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SPECIALIST RESIDENTIAL CARE FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS

1 REASON FOR REPORT

1.1 This report sets out for Elected Members a purchasing strategy to increase the number of specialist mental health places in care homes, sometimes referred to as EMI (Elderly Mentally Ill) places.

1.2 The emphasis of the report is specialist care for people with dementia, but the purchasing strategy is also relevant for older people with other psychiatric illnesses.

2 BACKGROUND

2.1 Real progress has been made in Dumfries and Galloway over the last five years around services for older people with mental health problems, and the region now has much to be proud of in this service area.

2.2 The direction of service development is set out in a key document "Older People with Mental Health Problems – A Framework for Services in Dumfries and Galloway", a second draft of which was produced in August 2002. This draft has been circulated widely and was the basis of a very well attended consultation day on 13 September 2002. The aim is that draft 3 will be produced in 2003 and will be updated on a yearly basis thereafter.

2.3 The areas where real and successful service development have taken place are:

- the Early Diagnosis and Assessment Service, with an additional social care contribution provided by "Memory Clinic Support Workers" employed by Alzheimer Scotland;
- the joint health and social care Community Mental Health Teams (Older People);
- day services both for people with dementia and people with other psychiatric illnesses provided by the independent sector.

2.4 At the same time Dumfries and Galloway also has areas which need considerable development if appropriate services are to be available along the whole service continuum. Three main areas are:

- specialist domiciliary care,
- specialist respite care,
- specialist residential care.

2.5 It is this last area that is particularly pressing and which is the subject of this report as there is a need to expand specialist residential care capacity in response to the demand for such services as older peoples' needs become more complex.

2.6 Over the last twelve months individual Elected Members and Area Committees have shown particular interest in specialist dementia care, and expressed real concerns about the lack of places particularly in Galloway. Specifically, the Framework document referred to in 2.2 above was formally agendered at the Mid Galloway Area Committee in April 2002 and the Stewartry Area Committee in May 2002. This report, therefore, also aims to update Members on current progress.

3 ALTERNATIVE CARE SERVICES

3.1 It is sometimes just not practicable for people with severe dementia to remain in their own home and we estimate there are likely to be some 600 to 700 people in this position in Dumfries and Galloway (out of a likely 2000 people with dementia). Alternative care services may include:

- health care,
- residential care,
- specialist housing.

3.2 Since the mid 1990s the Scottish Executive has offered explicit guidance that people should only remain in health beds if they require consultant led care. Consequently (mainly through the 1996-2000 Resettlement Programme) the number of health care beds for older people with mental health problems has been significantly reduced from 176 beds to the current 64. For the future it is proposed that these are designated "Intermediate Health Care", meaning that they do not offer continuing or long term care, but care for people at a mid stage of the illness which can be particularly challenging for the patient and their carers. The length of stay in Intermediate Health Care will vary significantly from person to person but it will normally be in the range of 6 months to 2 years.

3.3 However, if this strategy for health care beds is to be sustained, it is essential that good quality residential care places are available throughout the region. It is estimated that we need a minimum of 250 specialist dementia places. Currently we have around 80 places, and all are in either Annandale and Eskdale or Nithsdale localities.

3.4 An issue for the future is the consideration of very specialist housing for people with dementia. Currently this model of care is being actively considered locally for younger people (people under 65) with dementia and learning from that may well inform service developments for older people.

4 PURCHASING SPECIALIST RESIDENTIAL AND NURSING CARE IN 2002 - 2003 AND 2003 - 2004

4.1 The current purchasing policy is set out in the Framework referred to in 2.2 and additional documentation, and is based on the weekly rates ratified by Social Services Committee in June 2002. These were:

- £371 for specialist residential care (£46 above the residential care rate of £325);
- £397 for specialist nursing care (£20 above the nursing care rate of £377).

The aim is, not that Home Owners build additional capacity, but that they consider internal conversion to create small dementia or specialist units within existing Homes and attract the higher rates for these units.

4.2 During 2002, despite extensive discussions with Care Home Owners based on these rates, no new dementia units have been created. There are probably two main reasons for this. First Care Home Owners needed to be persuaded that the Council has a clear purchasing strategy and that specialist dementia care would be purchased by Care Managers on behalf of service users. There is now a real sense that a significant number of Care Home Owners have appreciated the recent documentation and consultation, and are persuaded of the need for change. They also acknowledge that currently they already have significant numbers of people with dementia within their Homes.

