

Southend Health & Wellbeing Board

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough
Council;
Terry Huff, Accountable Officer, Southend and Castle Point and Rochford
CCG

to
Health & Wellbeing Board

on
18 Sep 2019

Report prepared by:
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Council

For discussion	X	For information only		Approval required	
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Dementia Community Support Model

2019/20

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is as follows;

- 1.1 To update members of the Health and Wellbeing Board (HWB) regarding potential plans for remodelling the Dementia Community Support Model (Appendix A) for 20/21;
- 1.2 Seek the views from HWB board members on the proposed dementia community support model.
- 1.3 To note that the model is still to be approved at Clinical Executive Committee and Governing Body for both Southend and Castle Point and Rochford CCGs.

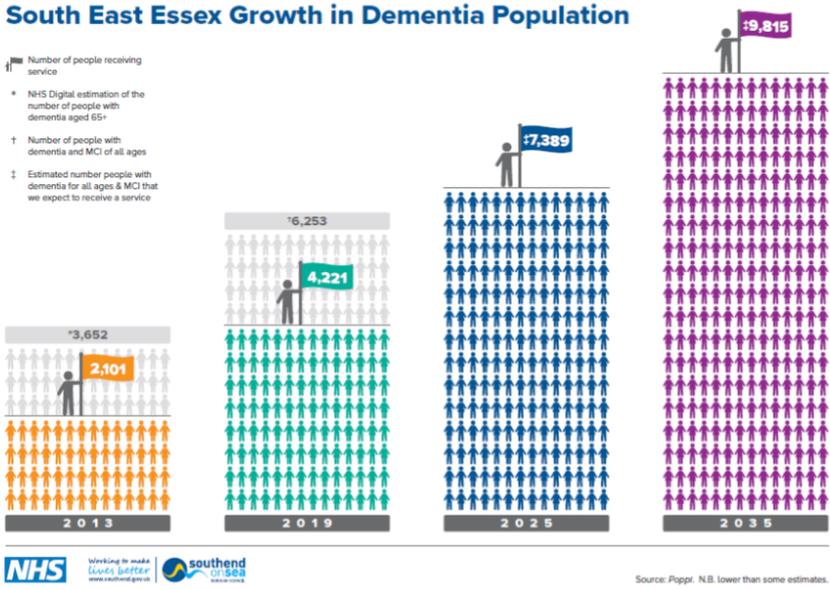
2 Recommendations

HWB are asked to;

- 2.1 Note the update for Dementia Community Support model for 20/21;
- 2.2 Give their views on the proposed dementia community support model.
- 2.3 Agree to review the new model after it has been fully operational for a full year to review the outcomes and decide whether to take a joint commissioner approach/ ICS.

3 Background & Context

- 3.1 In late 2018, following a decision taken by People Scrutiny in both Southend on Sea Borough Council and Essex County Council to close Maple Ward (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.
- 3.2 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 and one person has moved to Meadowview at the family's request because of their local connection to Thurrock.
- 3.3 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.



4 Proposed Dementia Community Support Model:

- 4.1 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.

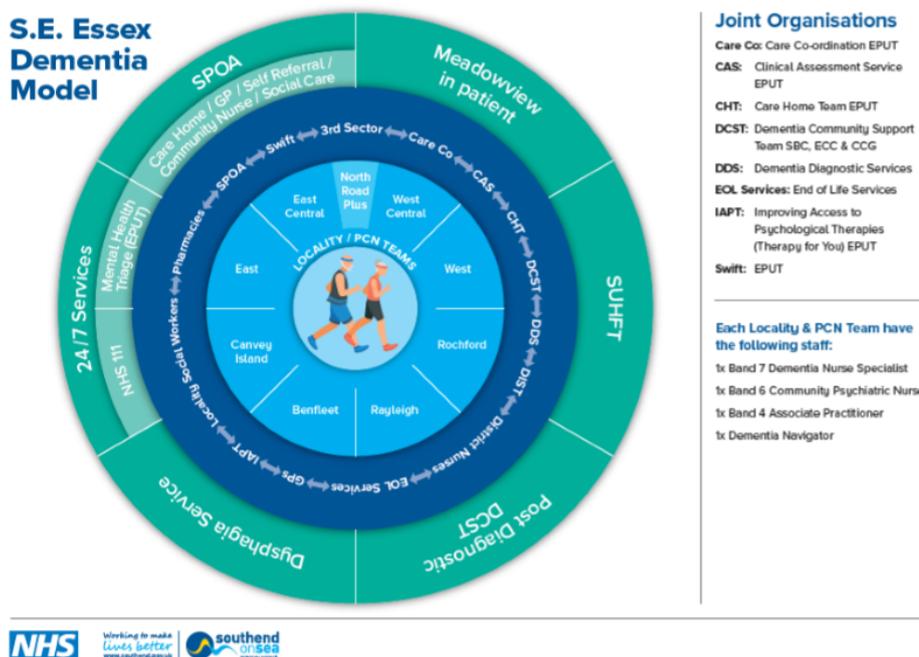
- 4.2 The new model is a culmination of work that has been taking place in the south east as well as the clinical group chaired by Dr Garcia. The south east has a good reputation for dementia services. This began with a series of public and stakeholder consultation engagement events; followed by system 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.
- 4.3 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.
- 4.4 The new model comprises of;
 - 4.4.1 **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.
 - 4.4.2 **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.
 - 4.4.3 **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.

