Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Appendix-2019-2

Project Name	Mental Health - Community Outreach Team (COT)		
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Guidance on Project Brief

The purpose of this form is to give an outline on the key aspects of the proposal to the Integrated Care Fund 2015-18

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

1 Outline project description

Please summarise the project in no more than 250 words

Mental health conditions are common among the elderly. NICE(2013) estimates that around 2 in 5 older people living in care homes have depression, and an estimated 4 out of 5 people in care hoses live with dementia or sever memory problems. Despite the high prevalence of these conditions, NICE advises that these mental health issues are often not recognised, diagnosed or treated. Scottish Borders has the highest proportion of people with dementia in care homes (69%)

The Community Outreach Team (COT) would specialise in meeting the needs of older adults with mental illness and dementia, working within care homes and community hospitals across the Scottish Borders and give advice and guidance to carers.

It would aim to provide proactive and responsive support to care homes and community hospitals to help them better meet the needs of their residents and inpatients with mental illness and dementia. Interventions would include carrying out mental health and memory assessments for residents, advising on the best type of treatment for the individual and advising staff on managing the symptoms and behaviours of people with mental illness, dementia and memory problems.

The service would also provide training and education for care home and community hospital staff to provide them with the skills and knowledge to provide effective care for residents and inpatients with mental illness and memory problems. Working with The Carer's Centre, they will offer advice and guidance to support carers in their home.

The project would build on the current set up, skills and support offered by the current Liaison nursing staff and would work closely with the existing Community Mental Health Teams, Primary Care and Acute Medical Services and The Carer's Centre.

2.	**Project's strategic fit** (see guidance notes section 2) *Which local strategic objectives and Scottish Government ICF principles will it meet?*

Borders IJB Strategic Plan objectives

1. Improve the health of the population and reduce the number of hospital admission
2. Improve the flow of patients into, through and out of hospital
3. Improve the capacity for people to better manage their own conditions and support those who care for them

This project would meet all three of the IJB strategic objectives listed above.

Scottish Government ICF principles

1. Co-production
2. Sustainability
3. Locality
4. Leverage
5. Involvement
6. Outcomes

3	**Project Aims/ Achievements** *Please give a high level description of what will success look like?*

How to access the service

- Referrals to the service can be made by GPs, or senior care home/community hospital staff.
- All referrals sent to a COT referral inbox (email or sky gateway)
- Referrals are screened on the same day and the referrer is informed of the outcome. If the referral is appropriate COT will contact the care home or community hospital by phone to arrange an appointment
- If the referral is inappropriate contact will be made and advice given on how to proceed
- The service will also be open to more informal contact and discussion about possible referrals
- The COT will then assess the individual looking at:
    - Advice and treatment regarding specific mental health issues
    - A person-centred care plan that will ideally involve the individual, family, carers and staff in maximising quality of life, physical health and comfort
    - Offer advice and training where necessary to staff to support them in meeting an individual's care needs and maintain them in their current care setting
- The service would also work with The Carer's Centre to develop training and advice for carers.

Aims:

- To provide prompt access to a specialist mental health service for patients in care homes & community hospitals, who have or are suspected of having a mental health need
    - Emergency referrals will be responded to on the same day

    - Urgent referrals will be responded to within 2 working days
    - Routine referrals will be responded to within 7 days
- To promote good practice and develop personalised care plans to maximise an individual's quality of life, in order to maintain them within their current care setting
- To promote the use and consideration of anticipatory care planning for individuals
- To provide a bio-psychosocial model of care in which both non-pharmacological approaches and medication are considered. This may include:
    - Modelling and implementing Stress and Distress techniques – the team will work with an evidence based, psychological model for identifying and treating unmet needs in dementia patients called the Newcastle Clinical Model. This model is used in a number of projects throughout Scotland with the aim of supporting care homes maintain residents within their own environment. It aims to reduce admissions to hospital by supporting staff and carers to develop a better understanding of dementia as well as building a range of skills to enable staff and carers to work with residents in a way that limits stress and distress in those individuals with a diagnosis of dementia
- Signposting to other services or organisations for further support e.g Palliative care
- Assessment and management of risks to an individual, staff or other residents
- To consider the involvement of other professional groups following the assessment of an individual's needs
    - Physiotherapy
    - Occupational Therapy
    - Consultant psychiatrist
    - Psychology
- The service will provide training and education to care home, hospital staff and carers based on best practice and/or individual needs
- To work with an individual, carers and staff to facilitate a successful transition into a care home environment from hospital and home

