Agenda Item 6

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**27 November 2014**
By:	**Assistant Chief Executive**
Title:	**Dementia service redesign**
Purpose:	**To consider progress with dementia service redesign, including outcomes of Memory Assessment Service pilots and the development of a business case for future provision of dementia assessment beds.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Consider and comment on progress with the programme of dementia service redesign; and**
2. **Consider and comment on specific plans for the future provision of dementia assessment beds.**

1. Background – Dementia service redesign

1.1 Given the older and ageing profile of the East Sussex population, older people's mental health services have been included as a priority within HOSC's work programme for several years. Since the publication of the first national dementia strategy by the Department of Health in February 2009, reports to HOSC have focused on the local response to this strategy which has included a programme of service redesign.

1.2 In 2011, HOSC supported plans for a shift away from investment in some NHS funded day services and reinvestment of this resource in a range of services designed to increase diagnosis and to provide ongoing support those people diagnosed with dementia and their carers. These included Memory Assessment Services (MAS), Dementia Advisors and Memory Support Services.

1.3 The last progress report to HOSC was in March 2013. At that time, the Committee noted the following key points about the status of new and continuing service models and initiatives:

- three different models of MAS were being piloted (one in each Clinical Commissioning Group (CCG) area), each designed to meet the desired outcomes in relation to increasing diagnosis. These would be evaluated after 18 months.
- a national awareness campaign was underway which was having a positive impact on referral rates.
- the Dementia Advisor service, provided in East Sussex by the Alzheimer's Society, was due to expand to nine advisors in 2013/14, in parallel with the expansion of MAS.
- ongoing funding had been secured for the dementia Carers' Breaks service. It was being reviewed with a view to increasing the service's capacity.
- Memory Support Services, designed to offer support with memory issues once people are diagnosed, were expected to go live in May 2013, reaching 900 newly diagnosed people in the first year.
- The Care Home In-reach Service pilot had been extended to September 2013 to enable further assessment on a monthly basis and integration with other care home in-reach services.
- A specific service for people with early onset dementia had been commissioned from the Alzheimer's Society.

2. Background - Dementia assessment beds

2.1 Within East Sussex there are currently two acute psychiatric assessment wards for older people with dementia. These are St Gabriel's ward within the St Anne's Centre on the Conquest Hospital site in Hastings and the Beechwood Unit at Uckfield Community Hospital. The wards are provided by

Sussex Partnership NHS Foundation Trust (SPFT) and they contain 34 beds in total (18 at St Gabriel's and 16 at Beechwood).

2.2 The intended role of the wards is to provide a specialist dementia assessment service for people (either diagnosed or undiagnosed) with acute or challenging needs which mean they are not able to be assessed at home (which is the preferred approach). The intention is for them to be relatively short stay wards, assessing the person's needs and designing a plan for their future care which could be at home with additional support, or in a residential setting.

2.3 In June 2013 HOSC received a report from the East Sussex Clinical Commissioning Groups (CCGs) which outlined a planned review of these beds to determine whether the currently commissioned services remain appropriate for meeting the needs of the population. HOSC determined that proposed options for the future included some which would constitute 'substantial variation or development to the provision of services' which would require formal consultation with the Committee under health scrutiny legislation.

2.4 A HOSC Mental Health Task Group (Councillors Carstairs, Ensor and Standley) was established to review the options and deliver a report and recommendations for consideration by HOSC. The Task Group's report was endorsed by the full HOSC on 21 November 2013.

2.5 A decision on the preferred future service model was taken by CCG Governing Bodies on 11 December 2013, taking into account a range of evidence which included HOSC's report and a wider consultation. They agreed unanimously that Option 4, to close both sites and create a wholly new model of bed-based dementia services, was the preferred option for implementation. High Weald Lewes Havens CCG Governing Body recommended a specific caveat that the model of care was subject to a full business case process, including Governing Body sign off prior to the closure of the existing sites, and that neither of the existing sites was precluded from consideration when identifying the future location for the new model of care.

2.6 The CCGs intended to establish a working group to develop the new model of care, options for delivery and a business case to be reviewed by the three CCGs during 2014. Clinicians and stakeholders were to play an integral part in this process of designing safe and sustainable services which reflect the needs of people who require bed-based dementia assessment, now and in the future.

2.7 In January 2014 the Committee reviewed the CCGs' decision and agreed to consider the business case when it had been produced. The Committee noted that, in the interim, the services would continue on both the current sites, although neither of the ward environments is ideal in terms of the facilitation of good quality dementia care. SPFT had responded to some of the difficulties by increasing some of the staffing ratios.