4.4.4 **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.

4.4.5 **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 General Hospitals 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 Southend University Hospital 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.

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



The principles of the model are:

- 4.5 Easy access, no wrong door approach to our service, pre, peri, post diagnosis through to end of life.
 - 4.5.1 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.
 - 4.5.2 The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers.
 - 4.5.3 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.
 - 4.5.4 Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.
 - 4.5.5 Where inpatient care is required that it is planned, purposeful of optimal length and has clear value to the person admitted.

Alignment to Southend 2050

- 4.6 The proposed changes align with the Southend 2050 five themes; Pride and Joy, Safe and Well, Active and Involved, Opportunity and Prosperity and Connected and Smart.

The National Dementia Alliance describes the following outcomes for people with dementia and their carers. These outcomes will directly measure the success of the new community model.

'We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'

'We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.'

'We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.'

'We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.'

'We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.'

The outcomes can be mapped across to the 2050 outcomes in the following themes:

4.6.1 Safe and Well

- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.

4.6.2 Active and Involved

- The benefits of community connection are evident as more people come together to help, support and spend time with each other.
- A range of initiatives help communities come together to enhance their neighbourhood and environment.
- More people have active lifestyles and there are significantly fewer people who do not engage in physical activity.

4.6.3 Connected and Smart

- People have a wider choice of transport options.
- Southend is a leading digital city with world class infrastructure that enables the whole population.

4.6.4 Contribution to the Southend 2050 Road Map

The dementia offer is already responding to some of the milestones for 2019, such as, **increased numbers of active people** and **community based social work practice embedded**. We are aligned with localities and Primary Care Networks to help us meet the 2020 milestones **Localities - integrated health and social care services provided locally** and are working with colleagues to be integrated with the **New social care home operational** and **More integrated transport provision** and **Campaign for a new hospital for Southend**.

4.7 The Primeministers Challenge 2020 sets out clear commitments that cover all aspects of dementia; risk, diagnosis, health and care support, workforce training, social action and research. A report written for CCGs Governing Body outlining the local response to the PM challenge can be found in appendix F.

Financial

4.8 The funding will be taken to the CCG Governing Body for approval but as a system solution there may be future opportunities to explore pooled funding options.

5 Reasons for Recommendations

5.1 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 SE 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.

6 Financial / Resource Implications

6.1 None at this stage

7 Legal Implications

7.1 None at this stage

8 Equality & Diversity

8.1 An Equality Impact and Quality Impact assessment have been carried out and are embedded in Appendix E.

9 Governance Route

Date	Meeting	Time	Lead Presenter
22/08/19	EDMT (Executive Departmental Management Team SBC)	11.30am	Jo Dickinson
28/08/19	CMT (CCGs)	CMT 11.30- 1.30pm	Jo Dickinson supported by Spencer Dinnage (Dementia Lead Clinical Services and Jacqui Lansley)
11/09/19	CMT (CCGs)	11.30am	Jo Dickinson, Jacqui Lansley, Dr Gupta and Dr Garcia
18/09/19	HWB (Southend)	PM	Jo Dickinson, Jacqui Lansley and Dr Garcia
19/09/19	Joint CEC (CCG)	PM	Dr Gupta and Dr Garcia supported by Spencer Dinnage and Jo Dickinson.
26/09/19	GB CPR CCG	PM	Jacqui Lansley supported by Jo Dickinson
27/09/19	GB Southend CCG	PM	Jacqui Lansley supported by Jo Dickinson
08/10/19	Southend People Scrutiny	PM	Cllr Harp and Dr Garcia

10 Appendices

 <p>Dementia Services Transformation Mode</p> <p>Appendix A -</p>	
 <p>Embedded documents 1.docx</p> <p>Appendix B –</p>	
 <p>Embedded documents 2.docx</p> <p>Appendix C -</p>	
 <p>Embedded documents 3.docx</p> <p>Appendix D -</p>	
 <p>Embedded documents 4.docx</p> <p>Appendix E -</p>	
 <p>GB Dementia Report 13.02.19V3.docx</p> <p>Appendix F -</p>	