Expected outcomes:

- Improved detection, assessment and treatment of common mental health conditions
    - In particular to increase dementia diagnosis rates within the care home population with the aim of finally reaching the Scottish Government's national Local Delivery Plan (LDP) standard for dementia diagnosis in The Borders
- Reduction in antipsychotic prescriptions
- Reducing hospital admissions, facilitating earlier discharge (reduction in delayed discharge days) and the need for care home moves
- Raise awareness of mental health in care homes and community hospitals
- Increased confidence and skills in caring for older people with mental health difficulties and dementia in care home and community hospital staff

	4 What areas of the Borders will the project cover *Will the project affect the whole of the Borders or a specific locality, if so please state?*

The project aims to work across the entirety of the Borders but initially it will begin roll out in the South and East (Berwickshire across to Jedburgh, Hawick and Newcastleton) An increase in the areas covered will continue as the staffing has been recruited to and feedback from care homes/ community hospitals in respect of what is or isn't working well has been considered.

It will cover all 92 community hospital beds and provide a service to the 695 care home beds within Scottish Borders. Therefore, it will provide a service to in excess of 787 individuals.

The project would anticipate having capacity to assess, plan treatment and intervene (where necessary) for 60-70 individuals per week, with capacity for support workers to work with around 40 individuals and staff teams implementing care plans, etc. In addition a rolling programme of training and implementation of stress and distress techniques will be undertaken with each care home and community hospital throughout the year. The programme will also support The Carers Centre in offering training and advice for carers.

The project will employ QI methodology in order to ensure its practice and service delivery is effective and of good quality

5	**Which care groups will the project affect?** (see guidance notes section 4)

Adults of any age within 24 hour care setting who have a dementia diagnosis or adults over the age 70 with a suspected mental illness eg psychosis or depression.

6	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

While this funding request is for 2 years the anticipation is that this becomes a permanent project and that costs saved by the reduction of inpatient beds and a reduction in occupied bed days (compared to the current base line) will fund the costs of the service.

7	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

The funding will be spent on the following areas

<u>Staff</u>
0.2 Team Manager time Provided through current MHOAS management time
2 x sessions of medical time per week (£24,394)
1 x WTE clinical psychologist (8a - £58,205)
0.5 x Band 6 Occupational therapist(£19,966)
2 x Band 6 nurses These posts currently exist and will be part of the project (£46,464 per WTE)
4 x Band 5 nurses 2 x Band 5 post currently available to recruit to. (£31,746 per WTE)
4 x Band 3 nurses 2.26 WTE Band 3 Posts currently available to recruit to (£24,423 per WTE)

<u>Travel</u>
Travel costs for all of the above average of approx £200 per month per employee (£24,000 per year)

Training
Training in the Newcastle model for the qualified members of staff in train the trainer. (£2,000) (one off)

Hardware
Laptops and telephones approximate total (£11,000)(one off)

Total recurring costs £444,169
Total existing resources to be put into the project £211,616
Total additional funding required £232,553 (Plus additional one off costs of £13,000)

8 What would happen if ICF didn't invest in the project?

The current service will continue. At present there are 2 nurses who cover the whole of the Borders visiting care homes and community hospitals. The current service has no resilience and there is no back up or cover for holidays, sickness absence etc there is little ability to respond to more than one crisis at a time unless in the same or nearby location.

The current service is as responsive as it can be but generally picks up cases at a late stage in the journey by which time staff working with the individual find it difficult to remain positive or see any potential for a positive outcome for them or the resident. It has been difficult to build relationships or build on previous training/educational opportunities e.g. stress and distress because of the now stretched services due to crisis admissions from community hospitals and care homes and continued delayed discharges.

Care provided to people with dementia may not readily meet their needs without advice and guidance from a service with expertise in the care and treatment of older adults with mental health difficulties. As a result care homes may feel unable to meet the needs of individuals, and struggle to provide care at the standard they would wish to do so.

It is anticipated that if there are fewer in-patient beds within Scottish Borders care homes and community hospitals will need to be supported to be able to continue to care for individuals as their illness progresses. Without this type of service if would not be unrealistic to suggest that admission to acute care in times of crisis is more likely. Care home's ability to tolerate challenges may become depleted if they are not supported to manage in times of difficult and responded to in times of crisis. The proposed service will aim to support care homes and community hospitals to avoid admission to acute sites wherever possible.

