ITEM No …5…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 22nd FEBRUARY 2023**

REPORT ON: **UPDATE ON BUSINESS MODEL FOR OLDER PEOPLE WITH MENTAL HEALTH NEEDS**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB5-2023**

1.0 PURPOSE OF REPORT

1.1 This report provides an update to the Business Case for the proposed model of care for older people with mental health needs, including dementia, that was presented to the Integration Joint Board in June 2019.

2.0 RECOMMENDATIONS

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

2.1 Notes the service provided within Psychology of Old Age (POA) services and the proposed direction of this provision.

2.2 Remits the Chief Officer to provide an update report at a future meeting of the IJB.

3.0 FINANCIAL IMPLICATIONS

3.1 The developments outlined in this report will be contained within the existing delegated budget for older people with mental health needs.

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4.0 MAIN TEXT

4.1 Current Position

4.1.1 Dundee IJB approved the business case for a proposed model of care for Older People with Mental Health Needs at its meeting of the 25 June 2019 (Article XVII refers). The national strategic direction for these changes was 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. This report provides an update on those service developments.

4.1.2 **Psychiatry of Older Age Service** - The service is based within Kingsway Care Centre. The services included are two Community Mental Health Teams for Older People, with an East/West geographical split. A Post Diagnostic (Dementia) Service.

A Care Home Support Service and a Psychiatric Hospital Liaison service. There are three inpatient wards on the Kingsway Care Centre Site, and an Intermediate care unit based in one of our partnership care homes.

4.1.3 **Community Mental Health Teams for Older People** - The teams support people aged 65 and over, and those under 65 with a diagnosis of Dementia. These teams operate an integrated service with a range of disciplines including Social Workers, Mental Health Nurses, Occupational Therapists and support workers. Aligned to each team are also Psychologists, Consultant Psychiatrists, Dieticians, Physiotherapists and Pharmacists. The aim is to assess people within their own communities, and provide a range of interventions to assist in improving and treating mental health issues. The teams operate an open referral system. The nursing part of the service operates 7 days per week across office hours. The service was able to employ additional nurses and support workers in the past 2 years due to funds transfer from a ward closure, and use of Scottish Government remobilisation monies. The service works closely with inpatient services, voluntary sectors and communities. The service does not routinely have a waiting list for people. The longest wait for non-urgent referrals is typically 7-14 days, with an average of 3 people at any time.

- **The Post Diagnostic Service** is a statutory service to deliver the HEAT target of offering a minimum of one year's post diagnostic support to people and their carers who have a diagnosis of dementia. They follow the Alzheimer's Scot 5 pillar model to support people. The service was enhanced with remob monies and meets the government targets continually highest for returns. They ensure that information and advice is provided early on to help people plan for the future and reduce need for statutory and crisis supports. They have arrange of groupwork and education options and work closely with Alzheimer's Scotland and other associated voluntary organisation. Additional PDS monies from the Scottish Government were secured to enhance the PDS role and service. This has enabled the Partnership to commission from Alzheimer's Scotland a part time Support Link Worker to facilitate support groups in Dundee for people diagnosed with moderate dementia.
- The PDS team continues to work closely with Health Improvement Scotland to test a minimum data set in addition to new reporting structures with ISD. Figures for Dundee remain positive.
- The team are looking at ways to improve service and a Cognitive Stimulation Therapy (CST) group continues to be well attended and received at various locations in Dundee.
- Further group work is being explored within the team, such as utilising the Hub at Royal Victoria Hospital for PDS groups, CST and health promotion groups as part of community engagement and vision under Reshaping Non-Acute Care
- The team also supports Alzheimer's Scotland on a carer education programme.
- Ongoing national PDS meetings every 3 months which the team attends.
- The team have completed the Quality Improvement Framework and identified gaps within the service to develop.
- Following the COVID pandemic, group work sessions within the community has recommenced and we have begun community profiling to establish needs in different areas within Dundee with the aim of further community engagement and capacity building.

4.1.4 **The Care Home team** is a multidisciplinary service offering support and education to all care homes across Dundee. It is comprised of a Team Lead, Registered General Nurses (RGNs), Registered Mental Health Nurses (RMNs) and Social Work Review Officers. The team have been pivotal in ensuring oversight to care homes through the pandemic, and leading on work around Early Indicators of Concern and Large-

Scale Inquiries under ASP. This team continues to have strong links with the Urgent Home Visiting Team (formerly the Urgent Care Home Team). A band 5 Occupational Therapist post is also being progressed in the team, which will be a new post as part of ongoing multi-disciplinary development and support to care homes. There is also a Mental Health Advanced Nurse Practitioner aligned to the Care Home Team.

