ITEM No …17……..…..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 JUNE 2019**

REPORT ON: **PROPOSED MODEL OF CARE FOR OLDER PEOPLE WITH MENTAL HEALTH NEEDS – BUSINESS CASE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB29-2019**

1.0 PURPOSE OF REPORT

This report provides the business case for the proposed model of care for older people with mental health needs, including dementia, that was outlined in the Remodeling Care for Older People report presented to the Integration Joint Board in June 2017 (Article XIII of the minute of the meeting held on 27 June 2017 refers). The national strategic direction for these changes is outlined in the Scottish Government's Reshaping Care for Older People policy, Scotland's National Dementia Strategy (2017 - 2020) and The Future Model of Residential Care for Older People (2014) with the local strategic direction set through the Dundee Frailty Strategic Planning Group.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report and the remodelling which has taken place to support older people with mental health needs, including dementia, as described in Section 4.1.

2.2 Approves the business case as outlined in the report in Section 4.2 and the associated financial framework as noted in section 3.0

3.0 FINANCIAL IMPLICATIONS

The financial framework, shown below, sets out the levels of investment required to deliver the change in service delivery model. The net financial saving resulting from the service remodelling of £311k has been reflected in the IJB's Revenue Budget 2019/20 savings programme as part of the Review of Community Based Health and Social Care Services.

	£
Revised Hospital Based Model for Older People with Mental Health Needs	3,218,204
Proposed Additional Community Based Services Model	362,739
Total Costs of New Model of Care	3,580,943
Current Budgeted Cost of Hospital Based Psychiatry of Old Age	3,892,082
Net Resource Release	311,139

4.0 MAIN TEXT

4.1 Current Position

4.1.1 As outlined in the Remodeling Care for Older People report (DIJB21-2017), services face the combined challenges of increased demand for care, an ageing population, with associated co-morbidities and pressures on funding. In response to these challenges the Dundee Health and Social Care Partnership (DH&SCP) is progressing improvement work to modernise pathways of care in partnership with other care providers. These remodelled integrated pathways of care are breaking down the boundaries between hospital and non-hospital care and moving care into communities.

4.1.2 Work has been undertaken through the Frailty Strategic Planning Group and with wider engagement with a broad range of stakeholders, to develop models which will support care being delivered around the older person rather than the person moving around the care system.

4.1.3 To support people with mental health needs, including dementia, these improvements included creating Community Mental Health Teams, further developing Local Authority Care Homes to support people with complex needs relating to mental health needs, including dementia, providing Post Diagnostic Support for People with Dementia and developing a Multidisciplinary Care Home Team.

4.1.4 A Post Diagnostic Team was established to ensure support is available to everyone who is diagnosed with dementia for the first year. The model of support is based on the Alzheimer's Scotland 5 Pillar Model. Dundee has achieved national recognition for this work.

4.1.5 For people with more complex needs, Community Mental Health Teams have developed over a number of years. We currently have two multidisciplinary teams with a range of professionals including Nurses, Social Workers, Occupational Therapists, Psychologists, Psychiatrists and Pharmacists. This ensures a comprehensive assessment is provided and personalised care and support is provided to people with complex needs in their own homes.

4.1.6 Many people with mental health needs, including dementia, require a care home placement and outcomes historically were not as good as we would have wanted with high levels of hospital admission and re-admission. To address this we have developed an Integrated Care Home Team. This is a multidisciplinary team which provides a growing range of support and advice to the care homes. As a result of this assessment and support model, additional staffing support is often agreed with the care home to allow them to continue caring for people during periods of crisis, which in turn prevent unnecessary hospital admission.

4.1.7 The older people's care home market in Dundee has limited specialist dementia or functional mental health care home placements and cannot accommodate the level of specialist residential provision required. To address this we have worked to further develop specialist residential care approaches within the four residential care homes which the DH&SCP operate (Janet Brougham House/Craigie House/Menzieshill House and Turriff House). While Janet Brougham House is the only care home with a purpose build dementia specialist environment, considerable work has been undertaken in all four homes to be more dementia friendly. Staff have received training in dementia and in working better with psychological distress.

4.1.8 The development of a Psychiatry of Old Age Liaison Service in Ninewells Hospital has further improved the ability to ensure appropriate onward care journeys for people who have both physical and mental health needs.

4.2 Proposed Business Model for Older People with Mental Health Needs

4.2.1 This report outlines a proposal to further develop a range of robust community models which have been identified using Day of Care methodology and a further deep dive. The proposed model includes further development of specialist dementia care in Local Authority Care Homes, development of intermediate care, an increase in intensive Community Mental Health Team support and extended Care Home Team working hours. These will further shift the balance of care and allow people to be cared for in their own home or in a homely setting.