By working with community based colleagues the proposed project will develop an ethos and culture which enables care providers feel supported and responded to when necessary and ensure there is easy access to expert advice, guidance, support and intervention as required. Alongside this practice individuals will be supported to transition into care home placements, reducing the number of failed admissions and helping care homes to feel more able to meet the needs of individuals expressing stressed and distressed behaviours. The anticipated outcome is this will bring about earlier discharge from older adult mental health wards, community hospitals and community based individuals. The relationship and interaction between the project and the community mental health team will facilitate planned and emergency transitions into care home placements from home, thus avoiding potential hospital admission in crisis.

The result being a reduction in bed days lost due to delayed discharge and reduced avoidable admissions. While the figures below focus only on older adult mental health inpatient beds it is anticipated that the service will have a positive impact on the whole of the hospital inpatient system, given the demographics of the Scottish Borders and that Dementia is the primary cause of death in females over 70 years of age area and the second highest cause of death (behind heart disease) in males of 70 years locally.

9	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

The project will release resources by supporting care homes to develop and sustain knowledge and skills to work with people with dementia and other mental illnesses throughout their journey; We anticipate shifting beliefs and culture to enable managers and charge nurses to be confident about providing care to this group of people. The potential impact on hospital admission and early discharge is significant. The project would help to facilitate the recommendations within the "Transforming Specialist Dementia Hospital Care" report to be implemented if carried out in conjunction with commissioning of services.

Over the past year there has been a rise in the number of bed days lost to care home waits across all inpatient facilities within NHS Borders. In 2017 – 166 individuals were delayed in hospital waiting for care home facilities, occupying 4429 days, the average length of delay per person in 2017 was 26.68 . In 2018, (to November) the number of individual delays dropped to 133 with 4227 bed days lost an average of 31.78 days delayed per person. The numbers for individuals awaiting specialist dementia beds also fell from 22 in 2017 to 20 in 2018 (although this figure does not include December 2018) however, the average length bed days delayed rose from 42.8 days to 54.9 days in 2017 and 2018 respectively.

The bed days lost within the older adult mental health wards is considerably higher. In 2017 there were 13 delays for care homes with 881 bed days lost (average 67.7 days per person) in 2018 while the number of delays remained the same (December figures not included) at 13 the bed days lost rose to 910 an average of 70 bed days lost per person. The team would anticipate having a significant impact on these figures. The average cost of older adult inpatient beds within NHS Borders is £473.85 per day, delays costing NHS Borders £417,461.85 and £431,203.50 in 2017 and 2018 respectively, in two wards alone which relates to only 13 patients.

The service would anticipate a positive impact on reducing length of stay across all wards across the acute site, mental health and community hospitals. Investment in the service would ultimately save funds from a whole system perspective but would also result in achieving the aims of the fund. The figures below show the potential savings that could be made by reducing admissions and lost bed days across NHS Borders :

Across all inpatient areas

- In 2017 there were 165 individuals whose discharge was delayed waiting for care home placements totalling - 4425 bed days lost.
- In 2018 (to November) there were 132 individuals whose discharge was delayed waiting for a care – totalling 4215 bed days lost.

The average length of delay rose from 26.82 bed days lost to 31.93 in 2017 and 2018 (to November).

SAVINGS

Reducing the bed days lost (across all inpatient beds)

- By 10% would produce a saving of **£201,518.93**,
- By 20% would result in savings of **£399,455.55** *based on Jan to Nov 2018 figures

It is not possible to determine the savings produced by admission avoidance accurately. We are representing this saving by removal of all bed days lost *(as above).

The project will aim to avoid 10% of admission at a saving of a further £199,716.40.

When admission avoidance is added to reduction in lost bed days potential savings are:

- **£401,235.33** for a 10% reduction of lost bed days
- **£599,171.95** for a 20% reduction to bed days lost.

10	**How would you identify/ recruit staff to support the project?**

Section 7 above identifies the staffing proposal. The following posts are currently vacant or occupied by members of the current team and would transfer to the new service they are

2 WTE Band 6
2 WTE Band 5
2.26 WTE Band 3

We would need to recruit to the remainder of posts on a temporary basis.

11	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080