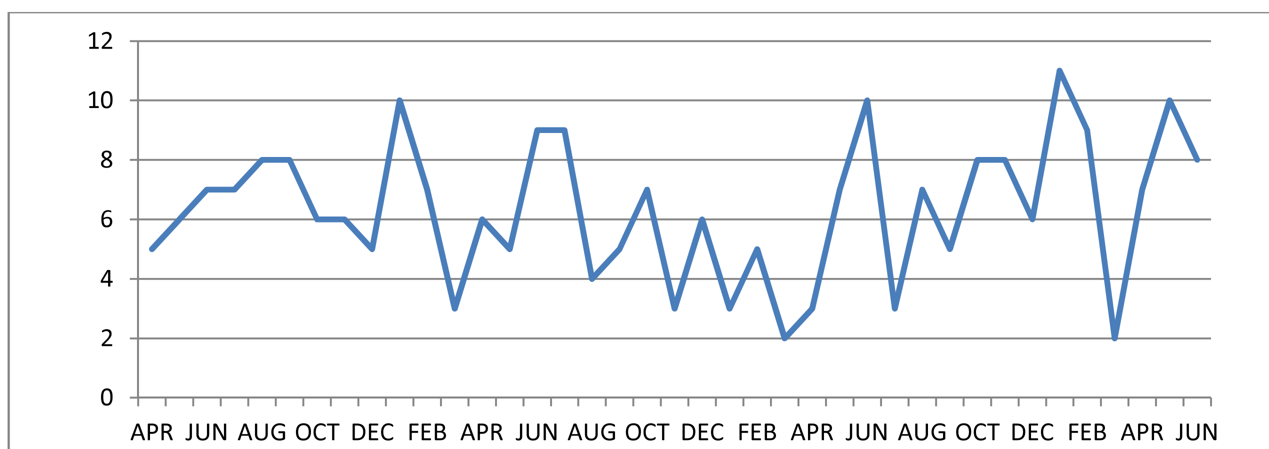

Table 1: Barnet monthly admission rate from April 2010 to June 2013

For comparison across boroughs, Haringey's admission rate has remained fairly stable with 38 admissions in 2010/11 and 39 admissions over the last 12 months (average 3.2 admissions per month). In contrast, Enfield has seen a significant reduction in admissions over the last few years with 80 admissions in 2010/11 and only 59 admissions during the last 12 months (average 4.9 admissions per month).

The average length of stay (ALoS) on The Oaks is 42 days for people with dementia and 50 days for people with a functional illness. Barnet's average length of stay is better than average across the three boroughs with a total ALoS of 42 days in Q1 this year and the last three quarters of 2012/13 showing 46(Q4), 35(Q3) and 33(Q2).

Table 2 below shows the number of Barnet patients in an acute bed on the 1st of each month. There is some variation with a range of between 7 and 16 patients and an overall average of 11.6 patients at any one time. In line with the small increase in average admissions per month during the last year there has been a slight increase in the number of Barnet patients at any one time.