4.3 However, secondly, they remain concerned that the additional price on offer does not meet the additional specification required, and that a conversion to a dementia unit may still not be financially viable in the longer term.

5 THE CONTEXT FOR FUTURE PURCHASING

5.1 Recent consultations and negotiations with Care Home providers have been taken forward by a team of 3 staff:

- the Joint Commissioning Manager (Mental Health)
- the EMI Care Manager/Development Worker for the east of the region (a post funded by Resource Transfer and created from the Resettlement Programme);
- the EMI Care Manager/Development Worker for the west of the region.

The latter is a recent post funded in 2002-03 through the Delayed Discharge Action Plan and the lack of specialist dementia places has been identified as a significant cause of delayed discharge.

5.2 Through this consultation process the team has developed a simple but clear purchasing specification. This does not seek to set up unrealistic expectations but it does have requirements significantly above those for non specialist beds. In summary they are:

- domestic scale units of 8 to 12 people;
- clear and effective management with knowledge of and skill in dementia care;
- higher staffing ratios and a workforce with training and skill in dementia care;
- safety features including access to a secure garden area.

5.3 The team believes that the potential now exists to achieve the target of a minimum of 250 places within two years as long as an effective purchasing strategy is adopted.

5.4 The proposed purchasing strategy is set out in full in **Appendix 1**. It has 3 main elements:

- the service specification (**Appendix 2**);
- a specialist mental health rate of £60 above the residential rate, and an enhanced rate of £30 above the residential rate;
- the offer of an initial, limited block purchase, of up to 18 months available to December 2004.

The specialist mental health rate and the enhanced rate would only be available to units which meet the specification in full.

6 FINANCIAL IMPLICATIONS

6.1 The increased costs arising from the purchasing strategy are estimated at £560,000 per year.

6.2 It is proposed that the NHS Dumfries and Galloway will make a contribution towards this cost through the Delayed Discharge Action Plan. Within this Action Plan £130,000 has already been identified to meet the increased costs of specialist EMI placements.

6.3 To manage the increased expenditure for Social Services, it is proposed that the increase in specialist places is phased in over 24 months between April 2003 and March 2005. It is, therefore, estimated that the additional £430,000 to be met by the Social Services, Older Peoples budget would be required as follows:

- year one (2003/04) target of 105 additional places, part year effect £100,000;
- year two (2004/05) target of 180 additional places, part year effect £220,000;
- year three (2005/06) target of 180 additional places, full year effect £430,000.

The £100k required in 2003/04 will be funded from additional monies available for older people's services.

6.4 The targets for additional places are proposed as follows (although these are intended as a guide rather than an inflexible figure):

	Year 1	**Year 2**
Annandale & Eskdale	20	35
Nithsdale	20	45
Stewartry	30	50
Wigtownshire	35	50
TOTAL	105	180

6.5 It is further proposed that the strategy is reviewed in late 2003 in order to consider:

- the progress made towards its implementation;
- the full extent to which service users need has been met;
- the financial implications for 2004/05 and beyond.

6.6 This purchasing strategy represents a significant investment in EMI places. However, only through such a strategy and investment is the lack of specialist care for some of the most vulnerable people in our society likely to be successfully resolved.

7 RECOMMENDATIONS

7.1 Members are asked to agree the proposed purchasing strategy for EMI places in care homes to be implemented in 2003/04 and 2004/05.

7.2 A further report is presented to Members in January 2004 setting out the financial implications for 2004/05.

Corporate Plan Links -	Inclusion	Specialist care for highly vulnerable people with severe dementia.
	Safety & Health	Specialist care contributes to improved safety and health of these highly vulnerable people.
	Life Long Learning	

Financial Implications -	Immediate	£100k (2003/04) funded from additional community care monies. £130k from Delayed Discharge Action Plan.
	Long Term	The proposed framework estimates costs of £560k of which £430k (full year effect from 2005/06) will be met by Social Services. However, no decision will be made on full implementation of the proposed strategy until after a review in late 2003.

Staffing -	Immediate	N/A
	Long Term	N/A

Consultation -	Service Users	Consultation Day in September 2002.
	Finance	Discussion with Finance Officer and Operations Manager within Social Services and Financial Services
	Chief Executive	
	Corporate Services	
	Other Council Departments	
	Key Partners	Extensive consultation with NHS Dumfries and Galloway and Independent Sector Partners.

