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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

Specialist Dementia Care

Report by Chief Officer, Health and Social Care

PURPOSE OF REPORT

1. To update the Joint Board on our wider strategy to support people with dementia, within a context of service redesign and specific operational pressures.

COMPETENCE

2. The matters arising in the report have no immediate legal, HR or financial implications, although specific reforms referred to will have to address these themes.

SUMMARY

3. The Integration Joint Board has responsibility for directing a wide range of health and social care services, including support for people with dementia. As part of the strategic planning work undertaken within this context, we are seeking to address growing demand for services within the dementia population by undertaking two major and connected pieces of work: to redesign mental health services, with a focus on supporting more people in community settings; and to redesign the residential estate in Lewis, creating additional bed capacity for people with dementia who need long term care and support.

4. This report focuses on the work we're doing to support people with dementia and highlights four specific issues that have emerged that have required to be addressed:
   - The capacity and capability of the medical wards to support acutely ill people with dementia;
   - The capacity and capability of the community care system to absorb people discharged from Clisham;
   - The need to ensure effective processes and environments are in place to support the assessment of dementia diagnosis; and
   - The need to consider a recently published Scottish Government commissioned paper on the delivery of specialist dementia care

RECOMMENDATIONS

5. It is recommended that the IJB:

   (a) Notes the wider strategic position and interplay between mental health redesign and the redesign of residential care in Lewis;
   (b) Notes the working being undertaken in relation to the four areas highlighted above;
   (c) Notes the contents and recommendations of the Scottish Government commissioned report *Transforming Specialist Dementia Hospital Care*
   (d) Agrees that while we should take cognisance of the report as part of our ongoing efforts to redesign services, we should not accede to the request from the Scottish Government not to charge patients discharged from dementia wards to community care; nor commission a specialist dementia unit in the Western Isles given our population size and resources.

Ron Culley, Chief Officer
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CONTEXT

6. The Integration Joint Board has responsibility for directing a wide range of health and social care services, including support for people with dementia. As part of the strategic planning work undertaken within this context, we are seeking to address growing demand for services by undertaking two major and connected pieces of work: to redesign mental health services, with a focus on supporting more people in community settings; and to redesign the residential estate in Lewis, creating additional bed capacity.

7. In respect of the former, the Joint Board received a paper at its meeting in June 2018 on Mental Health redesign, which is being taken forward within a challenging operational environment. Our ambition is to create an enhanced community mental health team working to the principles of the recovery model and to do this we plan to liberate resources from the closure of two mental health wards: Clisham and APU. Clisham was originally established as an assessment ward for people with dementia but has not effectively functioned in this capacity for several years – it had become a *de facto* long stay dementia ward, with additional utility as an overflow from the medical wards. By contrast, APU has continued to function in line with its original purpose as an acute psychiatric ward, supporting people who are mentally ill. These wards absorb a significant proportion of the mental health staffing resource relative to the amount of people who can be supported at any one time. The redesign process has been challenging because the closure of Clisham requires sufficient community care capacity to be in place to facilitate the discharge of existing patients, while the closure of APU requires a new clinical pathway to be in place with a host mainland Health Board absorbing acute presentations incapable of being supported on a medium-longer term basis within the Western Isles Hospital; this needs to be augmented with more effective multi-disciplinary reablement capacity locally.

8. In respect of the redesign of the residential estate, we aspire to deliver three major capital reforms. First, to create a new multi-functional care campus at Goathill in Stornoway, which would offer residential care, extra-care housing, respite and intermediate care to older people; this would boost community care bed capacity from the existing 74 to 102 beds. Second, to demolish the Ardseileach Day Care Centre and in its place build additional extra-care housing for adults with a disability and shift day care into the Grianan centre. Third, to create additional extra-care housing capacity in rural Lewis, thereby serving the needs of the population on the western seaboard of Lewis. This is a complex redesign process, which will be dependent on under strain capital budgets stretching across three discrete but connected projects, and effective alignment with the Strategic Housing Investment Plan, to draw down on additional Scottish Government capital made available for housing development. This matter is outlined in more detail under item 7.3.

SUPPORTING PEOPLE WITH DEMENTIA

9. The Integration Joint Board has responsibility for directing a wide range of health and social care services, including people with dementia. As part of the strategic planning work undertaken within this context, the Joint Board agreed a far-reaching dementia strategy in 2017. The principal goals of the strategy are: early diagnosis; optimising physical health, cognition, activity and well-being; detecting and treating behavioural and psychological symptoms; avoiding inappropriate admissions to hospital; and providing information and long-term support to caregivers. The implementation of our local strategy is overseen by the Dementia Managed Clinical Network, chaired by the Nurse Director. Implementation is progressing well, with many actions already complete.

10. The local strategy reiterates our wider ambition to support people with dementia to live in their own home or in a homely environment. In pursuit of this goal, and in accordance with Scottish

Government guidance about what had previously been termed 'continuing care', clinicians and social workers have been working through a process of assessment to determine whether the patients residing in the Clisham Ward needed to be in hospital under the care of a psychiatrist or whether they could be supported in a more homely environment.

11. The national policy context offers clear direction here; as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community – in other words they should support specialist short-term or episodic medical care. If an individual's care needs can be properly met in any setting other than a hospital, then they should be discharged and their post-hospital care and support needs should be met in this more appropriate environment by the community health and care team, with specialist support reaching in as required.