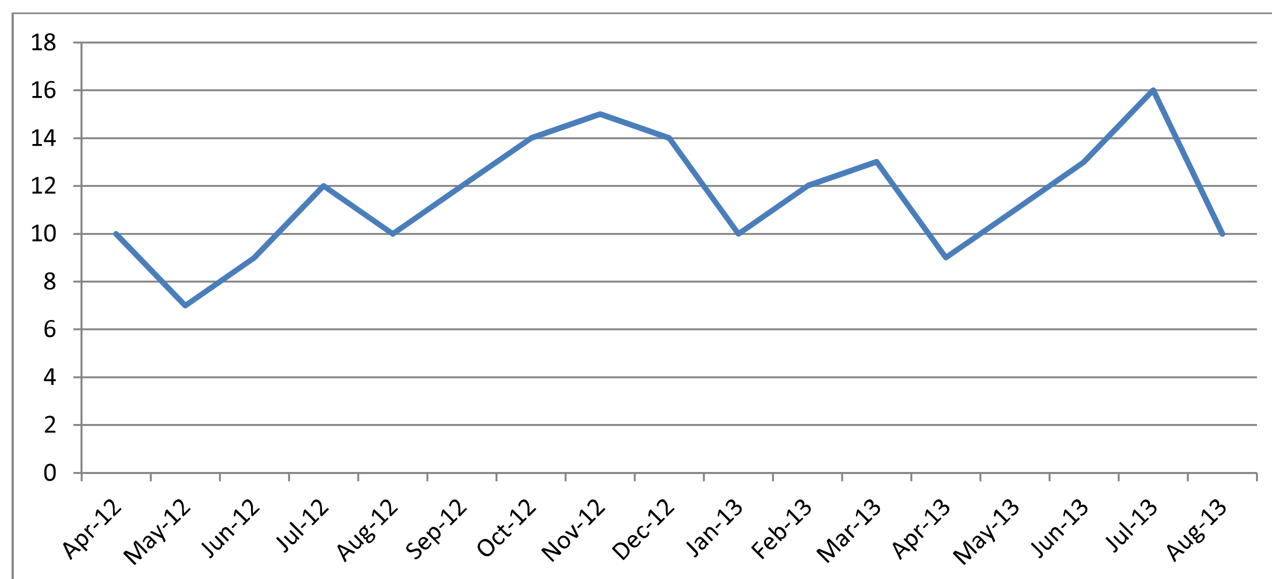

Table 2: Barnet patients in acute care on 1st of month from April 2012 to August 2013

Barriers to Discharge from In-Patient Care

The Royal College of Psychiatrists (2011) recognises the negative impact that prolonged admissions have on all agencies and the need to address the significant numbers of mental health beds that are occupied by people whose discharge is delayed. A national survey by the Faculty of Psychiatry of Old Age[4] found 13.3% of functional mental illness beds and 28.6% of dementia assessment beds were filled by patients whose discharge had been delayed. Delayed transfers of care (DToC) locally usually relate to patients who are waiting for residential placements and the necessary agreement regarding continuing care eligibility (CHC), funding or placement approval. Although there are efficient processes in place to address these issues between the Trust, Barnet LA, and Barnet CCG, the focus tends to be on patients who have already been admitted to hospital rather than the need for multi-agency intervention prior to admission. This is particularly the case for people with dementia and the need to respond to challenging behaviour (e.g. wandering, behavioural problems, aggression) that invariably increase with disease progression.

Although not yet quantified, a proportion of admissions to hospital could be managed by alternative models to hospital care. The person with dementia can, for example, present to A&E, after having been found wandering, and is then admitted out of hours. In these circumstances, vulnerable adults require immediate and supportive care plans at home or emergency respite in a residential setting rather than admission to an acute admission ward as the changes in their behaviour are expected and should be planned for via effective multi-agency arrangements. In light of this, commissioners

[4] Barker, A & Bullock, R (2005) Delayed Discharge in older peoples' mental health beds. Old Age Psychiatrist Newsletter, Autumn:9.

and the Trust plan to develop a future proposal around the development of a joint, multi-agency rapid assessment service to prevent unnecessary admissions, particularly for people with dementia.

2.1.1 Benefits of changes to the acute care pathway

The changes made to the acute care pathway provide benefits for patients, service providers and commissioners. The Trust's shift from more traditional geographically sectorised in-patient models to a centralised model based on primary pathology supports significant benefits to patients and services by providing expert interventions that are timely and appropriate.

Increased specialism helps to improve delivery within a particular unit e.g. focussed on functional mental illness or dementia. This also includes benefits in simplifying training and education of staff and consolidation of in-patient provision has enabled the appointment of additional staff and senior clinicians for the services e.g. dedicated Consultant Psychiatrist, Nurse Consultant and senior Admiral Nurse to improve clinical leadership. Improved service delivery and care leads to shorter rehabilitation periods and subsequent shorter lengths of stay on wards.