4.2.2 Often where a crisis arises in the community, this can result in an avoidable admission to hospital which can be prevented by providing more intensive support at home. This can be achieved by increasing the level of support provided by the Community Mental Health Teams. It is therefore proposed that an additional four Support Worker posts are created (two Support Workers in each team).

4.2.3 In addition to an expansion to the Community Mental Health Teams, it is proposed to increase the availability of the Care Home Team which will staffed to allow operation over 7 days with 8am- 8pm provision, Monday to Friday. This will further support the care homes to provide appropriate care to the residents, while also supporting the proposed changes described in 4.2.

4.2.4 Developing intermediate care can ensure there is a continuum of integrated community services for assessment, treatment, rehabilitation and support for older people who do not or no longer require to be in hospital. This does not currently exist for people with mental health needs, including dementia, and in a crisis this may result in an admission which is not needed on medical groups. It is proposed that specialist intermediate care for people with mental health needs, including dementia, be developed in Turriff House utilising one dedicated area in the care home. Families, residents and staff have been consulted and are supportive of this development. The layout of the home ensures this will not adversely impact on the care of other residents.

4.2.5 The needs of people in care homes have also become increasingly complex and a review was undertaken regarding the staffing levels needed to provide safe care. This identified pressures within the current staffing model as set against a rise in both specialist care requirements and complexity of need. The reduction of care home placements in Craigie House due to environmental factors, enabled a redistribution of staff across the four care homes. The exercise ensured that the residential services delivered by the DH&SCP continued to be delivered within the current financial framework, however it was acknowledged at this time that further work was required to reach the required safe staffing levels for future models of residential care and to provide the level of specialist support required for people with complex physical and mental health needs. This involves ensuring there is an appropriate staffing level, investment in staff development and enhancing the support provided by the care home team. It is therefore proposed to reduce the bed base across the four residential care homes from 104 places to 96, including the 8 intermediate care home placements described in paragraph 4.2.4. This will involve a reduction of 8 beds in Menzieshill House.

4.2.6 The improvement models described in Section 4.1 have resulted in a reduction in the level of demand for inpatient hospital provision. Continuing to develop innovative ways of working to provide specialist mental health care for older people can further prevent unnecessary hospital admission and allow people to remain at home or in a homelike setting. As the required bed base retracts the needs of people in hospital become increasingly complex and some investment is needed to ensure a high quality of care is maintained. This further reduction in the bed base at Kingsway Care Centre will enable the three ward model, outlined previously as part of Steps to Better Healthcare, to be implemented and it is proposed that this takes place within the current financial year.

4.3 Organisational Change Process

4.3.1 The proposed model sets out the changes across a range of services which are developed to support older people with mental health needs, including dementia. The proposals involve a redistribution of current resources which supports the further development and shifting of sources to community settings. This shift also ensures that the DH&SCP provides safe care within residential and hospital settings through the appropriate levels of staff, skilled to meet the needs of their particular population. The changes are managed within the current financial framework and will support the wider redesign programs within the partnership.

4.3.2 This redesign program is in line with the Older People's Clinical Board strategic aims. In developing the proposals any Tayside-wide impact was considered.

4.3.3 The DH&SCP is commitment to ensuring that staff are fully involved and engaged in the development of redesign programs. Transition work will be undertaken in accordance with The NHS Tayside Organisational Change policy and a Transition Group will be set up including representatives from management, HR and Staff side. There will be no requirement for redundancy however some staff may need to be redeployed. Staff working for Dundee City Council have been consulted regarding developments in line with agreed practice.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that social care demand will outstrip provision and that models of care will not be sustainable
Risk Category	Strategic
Inherent Risk Level	Very high
Mitigating Actions (including timescales and resources)	Work is underway to develop an action plan to address this. This includes looking at Community Rehab models, assessment models, and eligibility criteria
Residual Risk Level	High
Planned Risk Level	Moderate
Approval recommendation	Approve
Risk 2 Description	The current Care Home market does not provide suitable provision for those with dementia which places a risk on the model
Risk Category	Strategic
Inherent Risk Level	High
Mitigating Actions (including timescales and resources)	Work is ongoing to develop care homes within the partnership as dementia specialists.
Residual Risk Level	Moderate
Planned Risk Level	Moderate
Approval recommendation	Approve

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

9.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

David W Lynch
Chief Officer

DATE: 29 May 2019

Jenny Hill
Locality Manager