Mental Health and Memory Service: Community and Acute

Your guide to NAViGO services
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<th>Service</th>
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<td>Community mental health and memory service</td>
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This guide describes all the services within both our community and acute mental health and memory service (formerly older people’s mental health services).

NAVigo provides a range of care services to people with Dementia, associated diseases and functional mental health problems including practical advice and emotional support to carers.

In addition to assessment, diagnosis and treatment, our professional teams of mental health practitioners and psychiatrists signpost service users and carers to other services as required to enhance the quality of life for the person, their family and carers.

For up to date information on the services we can offer you, check online at www.navigocare.co.uk
assessment by GP should include:

blood screen
- B12
- TSH
- glucose
- folate
- FBC
- LFT
- calcium

cognitive assessment
- MMSE, 6 CIT,
- GPCOG
- OR clinical judgement

social circumstances assessment (to include information from carer).
- Risk of neglect
- isolation
- need for carer support
- if driving: inform DVLA
- level of nutrition

possible symptoms:
- presenting with memory problems
- mood changes
- reduced reasoning skills
- reduced communication skills
- reduced ability to undertake everyday tasks

role of:
- Dementia advisors
- complex case managers (ASC)
- integrated case managers for Dementia

exclude/treat:
- aggravating factors
- physical illness
- vitamin deficiency
- head injury / subdural haematoma
- hypothyroidism
- depression presenting as dementia i.e. history of low mood decreasing appetite or weight/sleep disturbance and cognitive decline
- delirium
- infection
- brain tumour

vascular Dementia – known patient with CVA and Dementia.

Are there behavioural problems/ psychosis/mood problems?

no

support in primary care

yes

referral via Single Point of Access to community mental health and memory service
information to be included in referral:

- medical history, including head injuries and operations in the last ten years
- vascular risk factors
- blood test results
- MMSE/6 CIT/GPCO scores
- current medications
- physical examination
- urgency of appointment
- suitability for local outpatient memory clinic or home visit
- risk factors e.g. behavioural/psychotic problems, problems with ADL, mood problems
- Contact details for relative or carer

consider referral:

- complexity or uncertainty about the diagnosis following primary care assessment and follow up
- a request by the service user for another opinion
- the presence of significant depression and/or psychosis, especially if there is no response to treatment by primary care, or acute distress to the service user
- suitability for cognitive enhancer medication treatment
- difficulty in managing Behavioural and Psychological Symptoms in Dementia (BPSD)
- the need for specialist opinion on issues such as financial capacity, driving or other similar medico-legal issues.

consider discharge back to primary care:

It is essential that the Community Mental Health and Memory Service (CMHMS) maintains a capacity to undertake new assessments and take on work with new users. The CMHMS must therefore be proactive in considering when a service user is ready for discharge back to the primary care team.

Discharge from the CMHMS to the primary care team will be considered when service users require only minimal intervention and:

- There is evidence of mental stability
- They do not require specialist mental health interventions
- They require to be seen at less than 3 monthly intervals
- The diagnosis and care plan are clearly established and there are no significant risk factors that are not being effectively managed
- They can attend their GP for follow-up, review and treatment
- They are believed to be compliant with treatment
- There are no significant risk factors that are not being effectively managed
- Key stakeholders (GP/service user/carer) have agreed to the discharge as part of the CPA process.

It is acknowledged that some service users, because of the nature and complexity of their mental illness, may require on-going treatment and support for many years and long term assistance will be offered when this is the case.
Referral point

Mental Health Single Point of Access

Triage assessment completed by SPA practitioner at Harrison House

Triage

Initial assessment of need

Moderate/severe book into new patient screening clinic (case supervision)

Crisis/urgent: 4 hour response by acute team or urgent appointment offered at Harrison House

IAPT Open Minds

NAVIGO will not discriminate on the grounds of age. Services will be allocated according to the needs and wishes of the service user

Are there any of the following issues/needs:
- Clear evidence of memory problems
- Complexities associated with physical health
- Service user deemed to be too frail for adult services
- Specific changes in presentation of mental state (of known service users) which require the specialist input of older adult services

Yes

Case management by mental health and memory team

No

On-going service required?

Adult community

Adult acute

Open Minds
How do I refer to the community and acute mental health and memory service?

Includes referrals for:

- Memory clinic
- Organic
- Functional teams
- Care Home Liaison team
- Occupational therapy
- Admiral Nurses
- Huntington's Disease Nurse
- Intermediate Care
- The Konar Suite

Individuals can be referred to the community and acute mental health and memory service via the NAViGO Single Point of Access (SPA) by any healthcare professional including GPs, care managers, community matrons or district nurses.

SPA then directs the referral to the most appropriate team within NAViGO.

The service user’s GP will always be consulted about a referral to our services.

Tel: (01472) 252360

Email: nel-ct.mhsinglepointofaccess@nhs.net

Fax: (01472) 302311
The Community Mental Health and Memory Service (CMHMS) treats people who have mental health needs and/or memory problems and supports them to live in their own home or a care home.

Staff have the specialist knowledge and skills to assess and treat people with mental health needs. Support is also provided for their family and/or carers.

The service comprises of staff from various professional groups with access to all teams within NAViGO.
The acute mental health and memory service provides services to people who need more intense treatment and support than can be provided by the community teams. This may include a home treatment team admission to our inpatient units: either Konar Suite or intermediate care.

Our inpatient services are for people experiencing more acute mental health problems who would benefit from a period of intensive assessment and treatment within a safe and secure environment.

