AGENDA ITEM 5

HOPSC/34/19

Committee Report to Health Overview Policy and Scrutiny Committee

Date 9 October 2019

SOUTH EAST ESSEX CLINICAL COMMISSIONING GROUPS (CASTLE POINT & ROCHFORD CCG AND SOUTHEND CCG)

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Recommendation: The Proposed Implementation of a Dementia Community Support Model
Part 1 (Public Agenda Item)

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1 Purpose of Report

The purpose of the report is to provide the Committee with:

1.1 An update on the issues and paper submitted to the Health Overview Policy and Scrutiny Committee on 10th October 2018 proposing the closure of Maple ward; and

1.2 Share details of the newly approved Dementia Community Support Model in the south east.

2 Recommendations

2.1 To note the update and share their views on the newly approved Dementia Community Support model.

2.2 To note the details of the dementia community model which is a permanent move and aims to go live April 2020;

2.3 To note the reduction in the ring fenced step up and step down beds in Clifton Lodge and Rawreth Court from ten to four. The number of beds available across both facilities remains the same; there is no overall reduction.

2.4 To note the CCG commitment to regular review of the bed base to see if there is further scope for reduction or increase due to work with community providers to offer a clinically suitable alternative.

3 Background & Context

3.1 In October 2018, the Committee considered and agreed the following:

(i) The proposed creation of additional Adult Mental Health 'inpatient beds' and associated temporary ward moves

(ii) The proposed temporary relocation of Cumberlege Intermediate Care

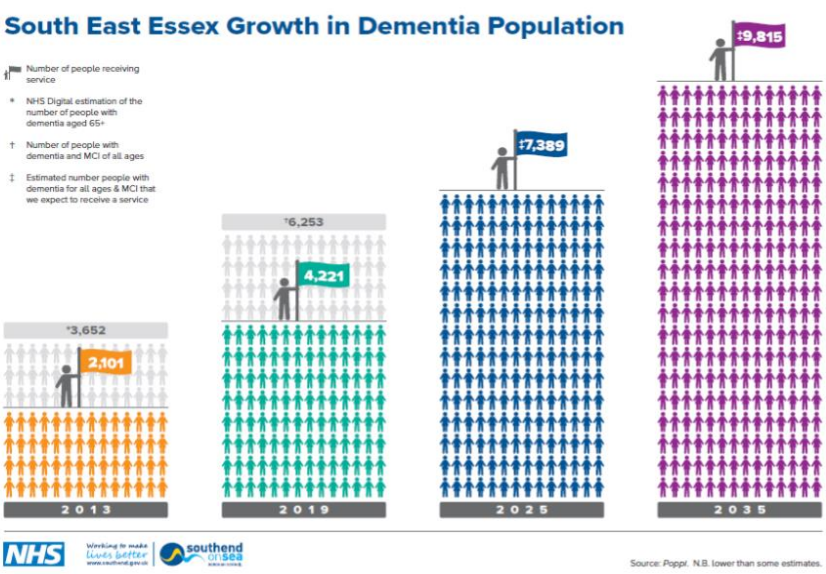
Centre (CICC) to facilitate the St. Lukes Primary Care Centre Development

AGREED: Whilst some members felt there could have been better foresight and planning to avoid the urgency of the proposals, the Committee supported the proposals to facilitate the continued development of the St Lukes Primary Care Centre and supported the request to defer formal consultation until proposals for a permanent move for the CICC was available next year.

3.2 The decision was therefore that Maple Ward would be closed - a 24 bedded organic assessment unit in Southend that was running at half occupancy. Dr Jose Garcia was asked to chair a clinical group to look at: the current dementia offer; identify the requirements of a new wraparound model to ensure robust community support to the person with dementia and their carer and to identify any gaps in knowledge and data.

3.3 As well as a commitment to develop a robust community model there was also a commitment to offer 10 beds (from the totality of 70 across Clifton and Rawreth) in Clifton and Rawreth (five in each) exclusively to the south east as step up/step down beds. The aim being to prevent as many people from the south east as possible being detained in Thurrock Meadowview ward. The beds have had a low occupancy rate overall since Maple Ward closed; one person has moved to Meadowview at the family's request because of their local connection to Thurrock and twelve other people have not needed to be assessed and detained in Meadowview due to the use of the step up beds.