3. Progress update

3.1 An update on progress with the service redesign programme, supplied by commissioners, is attached at **appendix 1** for HOSC's consideration. This includes an update on the development of a business case for the future provision of dementia assessment beds.

3.2 Martin Packwood, Head of Joint Commissioning (Mental Health) from East Sussex CCGs/ESCC Adult Social Care, and Ashley Scarff, Head of Commissioning and Strategy, High Weald Lewes Havens CCG will attend HOSC to discuss the report.

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Appendix 1

East Sussex Dementia Service Re-design: progress report
November 2014

1. Introduction

1.1 This report provides an update on the progress of the development and re-design of some dementia services. The delivery of new service developments was in line with a strategic approach to move away from the delivery of some day hospital services and reinvest in Memory Assessment Services, the expansion of the Dementia Advisors' service, and the creation of Memory Support Services.

1.2 Aligned with this was the consultation undertaken during 2013 regarding the provision of NHS beds for the admission and assessment of people with dementia. This was to ensure that in-patient beds, although a relatively small part of the overall provision of safe dementia services, were an aspect of care that was also considered as part of service re-design.

1.3 The report includes information on the evaluation of the pilot of different models for the provision of Memory Assessment Services in East Sussex, and the way in which this is now informing the approach to their long-term re-procurement. It also includes information on the Dementia Advisors' service and Memory Support Services as well as progress on the development of a business case for the bed-based dementia assessment service that was agreed as required action following the consultation on these services.

2. Memory Assessment Services: Pilot approach

2.1 When it was agreed to procure new Memory Assessment Services (MAS) for the diagnosis of dementia in 2012, consideration was given to a traditional competitive tendering approach. However, this approach does not always sufficiently encourage innovation, and a decision was therefore taken to invite bidders to participate in piloting new services in different ways. A number of providers were selected based on their proposals' diversity and potential to develop high performing MAS services, and then were evaluated as to whether the potential of each was realised.

2.2 The aim was to reach validated conclusions about the performance of each provider model. The three models were: NHS Partnership Trust / psychiatrist-led services; GP practice consortium provided services; or private-sector provided services. The evaluation would inform the re-procurement of MAS services on a longer-term basis (from April 2016).

2.3 Following due process, providers selected to pilot MAS services for each Clinical Commissioning Group (CCG) area were:

- Sussex Partnership NHS Foundation Trust (SPFT) - High Weald Lewes Havens CCG
- A GP Consortium - Hastings and Rother CCG;
- A private sector company - Eastbourne, Hailsham and Seaford CCG;

3. Memory Assessment Services: Evaluation of the Pilots

3.1 There were just over 1,100 diagnostic episodes completed across all providers during the 18 month pilot period.

3.2 The pilots were evaluated based on quantitative information, activity and qualitative information, satisfaction surveys of GPs and practices and patient opinion.

3.3 In parallel with collecting quantitative data, providers administered patient satisfaction questionnaires and undertook three GP satisfaction surveys. The latter were supplemented by the CCGs carrying out a GP / Practice survey in June 2014.

3.4 A summary from the analysis of both quantitative and qualitative findings can be found below.

4. Evaluation - Summary Findings

4.1 There were **7 key criteria** against which the pilots were evaluated.

4.2. ***Early recognition by GPs of the symptoms of dementia and referral for diagnosis*** *is a key national and local objective.*

4.2.1 Proportions of patients diagnosed with mild and / or moderate dementia (used as a proxy measure for achieving earlier diagnosis), and matching of GP on-referral and MAS post-referral assessments of severity (used as a proxy for improved identification).

4.2.2 The GP Consortium performed best against both these measures.

4.3 ***Identification of dementia sub-types and increased rates of appropriate prescribing of NICE approved drugs which can slow deterioration*** *(this is an important element of pathways)*

4.3.1 Convergence of local MAS profiles of dementia diagnoses with epidemiologically-based expectations was used as a proxy measure or 'check' for reliability

4.3.2 The GP Consortium and SPFT both evaluated well on this area.

4.4 ***Provision of information, advice and support following diagnosis of dementia*** *(this is an important element of pathways, and the Alzheimer's Society has been commissioned to* provide *Dementia Advisors (DAs) in East Sussex to whom MAS services can and should refer diagnosed patients.)*

4.4.1 The GP Consortium and Trust referred the higher numbers to the DAs

4.5 ***Minimising waiting times between referral and diagnosis*** *(this reduces anxiety and uncertainty and enables swift access to appropriate care, support and treatment).*