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Background Papers:
(as required under the Access to Information Act)

Older People with Mental Health Problems – A Framework for Services in Dumfries and Galloway

APPENDIX /-

Appendix 1 **Proposed Purchasing Strategy**
Appendix 2 **Specification for EMI Units – November 2002**

Ref: *D*-cr-SNRC-OPMHP
Date: 24 March 2003
Committee Date: 8 April 2003

APPENDIX 1

PROPOSED PURCHASING STRATEGY

SPECIALIST NURSING AND RESIDENTIAL CARE FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS – MARCH 2003

1. AIM

1.1 The aim of this purchasing strategy is to increase significantly the number of specialist places for older people with mental health problems (the abbreviation EMI is used in this document) across Dumfries and Galloway within the next twelve to twenty four months.

1.2 We intend that this increase be achieved by conversion of beds within existing Homes rather than an overall increase in capacity.

2. OBJECTIVES

2.1 The obvious objective is good quality care that appropriately meets the needs of people with severe dementia. For some people (but by no means all), especially people with severe dementia, we believe that appropriate care means provision within a specialist unit where the staff team are skilled and experienced in dementia care.

2.2 A second objective is appropriate use of hospital beds. Dumfries and Galloway NHS has significantly reduced its EMI beds in recent years and we intend that the remaining health care beds will be used either for:

- assessment and initial treatment (Cree West and Glencairn Wards), or for
- intermediate, consultant led care (Innistaigh, Allanbank, Treastaigh).

We do not intend that there will be any long term or continuing care NHS EMI beds. To achieve this objective, and to avoid delayed discharge, there will need to be in place specialist units which:

- can meet the needs of people with severe dementia who may be challenging or frail;
- command the confidence of carers, relatives, and friends.

2.3 A third objective is to work well in partnership with independent sector providers. We hope this will be achieved:

- by publishing a clear purchasing policy;
- by agreeing a specification that meets the objective of good quality, appropriate care, but is not unnecessarily onerous on providers;
- by offering a realistic price per bed.

3. THE SPECIFICATION

3.1 Our specification for specialist dementia units is attached. We envisage units that will meet two differing needs:

- the needs of people who may be physically fit, but agitated, restless and perhaps challenging,
- the needs of people towards the end stage of dementia who are physically frail.

We hope that larger Homes will include separate specialist units that meet each level of need. We realise that smaller homes (30 beds or less) are unlikely to be in a position to do so. The next paragraph is intended for such Homes.

3.2 Where a Home has one specialist unit for people who are more physically active, we understand that when a resident becomes very frail they may (essentially for their own safety) need to move from the specialist unit. To ensure good continuity of care, we want that resident to remain in the Home they know and will, therefore, offer an enhanced rate for the resident when they move into the non-specialist part of the Home to ensure the continuing needs of that person are met (as set out in their individual Care Plan).

3.3 We do not envisage that a Home will only have a single specialist unit for people with dementia who have become physically frail. Such a Home would be unlikely to be able to care for people with severe dementia in the earlier, restless stage, and so the objective of continuity of care would not be achieved.

4. PRICES

4.1 In 2003/04 the price to be paid for a bed in a specialist unit will be £60 above the residential rate (£385 at 2002/03 prices). For this price to be paid:

- the person must be assessed as requiring specialist EMI care;
- the unit must meet the Council's specification (as recorded by Council staff following a visit to the Home).

This price will be known as the Mental Health rate (MH rate).

4.2 For the situation described in 3.2 above, an enhanced rate of £30 above the residential rate (£355 at 2002/03 prices) will be paid, but only where:

- the person remains in the Home and has moved from a specialist EMI unit;
- their needs as set out in their care plan are being met.

This price will be known as the Mental Health Enhanced rate (MHE rate).

4.3 A resident moving from a specialist unit to the non-specialist part of a Nursing Home would attract the standard rate for a Nursing Home place.

5. BLOCK PURCHASE

5.1 Since the number of people with severe dementia is increasing and, in future, this will be largest group of people referred to Homes, we do not envisage specialist EMI units will carry any greater risk of voids than non-specialist units. (Indeed, we believe they will carry less risk).

5.2 However, to encourage Homes to create specialist units within the next twelve months, a block purchase of up to 18 months is offered:

- between 01/04/03 and 31/12/04 only,
- for all beds meeting the specification,
- for all the beds in a specialist unit to which CMHTs can nominate residents.