Inpatient admission is only considered when other options, such as home treatment, community support and respite cannot meet the needs of the individual safely.
There are two organic community teams aligned to both a consultant and speciality doctor, each linked to two commissioning groups.

The functional team works with both consultants and all four commissioning groups, please see the care pathway on page 5.

Each team has a clinical team leader, mental health practitioners, including Community Psychiatric Nurses (CPN), Social Workers, Support Workers, Occupational Therapists and administrative support.

The role of the team is to assess, treat and support individuals with complex mental health problems, either organic or functional, and their carers in the community.

The teams undertake home-based, specialist assessments to provide on-going care, treatment and support for people with more complex mental health problems and their carers, taking in to account their frailty and vulnerability.

The service also delivers support, advice and training to staff from other agencies who provide care to older adults with mental health problems e.g. care homes, voluntary agencies.
Memory service

Following assessment by the community teams and an appointment with the consultant / speciality doctor, a diagnosis is given.

A discussion with the service user and family takes place to discuss treatment options which may include prescribing Acetylcholinesterase Inhibitors (ACI) or Memantine (Ebixa).

The memory clinic team arrange to have the prescription for ACI’s dispensed and contact the service user, family and/or carers to arrange delivery of the medication.

The team advises of side effects, provide written information about the medication and advise who to contact with issues and concerns.

They maintain regular contact either by telephone or visits to monitor toleration of the medication during titration in line with Shared Care Guidance November 2011.

Care home liaison team

The care home liaison team are care co-ordinators within the CPA process for service users in the enhanced units (Haverstoe Suite, Grimsby Grange and Cranwell Court) and residential care homes.

The team is responsible for assessment, person-centred care planning, evaluation and review.

This involves the promotion of innovative and creative ways of working with service users who have complex behaviour and long term mental health problems living in care homes.
The Occupational Therapy (OT) team consists of a clinical specialist team lead, Occupational Therapists and support staff providing input to the range of teams within the acute and community mental health and memory services.

OTs assess a person’s ability to perform their everyday activities relating to personal care, productive activity e.g. meal preparation, shopping, hobbies and interests; and the ability to maintain social involvement with others. OTs aim to enable people to maintain their independence, to identify and reduce risk factors and to stay in their own homes for as long as possible.

OTs consider how the person with memory impairment or a mental health problem functions within their environment. OTs help people to find ways to do the things they want to do to enable them to lead a satisfying lifestyle. This could include the provision of aids and equipment to promote independence.

The team work with individuals and in group situations and carry out assessments and interventions in environments appropriate for each person e.g. their own home, community resources or care homes.

They are also involved in providing support, training and advice to carers and staff in other agencies who provide support to older adults with mental health and/or memory problems.
Admiral Nurses

NAVigo has two Admiral Nurses and a support worker based in the community mental health and memory service.

Admiral Nurses are mental health nurses working specifically with carers of people with Dementia.

They offer family and carers a skilled, person-centred assessment of their needs, provide information on the nature of the illness and services available, help the carer to develop or improve skills in caring, practical advice to help carers cope and emotional support which may be short term or on-going, dependent on need. This may be pre-diagnosis and/or may extend beyond bereavement.

Carers can self-refer or be referred by someone else who is concerned about them. They must have given their permission for the referral to be made via SPA.

Huntington’s Disease Nurse

NAVigo has a specialist Huntington’s Disease (HD) nurse who is based in the CMHMS.

The HD Nurse provides specialist assessment of need and risk for patients diagnosed with HD and will co-ordinate care across multi-disciplinary teams to meet the assessed need of the individual.

The Huntington’s Disease Nurse will plan, agree and delivers high quality care to the service users, their family and carers as well as any person at risk or affected by HD.
Home treatment

The purpose of the home treatment team is to be able to offer assessment and treatment in the service users’ home environment.

This service provides an alternative to admission to our inpatient suite at The Gardens or intermediate care at The Willows.

Home treatment offers this alternative to inpatient care during an acute phase of mental ill health and focuses on treating service users and supporting carers.

The approach of the team is in accordance with a person-centre philosophy.

Hospital liaison

The role of this team is to provide comprehensive mental health assessment, support and appropriate interventions to service users experiencing acute mental health problems while admitted to Diana Princess of Wales Hospital (DPoW).

A multi-disciplinary assessment will take into account the social, psychological, familial, spiritual, cultural and physical needs of the service user. The carer, family and any significant others along with the service user will be actively involved in the assessment process.

The overall objective will be to work jointly with the hospital based professionals to produce a management plan which is focussed on mental health issues. Risk assessment will be inclusive to the overall assessment process.
Intermediate care (The Willows)

The purpose of intermediate care is to offer individuals the care, assessment and treatment they may need when they are not well enough to manage at home but do not need to be admitted to hospital.

It is intended to help people at times of change, frequently following illness, accident or when a short period of intermediate care would prevent deterioration in health.

Intermediate care is provided from The Willows, and offers 24 hour care for seven people.

Konar inpatient suite (The Gardens)

Our inpatient services are for people experiencing more acute mental health problems who would benefit from a period of intensive assessment and treatment within a safe environment.

Inpatient admission is only used when other options, such as home treatment, community support, intermediate care and respite cannot meet the needs of the individual.

We assess and treat service users with dignity and respect to achieve their full potential and promote independence.

Konar Suite is located at The Gardens, a purpose-built unit designed to meet the needs of people suffering acute mental health problems.

We provide 24 hour care for up to 10 people.