3.4 The infographic below shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown, if the number of people with dementia rises as expected, the current service will not be able to safely manage and support the number of people with dementia. The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. The business case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.



3.5 The above is also inextricably linked to two other pieces of work:

- The requirement to develop St Luke's primary care centre through NHS England capital funding (circa 1.5m).
- The requirement to address pressures on adult mental health beds across south Essex and the impact this is having on both their treatment and wellbeing.
- Updates on all can be found in section 4.

4 Update

Detail from paper to Scrutiny & Council in October 2018	Update
Facilitate the improvement of St Luke's Primary Care Centre. Thus enhancing facilities and access to primary care in Southend. Opportunity to increase the current list size by approx. 4,000 patients from its current 6000 to 10000.	All is going ahead and work currently taking place. Plan for a new GP surgery to be operating from the new site in Feb 2020.
Move intermediate care beds from CICC to Maple ward at Rochford hospital. This will increase the capacity for intermediate care provision from 16-22 beds across south east Essex.	Increased capacity is very helpful and being utilised. Facility is modern, bigger and can accommodate bariatric patients (the former CICC site could not do this).
Move existing south east Essex dementia care assessment beds from Maple ward to Meadowview Ward at Thurrock Community Hospital in Grays. As these patients have an urgent need for specialist assessment and treatment they need to be formally detained under the Mental Health Act, and that means they need to be Admitted to hospital (and not any other such facility such as nursing or care home).	There has been a considerable reduction in the numbers of people that have needed to access dementia assessment beds over the previous eleven months compared to numbers that were detained on Maple ward. The numbers that have been prevented using the beds across the south east in Meadowview is 19 over the 11 month period. This has been due to the use of the step up beds available in Clifton and Rawreth and gatekeeping by the Dementia Intensive Support Team. Further information about the proposed Dementia Community Support model can be found in section 5 of the report.

5 Proposed Dementia Community Support Model:

5.1 As a system we are driving through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer and more fulfilling lives in the community for as long as possible. We want to manage rising risk, take a preventative approach and avoid crisis by deploying resources pro-actively. The desire includes the mobilisation of all the assets at our disposal

(within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

5.2 The opportunity to test in the south east arose in November 2018 due to a requirement to reconfigure dementia inpatient beds in order to provide additional mental health beds. A small augmentation to the South East Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in significant reduction in admission to dementia beds.

5.3 The new model is a culmination of work that has been taking place in the south east as well as the clinical group chaired by Dr Garcia. The south east has a good reputation for dementia services. This began with a series of public and stakeholder consultation engagement events; followed by system checks such as EQUIP, clinical tasking of diagnosis, running the Dementia Quality Toolkit (DQT) in practices; plus a number of test and learns of different scale and magnitude. Examples can be found on page 7 of the business case.

5.4 During the last nine months the Dementia Intensive Support Team (DIST) have developed a strong working relationship with Day Assessment Unit (DAU) and SWIFT (physical health community support team) to help support the admission avoidance process.

5.5 The new model in the south east comprises of the following principles:

5.5.1 Easy access, no wrong door approach to our service, pre, peri and post diagnosis through to end of life.

5.5.2 The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

5.5.3 The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers.

5.5.4 The emphasis is on identifying rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

5.5.5 Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.

5.5.6 Where inpatient care is required that it is planned, purposeful of optimal length and has clear value to the person admitted.

The Dementia Community Support Model:

5.5.7 **The Locality Teams** are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient,

and all will be able to input into and update the dementia care plan. We aspire to work with PCN's as they develop to explore how they can complement the dementia locality offer. It is envisaged both will work closely together. On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

5.5.8 **Care Home Team** A Dementia Nurse Specialist leads in the care home team offering expert advice and supports the GP when diagnosing. Registered nurses can offer training and support to care home staff on site which will enable understanding of their clients; understand a response appropriately that can be challenging and identify rising risk. This will help reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases). The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer. Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for resident's families.