4.5.1 The NHS Trust and GP Consortium performed well on this area

4.6 ***Diagnostic process should be as convenient as possible*** *(this was a local objective due to high numbers of older patients and it was important to balance this with clinical quality and reliability.)*

4.6.1 Numbers of attendances and their locations were recorded as proxy measures of this.

4.6.2 The GP Consortium performed best on this criterion with earlier diagnosis and fewer attendances

4.7 ***Providers were encouraged to pilot different approaches to the amount and mix of professionals' time they deployed to complete diagnostic episodes and achieve value for money.***

4.7.1 Each provider had a valid approach.

4.8 ***Feedback from GP / Practices***

4.8.1 The GP Consortium was most successful in encouraging early referral behaviour and recognition of dementia as well as improving knowledge and understanding of the referral pathway. GP respondents also assessed the GP Consortium as providing the highest quality of communications and management plans on discharge.

4.8.2 SPFT also performed relatively well in this area.

4.8.3 The patient satisfaction survey results were not conclusive.

5. Conclusions and Approach to Re-procurement

5.1 Memory Assessment Services provided by the GP Consortium and NHS Trust performed fairly similarly in many respects based on the evaluation, whereas the private sector provider was an outlier in many ways and performed poorly.

5.2 The GP Consortium performed better in the view of referring GP practices that responded to the survey and delivered quality services to their greater satisfaction than did the Trust.

5.3 Eastbourne, Hailsham and Seaford (EHS) CCG and Hastings and Rother (H&R) CCG

5.3.1 MAS services are currently being re-procured for EHS and H&R CCGs with new contracts due to commence in April 2016.

5.3.2 Summary findings from the pilot evaluation are being included as part of the procurement documentation provided alongside service specifications, and bidders are being invited to set out the extent to which their proposals demonstrate learning from the pilot since this will be amongst the selection criteria against which their proposals will be judged.

5.4 High Weald Lewes Havens (HWLH) CCG

5.4.1 A clinical review of the existing dementia pathway and research of best practice, undertaken by the HWLH CCG has identified a number of wider issues and opportunities for improvement for patients and carers. To address these issues, regional resources have been secured to appoint a Senior Project Manager, who is working with the Clinical Lead and all partners, to develop a new model of care which will help people with dementia, and their family carers, to 'Live Well' with the condition. To enable this work to be undertaken and to ensure business continuity,

steps have been taken to build in the re-design timetable into existing contracting and commissioning cycles.

5.4.2 Therefore, the Memory Assessment Service, currently provided by the Sussex Partnership NHS Foundation Trust, has been extended for a further 12 months (post-March 2015) to ensure service continuity whilst a new model of care is being developed.

6. Dementia Advisors Expansion and Memory Support Services

6.1 It is important that following a diagnosis of dementia, people are provided with high quality information about the condition and its effects, as well as guidance, advice and support on an on-going basis to help people find the care and treatment they need, as and when the condition deteriorates.

6.2 This information, advice and support is commissioned from the Alzheimer's Society which provides Dementia Advisors to whom patients are referred by Memory Assessment Services (MAS). With the expansion in capacity of MAS to see and diagnose more patients, there has been and will continue to be a parallel expansion in the provision of Dementia Advisors - from 2015/16 commissioned capacity will increase to support 1,400 annual referrals to Dementia Advisors.

6.3 MAS can also now refer more diagnosed patients to Memory Support Services, which provide psychosocial interventions and activities for people recently diagnosed with mild to moderate dementia. Four types of courses are offered in community venues throughout the county: Memory Management; Cognitive Stimulation; Reminiscence, and; Living Well with Dementia.

7. Developing services into the future as part of the East Sussex Better Together strategic approach

7.1 High Weald Lewes Havens CCG is undertaking specific work focused on the dementia pathway. It is intended that the learning from this work will inform the wider health and care community across East Sussex as appropriate. This work, in partnership with patients, carers, public, providers and other stakeholders is working to develop a new model of care which:

7.1.1 promotes a Long-Term Conditions approach

7.1.2 offers a 'Network' of high quality services and specialist care for people with dementia and their family / carers, within a multi-agency team that pulls together the skills of relevant professionals across the dementia network

7.1.3 brings together universal and specialist providers from all sectors that support people with dementia

7.1.4 accommodates people who may have the following additional needs like; early onset dementia, learning disability and neurological conditions such as Parkinson's disease for example

7.1.5 is easy to navigate with a single care coordination system

7.1.6 integrates services to ensure a whole-systems approach involving all relevant health and social care stakeholders

7.1.7 harnesses the knowledge and experience of people using services and their family / carers

7.1.8 prevents people from getting into difficulties by proactively supporting their condition and providing information, care and support when they need it most; in a timely and responsive way

7.1.9 enables people to live as independently as possible in their own home if this is their preference

7.1.10 enables people to plan for their future care decisions early on in their journey with dementia that gives people confidence that their wishes will be respected

7.1.11 treats people with dignity and respect.