Having separate in-patient beds for dementia and functional beds has been consistently regarded as good practice (Audit Commission 2002, Care Services Improvement Partnership 2005, Royal College of Psychiatry 2006, The Mental Welfare Commission for Scotland 2010). The Mental Welfare Commission for Scotland paper highlighted the problems with mixed-provision: people with dementia invade the personal space of other people. Also, providing activities that are stimulating and meet the needs of each individual was cited as challenging. The RCPsych's paper from the Centre for Quality Improvement in 2008 highlighted that violence and aggression is higher in mixed pathology units than in in-patient units providing care separately. This is an important finding. Another issue, highlighted by the National Collaborating Centre for Mental Health in 2006, was that good palliative care is more difficult to deliver in mixed pathology units.

At a ward level, the artifacts of these changes are providing substantial benefits for patients and include:

Improved Clinical Decision Making

The Oaks has moved away from the traditional and long weekly multi-disciplinary ward rounds to a more agile and frequent daily review process where senior clinicians can assess and adjust plans together more quickly as new information is received. The older more traditional model was to a large extent dictated by the fact that the consultant psychiatrists were not ward-based and worked across various services including the Oaks. Care Programme Approach (CPA) meetings tended to occur during the weekly ward rounds, organised around the consultant psychiatrists availability, and this meant that it wasn't unusual for ward rounds to last 4-5 hours. The new clinical review process supported by the full time Consultant Psychiatrist and Nurse Consultant means that CPA meetings are organised around the availability of the family, where appropriate, and other key professionals and do not happen during the professionals daily clinical review process. It also means that the relevant named nurse or nurse-in-charge is not removed from clinical duties for extended periods of time but for shorter and more manageable time periods.

The daily review meeting also enables the care team to plan and implement actions in a more timely way which aids in reducing unnecessary delays to tasks and processes related to patient discharge.

Improved Support for Carers

Re-investment within the Oaks has supported the establishment of a senior Admiral Nurse for our inpatient services. The Admiral Nurse works directly with family and carers of people with dementia. A new initiative within the Oaks and Silver Birches has been to have a 'family meeting' with relatives/carers (where appropriate) within the first week of the patient's admission. There is a structured format to the meetings and where possible includes the patient's named nurse and/or ward doctor. The aim of the meeting is to gather a richer picture of the patient's needs, offer a carers assessment and give information about the ward and any aspect of care and treatment. The Admiral Nurse documents the discussion in the meeting and any other additional information and a copy of this is provided to the carer/family member. The Nurse Consultant carries out the same role for carers/family members of patients admitted to the Oaks with a functional illness

Improved Staff Development and Supervision

One of the key areas of responsibility for the Nurse Consultant position involves staff development. The Nurse Consultant leads on and delivers an innovative staff development programme for qualified and unqualified nurses across the older people's wards. This consists of a programme of formal study days and ward based 'team days' that are planned up to a year in advance. Senior clinicians from all disciplines lead on each of the 24 days delivered each year and some of the experiential training has been supported by using actors.

2.1.2 Equality Impact Assessment

The attached Equality Impact Assessment and Analysis form for this ward consolidation initiative has been completed and identifies possible minor positive impacts and some negative impacts related to the protected characteristics of age, disability and ethnicity. The change affects a small number of patients and their families with around 80 admissions per annum and with an average length of stay on the ward during the last four quarters of 33, 35, 46 and 42 days.

2.2 Community Provision

A substantial part of community mental health service provision for older people in Barnet is aimed at providing support to the high number of residential and nursing care homes within the borough. Following the closure of Dolphin Ward, reinvested Consultant Psychiatrist sessions (0.5wte) have assisted in maintaining and developing support to key homes in the borough, including: Apthorp Lodge, Elmstead House, Clore Manor, Candle Court, Clara Nehab House and Lady Sarah Cohen House. Medical and non-medical staff provide regular 'clinics' within these homes on either a weekly

or monthly basis depending on need. Community and Day Hospital nursing and therapy staff have also been re-focussed, having previously input to Dolphin Ward, and who now spend more of their client contact time within the community and outpatient settings. In addition to this, the Trust have created an Admiral Nurse post in Barnet to provide support for carers of people with dementia, who can experience significant carer burden, and this has been operating well since the start of the financial year.