4.1.5 **Liaison service** - This service previously moved back to POA Dundee from the Discharge Hub in August 2020. It comprises of 2 Band 6 RMNs working alongside a Consultant Psychiatrist to deliver advice on mental health older people's issues in Acute and MFE hospitals. There is also a Mental Health ANP aligned part of the week to the service.

4.1.6 **Ward Provision** - The ward provision at Kingsway Care Centre comprises of 3 wards, each has 14 beds. Two wards are for the assessment and treatment of people with Organic (Cognitive) mental health conditions, the wards primarily have over 65s, however will accept those under 65 with a diagnosis of dementia. Due to enhanced community interventions the people being admitted to the wards are showing a higher level of need, and tend to have a longer admission. The third ward is for people aged over 65 with Functional Mental Health Needs. There is a full range of disciplines employed in the service to support. The wards tend to run at 95-100% occupancy. People are followed through their inpatient journey from the social work and nursing community team attached to the POA service.

4.1.7 **Intermediate Care Unit** - The Intermediate Care Unit at Turriff House opened in November 2021 and has 8 beds. This was funded through the closure of ward 2 at Kingsway Care Centre to allow appropriate care to be carried out in a more appropriate community setting for older people with mental health needs who do not require a hospital admission, or no longer require to be in hospital. Our Care Home team support the Unit. This has provided a more individualised approach to supporting this population.

4.1.8 **Advanced Nurse Practitioners-Mental Health Advanced Nurse Practitioners (CMHT)**

This year we interviewed for two Mental Health ANP's which would cover East and West in recognition of the growing need to support people at home with more complex needs, establish greater links with primary care and also assist our Consultant Psychiatrist's in their role. We were successful in recruiting two trainee Mental Health ANP's from within the service who have commenced their Advanced Practice MSc at Dundee University in September this year.

4.19 Future considerations include development of band roles in both ward and community settings to support nursing role and provide a promotion pathway for Band 3 staff. We plan to review the bed model in line with the Reshaping Non- Acute Care Work. We will review the criteria and use of our Intermediate Care Model. We plan to enhance our links with Primary care and further develop our ANP model.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

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

8.0 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	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None

DATE: 27 January 2023

Vicky Irons
Chief Officer

Jenny Hill, Head of Health and Community Care
Allison Lee, Associate Locality Manager, Health and Community Care

PSYCHIATRY OF OLDER AGE SERVICE,DUNDEE

SERVICE OUTLINE AND UPDATE FROM IJB REPORT 2019

COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE

- The service is for people over 65 with a mental health need, or under 65 with a diagnosis of dementia
- There is an East and a West team, both working in the same model over a geographical split.. Both have a range of disciplines, including Social Workers, Mental Health Nurses, Occupational Therapists and Support Workers.
- The service also employ Psychologists, Pharmacists and other AHPs including dieticians.
- Staffing establishments have been increased in the last 2 years with increased nursing and support worker posts

COMMUNITY MENTAL HEALTH TEAMS, OLDER PEOPLE (CMHTOP)

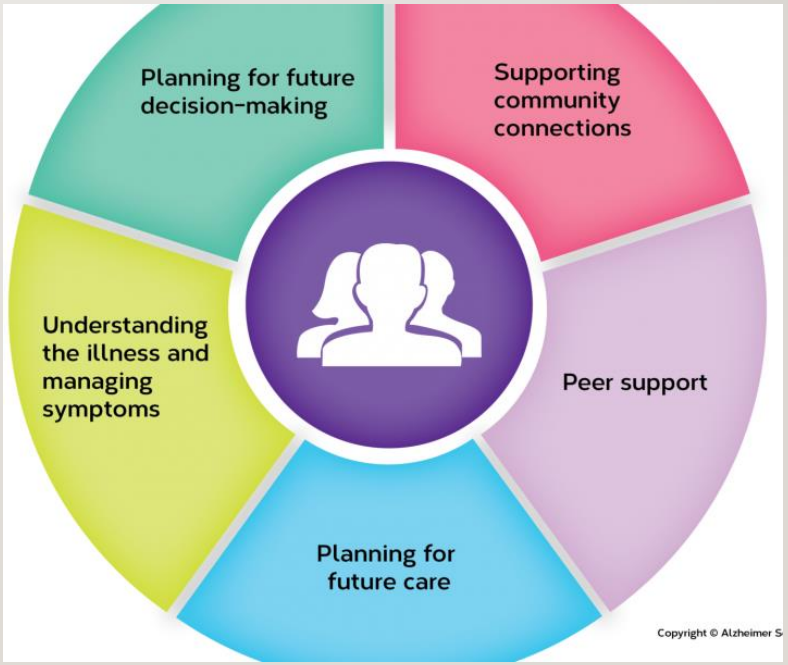
- This is in line with supporting people to lie in a community setting for as long as possible with increased interventions
- The teams operate a Lithium and anticholinesterase support clinic
- Links established to GP cluster meetings
- There are 2 trainee Advanced Nurse Practitioners now in post, this is in line with national models recognising the growing needs of supporting people at home with more complex needs, establishing better links with primary care and supporting consultant Psychiatrists in their role.