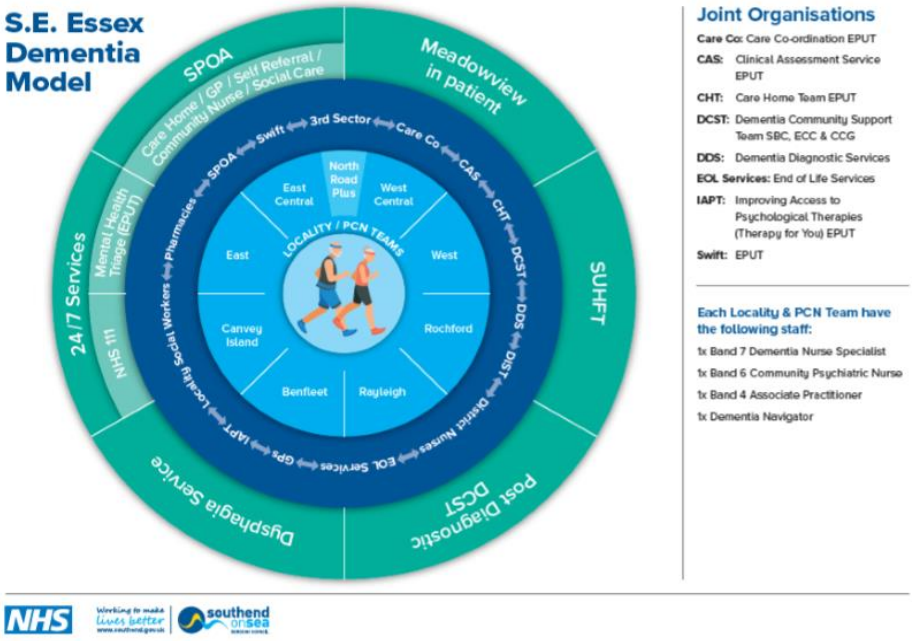
5.5.9 **Clinical Assessment Service** Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services. The service consists of a Mental Health Nurse Practitioner, Community Mental Health Nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

5.5.10 **SPOA (Single Point of Access)** Staffed with a Dementia (Mental Health) Nurse Specialist and an Associate Practitioner, this will provide a single access point to community dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.

5.5.11 **The Dementia Intensive Support Team (DIST)** work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend University Hospital (SUHFT) A&E Department, DAU (Day Assessment Unit) and SPOA (Single Point of Access). The interventions offered by the Service are aimed at managing pre crisis and

enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to SUHFT the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

5.5.12 The visual below shows the narrative of the new model in an easy to understand diagram.



6 Financial

6.1 The funding for the new Dementia Community Model has been clinically approved at the CCG's Joint Clinical Executive Committee and at both Southend and Castle Point and Rochford Governing Body meetings. The model will be implemented from April 2020.

6.2 Pooled funding will also be explored with system partners.

6.3 There is an expectation that the model will save costs across the system and over the next six months, before implementation, we will identify practice level activity and associated costs to baseline these figures. Numbers will be baselined across localities/Primary Care Networks.

7 Clifton and Rawreth Lodge Beds

7.1 Five beds have been made available at Clifton Lodge (and the same at Rawreth Court). This was an assurance given to Full council in Southend in November 2018. These beds have been ring fenced for south east patients as long as they are needed. They were intended to have two different uses:

Step Up - ability for people to use the Clifton/Rawreth beds as an opportunity to avoid assessment at Meadowview. A short stay that can monitor/treat behaviour that challenges/ meds review and carer respite. Plus assess if a longer stay is needed in a regular bed.

Step down - at the point at which patients can appropriately have their mental health act section removed they can be transferred to Clifton Lodge/Rawreth Court for any on-going treatment, monitoring and discharge planning.

7.2 The beds in Clifton and Rawreth have been very helpful as they have supported patients to have short term interventions that have enabled them to step up so they do not require use of the detention beds in Meadowview.

7.3 The number of ring fenced beds required in the south east moving forward can be reduced from ten to four. There have been, on average, 2, 3 or 4 used in any given month. This number will be reviewed on a regular basis to ensure the bed numbers meet the needs of the population. The first review will take place in six months and then regular quartlery reviews will take place from April 2020 when the new community model is introduced within the system.

7.4 The introduction of the new community model will enable people to have the right care and support in the community and the care home team will ensure that the person is getting the right level of support in their care home and are appropriately placed.

