**AGENDA ITEM NO 8**

**REPORT NO IJB 22/19**

**ANGUS HEALTH AND SOCIAL CARE**

**INTEGRATION JOINT BOARD – 24 APRIL 2019**

# DEVELOPMENT OF ANGUS CARE MODEL (PSYCHIATRY OF OLD AGE) REVIEW AND REDESIGN OF DISCHARGE MODEL

**REPORT BY VICKY IRONS, CHIEF OFFICER**


## ABSTRACT

The purpose of this report is to update the Integration Joint Board (IJB) regarding the planned review and redesign of the discharge model in Psychiatry of Old Age, as part of the Angus Care Model.


## 1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) note the content of this report.

(ii) note the further exploration and development regarding the required analysis underway.

(iii) recognise the challenges associated with proposed innovative approach

(iv) request a further update regarding progress at future meeting (August 2019).

## 2. BACKGROUND

2.1 The Angus Care Model includes a review and redesign of inpatient facilities across Angus. Within Psychiatry of Old Age this has involved a gradual reduction in Inpatient provision in response to requirements, changes and challenges in patient presentation and the improved community support which enables more people with dementia to remain at home for longer.

In 2014, there were 42-45 available beds. Based on previous occupancy levels/demand this has been reduced to 22 dementia inpatient acute assessment and treatment beds (Appendix1).

This plan is to outline an alternative and innovative intermediate approach to care provision for people with dementia. At present, once an individual's acute assessment and treatment is completed, often there remains a level where specialist nursing care is still required (stress and distress). This currently cannot be provided in Nursing/Care Homes, and does not require an acute inpatient assessment bed. An alternative model is required to improve the discharge pathway.

The length of stay varies for this patient group, this ranges from 8-12 weeks to 3+ years. The latter is primarily due to the fact that, at present, Care Home provision cannot meet the needs

of this patient group. This results in lengthy inpatient stays which could be avoided if an alternative model is developed and the discharge pathway improved.

## 3. CURRENT POSITION

3.1 There are a number of patients where assessment and treatment has been completed however, they are unable to be discharged from Willow or Prosen Units as their levels of stress and distress are such that the Nursing/Care Homes within Angus are unable to meet their requirements.

This results in patients remaining in an acute inpatient bed when they no longer require this. This has a direct impact on those who do require an acute clinical setting, as these two distinct groups of patients' needs cannot be appropriately and safely met alongside each other.

There is a need for specialist intermediate care for these individuals until such a time that their stress and distress/presentation/needs can be met in mainstream Nursing/Care Home. At present this means that the typical length of stay in a dementia inpatient bed ranges from 3 months to 3+ years.

## 4. PROPOSALS

4.1 The proposal is to explore alternative innovative approaches to care provision for these individuals. A Project Team has been established.

This will require us to consider/explore/analyse the following:

- Suitable environments/service providers interested/able to provide the level of care required
- The cost of the above versus current cost of inpatient care in the context of the IJB financial position
- Number of beds required in specialist intermediate care
- Number of inpatient assessment beds required
- Increasing specialist support to care providers i.e. augmenting current Dementia Liaison Team and costs associated including an Out of Hours resource
- Identify workforce issues
- How will this improve outcomes and the patient /family journey
- How transitions will be managed safely and appropriately i.e. from hospital to alternative models and from these models to mainstream nursing care
- Contracting and legal processes
- Governance arrangements and standards

## 5. FINANCIAL IMPLICATIONS

5.1 The financial implications of any proposed changes are still being assessed. The resources currently under review include those associated with the Willow Unit (Stracathro) and Prosen Unit (Whitehills, Forfar). This includes nursing, medical and other health staff alongside supplies and property costs. While some costs may re-emerge in future models, the nursing resource 47.67 WTE with an annual cost £1,885,146.

The Project Team will develop the service specification, patient to staff ratios, levels of care expected, skill mix of staff and number of places required in future models and confirm the weekly cost of care. We also anticipate that alternative models of care will require support from Psychiatry Services in the form of Dementia Liaison.

As costs are identified for the delivery of an alternative service mode, we will be able to compare this with our current costs and provide a more detailed report. This will take account of financial constraints, service standards and address the service challenges.

The IJB's Strategic Financial Plan has indicated an expected financial benefit from this development, such that it will contribute to assisting the IJB manage its overall service delivery within available financial resources.

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List of Appendices:
Appendix 1 – Current Dementia in Patient Provision

**Appendix 1**

**Current Inpatient Dementia Provision**

1. **Willow Unit, Susan Carnegie Centre** (12 beds – admission available 24/7)

   Single ensuite rooms in a specially designed unit for people with dementia on the Stracathro site.

   This unit benefits from sharing resources within Psychiatry of Old Age with the 13 bedded Functional Acute Assessment and Treatment Unit (Rowan) as they are situated next door.

   - Emergency nursing (psychiatry) response as required (Prevention and Management of Violence & Aggression)
   - Managing periods of high intensity/activity/acuity
   - Shared medical cover including duty doctor availability Out Of Hours Services, weekends and public holidays
   - Support from community based services e.g. Dementia Liaison Team
   - Onsite consultant input – daily

   This unit also benefits from joint working and support from Medicine for the Elderly, medical and nursing staff. This will be further improved when the Stroke Rehabilitation Unit and the Assessment and Rehabilitation Ward move into the vacated space of the Mulberry Ward in the Susan Carnegie Centre.

   Where it is safe to do so, POA will manage the often complex and co-morbid physical health issues that individuals experience or are a direct consequence of their dementia. This supports evidence based practice of minimising or avoiding where possible, multiple moves of environment for people with dementia.

2. **Prosen Unit, Whitehills Health & Community Care Centre** (10 beds – admission available on a planned basis Monday – Friday in hours, providing medical staff are available).

   Single ensuite rooms in a specially designed unit for people with dementia on the Whitehills site. The Inpatient Consultant provides psychiatric medical input into Prosen Unit on a weekly or as required basis.

   Day to day medical/physical health care is currently provided by the Psychiatric Trainees and this situation, due to vacancies in these posts, is expected to continue. Recently this cover has been inconsistent and has required colleagues in Medicine for the Elderly to support. Out of Hours medical cover is provided by NHS 24.

   This Unit benefits from well-developed working relationships with staff in Clova Unit staff, in terms of managing ongoing physical nursing needs and end of life care.