7.2 As dementia progresses, there is a need for increasing support for patients, families and carers particularly through 'transition points' if the condition is to be managed in a pro-active and holistic way like other long-term conditions. The Carer's Trust has identified ten points of change in the journey with dementia, which if managed appropriately, with the right intervention, could prevent decline and unnecessary admissions to care placements. HWLH CCG is using this 'transition framework', (together with evolving evidence of what works best) as a platform for its local thinking, and engagement and consultation.

7.3 For their part, Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs are considering potentially expanding primary care led Memory Assessment Services to take on responsibility for more patients currently on Sussex Partnership Trust caseloads. A large number are in many instances in receipt of relatively infrequent input of low intensity which could potentially be undertaken outside of specialist psychiatric provision.

7.4 Should this extended role be located in primary care, it might be possible to continue building its expertise, skills and capacity to overcome stigma and encourage early presentation when situations are deteriorating, improving responsiveness and avoiding crises. This could align with greater community based care, supporting those most at risk and aligning with the work being tested in HWLH.

7.5 There will continue to be a full programme of engagement rolled-out in 2015.

8. Bed based dementia assessment services

8.1 Following consultation in the summer of 2013, it was agreed by the CCG Governing Bodies in December 2013 that a "wholly new model of bed-based dementia services" should be developed. A Working Group was established involving CCG clinical leads, Commissioners and Trust clinicians and managers, with input from wider Stakeholder Interest Groups.

8.2 The Working Group was tasked with developing:

- The New Model of Care
- Options for Delivery
- Business Case

8.3 The Working Group was established in February 2014, and subsequently met three times between April and June.

8.4 A Stakeholder Reference Group involving Healthwatch and a range of voluntary sector and user representatives was also set up in parallel and met two times to review the same information provided to the Working Group, as well as to consider the outcomes of its on-going deliberations.

8.5 A Business Case was drafted. As part of this work, discussion with CCG members and with the provider about understanding the interdependencies of the model, phasing, and associated costs need to be incorporated into the final business case.

8.6 This update provides HOSC members with progress to date on the development of the model of bed based assessment care.

8.7 The model principally concerns admissions of patients with dementia to NHS beds staffed by specialist psychiatric and nursing staff. As this does impact on 'acute' care for this patient group, the scope therefore covers a "sudden inability to maintain the current plan of care" for patients with dementia.

9. Health Needs Analysis

9.1 Needs analysis indicates that there are estimated to be approximately 10,000 people with this condition in East Sussex, with current annual admission rates at around one in a thousand patients.

9.2 This suggests that although an essential component, in-patient beds are a relatively small part of the overall provision of safe dementia services compared with the delivery of community based services for the care and treatment of this group.

10. Developing the Business Case

10.1 In previously determining their preferred option at meetings in December 2013, CCG Governing Bodies had already signalled that, based on need, specialist NHS dementia beds would not be re-commissioned at current levels on both existing wards, and could instead be consolidated on a single site in numbers no greater than used or needed.

10.2 The outcome of the consultation considered by the CCGs indicated that neither of the two existing wards was ideal to support effective care for patients with Behavioural and Psychological Symptoms of Dementia (BPSD), due in one case to its location and associated difficulties recruiting and retaining permanent staff, and in the other due to its design. However, neither was excluded due to possibilities for improvement through refurbishment.

10.3 Further to this, the CCGs agreed to explore the impact of increased community provision on required bed capacity as part of a strategic approach to improve the quality and capacity of services available.

10.4 It became clear during consultation that this approach would require understanding better why patients were being admitted and staying in NHS beds, and what effect community-based alternatives could have on admissions, lengths of stay and occupancy As such, rather than agree a solution to this smaller aspect of the services, the preferred option was to undertake this additional review to achieve this understanding.

10.5 Achieving this ‘better understanding’ was a key focus of the Working Group, which drew on an audit of admissions to each ward recording admission source, Mental Health Act status and discharge destination related to lengths of stay, and importantly provided an opportunity for primary and secondary care clinicians to discuss patient profiles and explore the needs of those currently being admitted.