COMMUNITY MENTAL HEALTH TEAMS

- The teams have an open referral system
- Typically there is no waiting list. The average wait when there is one is 7-14 days, with approximately 3 people.
- There is a duty system in place, nursing service is 7 days per week
- Strong links with the wards at Kingsway Care Centre and Intermediate Care to support whole journey

POST DIAGNOSTIC SERVICE (PDS)(DEMENTIA)

- Service introduced to fulfil the Scottish Government HEAT target of offering everyone with a diagnosis of dementia a minimum of one year's post diagnostic support, following the Alzheimer's Scotland 5 pillar model



PDS SERVICE

- Additional Scottish Government monies were used to enhance the PDS role and service in 2021/22
- The service is benchmarked across Scotland through Health Improvement Scotland ,and consistently scores high in data sets.
- Links with Alzheimer's Scotland in Dundee
- Cognitive Stimulation Groups continue to be offered
- Support groups for people with moderate dementia and carer's groups supported

PDS

- Following the COVID pandemic, group work sessions within the community has recommenced and we have begun community profiling to establish needs in different areas within Dundee with the aim of further community engagement and capacity building.

CARE HOME TEAM

- Integrated Service comprising of Registered General Nurses, Registered Mental Health Nurses and Social Work review Officers
- To introduce an occupational Therapy post this year
- Provides direct support and education to care homes to meet the increasingly complex needs of our care home residents
- Pivotal in the Enhanced Oversight role to care homes during the last 3 years
- Emphasis on supporting person in care home, and reducing unnecessary hospital admissions

CARE HOME TEAM

- Education programme underway, open to all care homes
- Link to Care Home Provider's Forum
- Role in quality assurance, and any Large Scale Inquiry Procedures
- Close links maintained with the Urgent Home Visiting Service

HOSPITAL PSYCHIATRIC LIAISON SERVICE

- This service is under POA services, but based within the discharge hub in Ninewells and Royal Victoria Hospital
- Comprises of Consultant Psychiatrist, Trainee Psychiatrists and Mental Health Nurses
- Part time Advanced Nurse Practitioner introduced in 2021
- Close links with the CMHTOPs
- Provides mental health advice and support on individual patient cases
- Refers into the CMHTOPs as required

INPATIENT SERVICES KINGSWAY CARE CENTRE

- Three inpatient wards on the Kingsway Site. Wards 1&3 have 14 beds and are for people with a diagnosis of Dementia who require inpatient assessment and treatment.
- Complex needs have increased within inpatient environments as community services are supporting people at home longer
- Increase in younger more physically able patients
- Close links with community and care home teams
- Occupational Therapy ,Psychology, pharmacy and activities support worker input

INPATIENT SERVICES CONT…

- Ward 4- has 14 beds and is for older people with Functional Mental Health issues (any other mental health issue not related to Dementia/Cognitive impairment
- Close links with community teams
- High level of occupational therapy input
- Close links made with spiritual care/carer's centre and advocacy services
- Links closely to Intermediate care unit to facilitate timely safe discharge where required
- In all wards there is a current difficulty of recruiting mental health nurse into inpatient settings, and there are currently 9 RMN vacancies. This is a national issue.

INTERMEDIATE CARE UNIT

- The Intermediate Care Unit is based within a wing in Turriff House Care Home which is a partnership home. Opened as part of ward realignment from 2019
- There are 8 beds in the unit
- Supported by the enhanced Care Home Team and CMHTOPs
- Provides both ‘step up’ and ‘step-down care’ to prevent unnecessary hospital admission and facilitate timely safe discharge where appropriate
- Initial review on use has been positive, review of criteria to take place February 2023

FUTURE CONSIDERATIONS

- Enhanced links with Primary Care
- Further exploration of ANP/specialist nurse roles
- Currently one nurse undergoing Cognitive Behavioral Therapy qualification
- Review of Functional Standards for Older People
- Review data available in service
- Review patient/carer feedback
- Transition work to be reviewed across services

FUTURE CONSIDERATIONS

- Review inpatient needs and pathways further
- Explore role of band 4 role in POA settings
- Closer links with CMHT Social Care Teams
- Further consider recruitment and retention issues
- Involvement in ARBD pathway work
- Consider how more complex and challenging needs in the service are met going forward