8 Reasons for Recommendations

8.1 There are many reasons why an enhanced community model is paramount, which include:

- Being able to pro-actively review patients so people with rising risk are monitored and not just those with the highest need.
- Growth of number of people likely to have a dementia diagnosis in the south east over the next 15 years.
- Supporting the integrated care plan; Co-ordinator of care role and regular dementia reviews.
- Increased risk of crisis, hospital admission (both acute and mental health) increased CHC funding, increased care home and care package usage.
- Increased carer stress due to reduced support and understanding of their unique role.

9 Workforce - Dementia Community Support Model

9.1 The south east Essex dementia teams have always had passionate and committed staff who are loyal. The team has consistently been fully staffed and whenever vacancies are advertised strong applications are received. The model we are planning to implement is innovative and cutting edge and national award finalists. Staff will be working with people in a preventative way which affords people a better quality of life in their community. We are assured that workforce will not be a risk that will prevent the new model being implemented and delivering the benefits as planned.

10 Consultation

10.1 There has been consultation over the last few years with public, patients and stakeholders regarding clinical and community services..

11 Outcomes/Benefits

11.1 The expected benefits of the new model are as follows:

- Introduction of an integrated care plan, incorporating both dementia and frailty that can be viewed and used across services and systems on SystmOne.
- Locality teams that align to Primary Care Network's to offer bespoke support to primary care.
- Locality teams will support rising risk and have integrated pathways with DAU, SWIFT and Complex Care Coordination.
- Locality teams will offer 'lifelong' support, advice and review; and are able to take the care coordination role.
- Reduced GP workload as less appointments are taken up by people living with dementia and their carers in GP surgeries and more people are seen by the dementia locality team.
- Better links to social care and ability for dementia nurses to implement packages of care.
- A better quality service for people with dementia that ensures they do not have to repeatedly tell their story and that there are fewer hand offs.

- Greater level of personalised support, advice and health promotion to carers.
- More support to care homes and GPs via a care home team.
- Reduced memory assessment pathway by introducing diagnostic phasing over a range of entry points to enable a better fast track diagnostic offer that enables quicker access to post diagnostic support.
- Established links to frailty.
- Delirium recognised, identified and treated faster.
- A 'watch and see' approach to Mild Cognitive Impairment (one third of cases converts to dementia) that ensures no one falls through the net.

12 Test and Learns

12.1 A number of test and learns have been tried across the system to test the new model and ways of working. They have proved successful and have been scaled up. Details of the test and learns can be found on page 7 of the business case.

13 Testimonial

13.1 *'We as a family have found the DIST team to be a amazing help to us, before they were involved in the care of my mum we were struggling to know what way to turn we had been to many appointments at the doctors and Private hospital appointments to try and get some help and get our foot on the ladder so to speak but had had no luck it was just taking so long and to be honest they won't very helpful.*
My mum had been confused and very aggressive for quite some time but we felt like it was getting worse and something needed to be done.
We've never had to deal with I'll health or doctors in the past so this was all new to us and very daunting.
Out of desperation and a last resort I ask for help on our local Facebook page as the situation was getting worse, and straight away Diane's name was being put forward. I texted her that evening and within minutes she was in contact with me and the ball was rolling.
Within days she was at my parents house having a meeting and sorting out a bad situation, and from that point on we've had so much help and support mum is on mediation now and although the situation will never get any better it's under control with the help of the DIST team (Tony and Diane).
I fill that they have become friends and I fill that I could call them at any time day or night and they would be there for my me, my mum or my family.
My mum was very nervous about seeing someone and facing the problems she has but she is so at ease with Tony and Diane especially Tony she has taken a liking to him and trusts what he tells her.
The DIST team have become a very important part of our life and we don't know where we would be without there care and support we are eternally grateful they go above and beyond and really do actually care.
Thank you so much.'

14 Legal Implications

14.1 None at this stage.

15 Equality & Diversity

15.1 An Equality Impact and Quality Impact assessment have been carried out.

16 Background Papers

The following papers have been considered and are included in the business case:

- Essex County Council Public Consultation
- South East Essex Locality Strategy
- 2050 and Transforming Together (one sider)
- Southend 2050 Roadmap summary
- Southend 2050 Five Year Road Map to 2023
- Wraparound Support Scenarios
- SEEMS slides
- Care Home Toolkit
- Dementia Friendly Primary Care Practice
- Domiciliary Care Food and Fluid Flow Chart
- Domiciliary Care Personal Care Flow Chart
- Domiciliary Care Toolkit
- Dementia Integrated Care Plan