The block purchase will be based on the 2003/04 MH rate (inflated between 01/04/04 and 31/12/04 in line with agreed increases at that time).

6. FURTHER INFORMATION

Further information is available from:

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APPENDIX 2

SPECIFICATION FOR EMI UNITS – NOVEMBER 2002

1. OVERALL AIMS	NOTES/EVIDENCE
1.1 To offer places in specialist EMI units that meet specific needs of people with dementia or similar mental health problems.	Whilst the emphasis is on dementia care, the aim is not to exclude people with similar needs for whom a dementia unit may be appropriate.
1.2 To ensure people who can be restless and challenging but do not require inpatient health care can be well cared for outside hospital.	It is envisaged that in a unit of around 8 people, a small number may be significantly challenging. Others will be restless/agitated with severe dementia.
1.3 To ensure people with severe dementia who then become physically frail are offered continuity of care.	It is important that as people become more frail they are not subject to risk from people who are more challenging. Dementia units for people who are physically frail will be paid the dementia rate. Homes will need to specify how they offer continuity of care.
1.4 To facilitate timely discharge from hospital for those people who no longer need health care.	It is important that good links are established with local CMHT, and that units are skilled and confident in caring for people with complex needs but who not require consultant led care.
2. THE PHYSICAL ENVIRONMENT	
2.1 General expectation that environment meets the needs of people with dementia.	Advice sought from appropriate source e.g. Dementia Services Development Centre.
2.2 The unit is domestic scale, as far as possible replicating ordinary homes.	Guideline 8 places, although units smaller and larger (maximum 12 people) can be considered. Units must have sitting and dining areas for exclusive use of the unit. Single bedrooms (unless resident clearly decides to share).
2.3 Features that encourage orientation.	Design, layout, decoration, lighting and visual cues are all used creatively to inform residents.
2.4 Security and safety features that allow residents to move around inside and outside the unit safely.	Window/door safety features. Access to a safe and secure garden area essential, preferably unaided.

3. LEADERSHIP	NOTES/EVIDENCE
3.1 General expectation that there is skilled leadership within the Home to ensure good specialist care is maintained.	Skilled leadership is essential to ensure good quality care. Evidence is required that there is carefully considered and clear leadership in place at both Home and Unit levels.
3.2 The Manager of the Home is either qualified in dementia care or ensures a person qualified in dementia care is in a leadership role within the EMI unit.	The aim is that a manager with an appropriate qualification in dementia care has direct impact on the care delivered in the Unit. This qualification will be RMN, ENM, Diploma in Dementia Care or equivalent.
3.3 The Manager of the EMI unit is knowledgeable and experienced in dementia care.	The Unit leader or manager must be experienced or skilled in dementia care. If this person is not the person in 3.2 above, she or he must have demonstrable experience in dementia care, and have received specialist training.
3.4 The Unit has clear policies and procedures to offer dementia care.	General policies and procedures will be laid down by the Care Commission. Specialist units must have in place policies and procedures that recognise the needs of people with dementia and are based on: - person centred values; - good use of knowledge of the life of the person with dementia; - good care planning; - understanding of dementia care mapping; - understanding of the progression of the illness; - understanding of risks.

4. STAFF TEAM	NOTES/EVIDENCE
4.1 General expectation that each EMI unit has a dedicated staff team: - adequate for the task; - appropriately skilled in dementia care; - motivated to work in a difficult and challenging service area.	Sustaining good quality care for people with dementia is a challenging task for staff. Such care is most likely to be delivered by a stable staff team who are committed to a particular group of residents. It is understood that staff may have to move within a Home to cover sickness and other issues, but specialist units must have clearly named staff working in each unit.
4.2 Minimum staff levels: - one staff to 4 residents during the day; - one staff to 7 residents at night.	Assuming a Unit operates around 2 day time shifts of 8 hours: - an 8 place unit will have a minimum of 4 shifts a day (32 hours); - a 10 place unit will have a minimum of 5 shifts a day (40 hours). The required night time staffing is likely to be achieved by one member of staff within the unit and access to a second member of staff whenever required.
4.3 The staff team are experienced and/or receive appropriate training in dementia care.	Good experience in dementia care will grow through the dedicated team described above, with the majority of the staff team having experience which is passed on to newer members. Evidence of a clear and sustained training programme is essential.