10.6 This review showed that whilst there were many patients with BPSD requiring highly specialist medical and nursing care found only on NHS wards [DICU\; Dementia Intensive Care Units], there were others whose ‘acute’ needs arising from a “sudden inability to maintain the current plan of care”, did not require such intensive levels of medical treatment and supervision or high nursing staff ratios.

10.7 A small number of ‘patient-cohorts’ were identified by the Working Group which had common characteristics in terms of their potential for either admissions being avoided or lengths of stay being reduced. The sorts of community-based services which could provide alternatives to bed-based care for these patient-cohorts were then discussed alongside necessary changes in their operational organisation.

10.8 Common characteristics of patient-cohorts being admitted were identified as:

10.8.1 those not previously known to SPFT services who are admitted due to concerns about safety, often without insight and hence subject to detention under the MH Act, but whose needs become apparent and stable after a relatively short period and do not need DICU levels of NHS care

10.8.2 those known to SPFT services who are admitted due to “a sudden inability to maintain the current plan of care” – the urgency with which this group’s care plans have to adapt to new levels of need will be common, but their actual levels of need and intensity of services they require may vary considerably, and these need not necessarily merit the intensity of care provided in DICU beds

10.8.3 those, whether previously known to SPFT or not, whose PBSD means they have the most complex presentations and unstable needs and have to be admitted to DICU

10.8.4 Trust clinicians assessed the average length of stay required to achieve the clinical objectives for patients needing DICU admission as 8 weeks, with a maximum of 12 weeks, after which further benefits were unlikely to accrue

10.8.5 it was acknowledged that the majority of patients in cohort 1 did not require DICU once stabilised and with suitable alternative locations being made available could be discharged after an average of two weeks

10.8.6 it was also acknowledged that a proportion of patients in cohort 2. could have their admission avoided if a wider range of community-based acute services were available quickly to replace the plan of care that was no longer able to be maintained, since for many the urgency of addressing changing needs was the current cause of admission rather than changes in severity of symptoms meriting DICU levels of care.

10.8.7 it was noted that it would not be possible to pre-determine which patients in cohort 2 could have admissions avoided with advanced directives specifying their rapid access to newly available community-based acute services, but that it could be confidently predicted based on an audit of admissions, that a number could be avoided in this way.

10.8.8 finally, it was noted that one of the principal reasons for lengths of stay currently exceeding the average period of 8 weeks required for clinical objectives of admission to be achieved, was the need for Adult Social Care services to arrange long-term, often Care Home based, packages through a comprehensive process of assessment, involving providing for patient and family choice in the context of financial contributions

10.8.9 It was therefore agreed that unnecessarily continuing occupancy of NHS-provided DICU beds could be avoided if alternative locations were provided for patients whose needs now involved establishing their minimum long-term dependency levels and planning their transfer to arrangements providing for these needs to be met.

11. Features of Potential Service Model

11.1 The new model of service developed by the Working Group proposes the establishment of 'acute' dementia services which consist of not only NHS beds but also a wider range of community-based services, and incorporates a clinical 'gate-keeping' function to ensure access to this range of services is proportionate to need.

11.2 The Group supported new distinctions being drawn and functions attributed between 'community' and 'acute' dementia services. The types of functions and where these may best be provided are shown below.

11.3 **Community Dementia Teams / Services**
Assessment and Complex Case Management
Advanced Care Planning Directives

11.4 **Acute Dementia Teams / Services**
'Crisis' Assessment / Gatekeeping
Access to 'acute' services:

- Extended Hours Team
- Care Homes / respite
- Care Home In-reach
- Step-up / Down Beds
- DICU Beds

11.5 The development of the final business case will seek to ensure the following:

11.5.1 a diverse range of 'acute' dementia services available with enhanced quality and accessibility

11.5.2 a more community-oriented focus to dementia services able to meet the increasing demands arising from increasing numbers of elderly with dementia

11.5.3 improved value for money provided by current bed-based dementia services across East Sussex.

12. Looking to the future

12.1 The CCGs will continue to progress their intentions for improving dementia care in line with the actions described in this update and are committed to maintaining safe and high quality services now and in the future. This will, of course, include the continued re-procurement of Memory Assessment Services and the finalisation of a business case for bed-based assessment services.

12.2 These will support our wider shared vision to develop services which are pro-active, helping individual patients to manage their health and well-being with better sign-posted, joined-up care, wrapped around individual needs. This will mean greater investment in integrated, community based health and social care, and good access to hospital care only when this is really needed.

12.3 The CCGs value the input from HOSC in this work and look forward to further updating on progress in due course.

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