A new development for Barnet has been the recent agreement to establish a new service for the Memory pathway in Barnet. The new service will form part of a centralised dementia hub that will include key partner agencies including the Alzheimers Society. The service will provide assessment, diagnosis and treatment for all referrals of people with suspected dementia. This will be an exciting new development for Barnet. Early diagnosis of dementia is a government priority and the National Dementia Strategy 2009[5] describes the value of early diagnosis and intervention. The following positive impacts are listed: early provision of support at home can decrease institutionalisation by 22%; even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6%; older people's mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care.

The Prime Minister[6] is committed to ensuring that memory clinics are established in all parts of the country and are accredited according to the standards outlined by The Royal College of Psychiatrists, Memory Service National Accreditation Programme (MNSAP) standards. Key commitments listed in the Prime Ministers Pledge 2012 include:

- increasing diagnosis rates through regular checks for over - 65s
- better information for people with dementia and their carers
  promoting local information on dementia services e.g. by rolling out web information for local areas.

Nationally, only about one third of people with dementia receive a formal diagnosis and the Department of Health's National Dementia Strategy[7] aims to ensure that effective Memory Clinic services for early diagnosis and intervention are available nationally. With an expanding older people population, Barnet can expect a 21% increase in the number of older people during the next decade. Local services have seen a 15% increase in demand during the last two years, mainly as a result of the incremental drivers to diagnose people in the early stages of their dementia.

The National Dementia Strategy provides evidence that such services are cost effective. Once established, such services can release substantial funds back into health and social care systems. The evidence available indicates that:

- Early provision of support at home can decrease institutionalisation by 22%
- Even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6%

[5] Department of Health (2009) Living well with dementia: A National Dementia Strategy
[6] Department of Health (2012) Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015
[7] Department of Health (2009) Living well with dementia: A National Dementia Strategy.

- Older peoples mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care
- Carer support and counselling at diagnosis can reduce care home placement by 28%
- Early diagnosis and intervention improves quality of life for people with dementia and;
- Early intervention has positive effects on the quality of life of family carers

(Summary of benefits taken from DoH National Dementia Strategy 2009)

2.3 Liaison Psychiatry

Although not the full RAID model, the Trust will be delivering an enhanced Psychiatric Liaison service to Barnet Hospital in this year. The service will be evaluated with a view to considering what level of liaison services is required for 2014/15 onwards.

The Rapid Assessment, Interface and Discharge (RAID) model provides an innovative liaison psychiatry service which will improve quality of care, drive down lengths of stay and reduce readmission rates across the whole spectrum of mental health co-morbidities in the acute hospital including dementia, self-harm and substance misuse. This is the model that was developed and implemented at Birmingham City Hospital, and has been thoroughly evaluated and accepted nationally as a benchmark platform for acute hospital liaison services. There are two key components:

- direct assessment and treatment of patients presenting with overt mental health problems, allowing the existing Barnet hospital pathways to function smoothly and reduce unnecessary delays, similar assessment and treatment of patients who present with co-morbid mental health problems such as dementia
- high quality education & support for the Barnet Hospital staff through both formal teaching and informal techniques, to rapidly skill up NMUH staff in identification of patients who might benefit from RAID input and improve their own care of such patients.

3.0 Summary and conclusion

Since the temporary closure of Dolphin Ward in 2011, The Trust has been able to satisfactorily manage in-patient demand and is continuing to reduce total bed numbers with further reductions planned to The Oaks which is going from 25 beds to 21 beds this year. No further bed reductions are planned at this stage.

The in-patient pathway consolidation and a move away from geographically based wards with mixed pathology to separate in-patient units for people with functional illness and dementia has resulted in re-investment within community services including the introduction of Admiral Nurses, increased specialisation within in-patients and improved clinical leadership with a dedicated Consultant Psychiatrist and Nurse Consultant for the Oaks ward.