12. Within this context, multi-disciplinary assessments of the patients in Clisham Ward have been progressed and, when a patient is identified as no longer requiring hospital care, arrangements are put in place to identify suitable homely accommodation. Such patients form a cohort of individuals – along with those in other wards - who are awaiting more appropriate accommodation out with hospital. This process was enacted after the Joint Board's preference to decommission the Clisham Ward was expressed. We have been making steady progress with this over the summer and now have only two patients residing in Clisham. When those patients are discharged, we will suspend admissions and focus on putting the new service into place.

13. As we have worked through this process, four further issues have emerged that have required to be addressed:

    - The capacity and capability of the medical wards to support acutely ill people with dementia;
    - The capacity and capability of the community care system to absorb people discharged from Clisham;
    - The need to ensure effective processes and environments are in place to support the assessment of dementia diagnosis; and
    - The need to consider a recently published Scottish Government commissioned paper on the delivery of specialist dementia care

14. The remainder of this paper describes the work we are undertaking in each of these areas.

<u>Supporting People with Dementia in Acute Care</u>

15. As we have worked through the process of redesign, we have kept a clear distinction between three categories of patients with dementia who may find themselves receiving care within the Western Isles hospital:

    a) People admitted to hospital because of their dementia under the care of a psychiatrist (the historical function of Clisham)
    b) People with dementia who are admitted to hospital because they are ill or in need of surgery or some other planned medical intervention.
    c) People with dementia who were admitted to hospital because they were ill or in need of surgery and are now a delayed discharge

16. As we have progressed with the reforms, and as psychiatry admissions have diminished, we recognise that we have given insufficient attention to the challenges of managing stressed and distressed behaviours of people with dementia who occupy beds in the medical wards (whether

delayed or not). This can be disruptive to other patients, many of whom will be acutely ill, and indeed it can be stressful for the person with dementia, especially if they are physically recovering and exhibiting a desire to wander.

17. Recognising the need to support the medical wards to cope with a future where more people with dementia are admitted for reasons other than their dementia, we have developed a ten point action plan to create more resilience, strengthen the links between the mental health team and the medical wards and enhance the capability of staff through a focused programme of training.

Managing Community Care Capacity

18. The other area that the closure of Clisham impacts is community care. Although we envisage a transition to a new care campus and ancillary developments by 2020, it is evident that we will need to manage the strain of having removed 12 long-stay beds for people with dementia (through the closure of Clisham) within our local system. Indeed, that is one of the reasons that the discharge of the existing Clisham patients is challenging – because it further pressurises long term care.

19. As members of the Joint Board know, we have put considerable effort into managing the discharge process over the last two years, with some notable success. This was in part guided by analytical work designed to test whether our challenges in managing demand were related to capacity or process. What we found in 2016 was that our home care hours per capita and care home beds per capita aligned with the Scottish average; hence, our focus on processes and whole system working. We are currently in the process of updating this analysis but we are aware of new capacity issues which have developed within our local system. In particular, neither the homecare service nor residential care has operated at full capacity over the last few months due to vacancies. This led to additional pressures within the hospital and for a period of a few months, delays increased beyond our agreed target level. While the picture has improved recently, we are very aware of how recruitment issues can impact whole system flow.

20. We face a further challenge over the next period in respect of the sustainability of our three remaining care units in Point, Uig and Carloway. These units are not especially flexible in terms of service users' needs and they are difficult to staff. However, beyond these day-to-day operational considerations, we are now managing regulatory conditions which will require us to review their sustainability. Our ambition had been to maintain the service until such times as the new residential capacity is available at Goathill and in Rural Lewis but it may be that regulatory pressures require earlier action (see item 7.6). If so, this could take a further 14 beds out of our local system. We are currently undertaking scenario planning to look at the impact of bed reduction across the system, which in turn will prompt discussion about the options available to us to create bridging capacity.

Supporting Dementia Diagnosis

21. A key objective within our local strategy is to increase the number of people receiving a diagnosis, which would allow for effective post-diagnostic support to be provided and the person receiving coordinated supported beyond that as their needs increase over time. Alzheimer Scotland has produced well-regarded models of care, which we hope to implement as part of our dementia strategy.

22. In addition, we are seeking to align the diagnostic pathway with wider reforms within primary care. In the past, diagnosis has normally required a psychiatrist to work with a patient through an assessment process that would lead to a decision around diagnosis. However, psychiatry is a relatively scarce resource and as such we have been seeking to develop a pathway which

starts in primary care and is largely supported by specialist nursing input, with appropriate connections to the GP as an expert medical generalist and ultimately the psychiatrist as the specialist in the field. This new model should liberate psychiatry time and support our wider transition towards a community facing psychiatry service. As part of this, further consideration is being given to whether any specific bed-based dementia assessment capacity is required.

Specialist Dementia Care

23. As we have rolled forward with our plans to reform mental health and boost community care capacity, the Scottish Government has commissioned a report on specialist dementia care, which was authored by Alzheimer Scotland's specialist dementia nurse. The report, which was published in June 2018, is broadly supportive of our wider strategy. Indeed, from an audit of dementia wards across Scotland, it recognises that most patients could be better supported in more homely community care environments. It therefore requests that Joint Boards across Scotland give consideration to decommissioning existing wards and instead give thought to new and more appropriate capacity. This is precisely the endeavor we are working on – and we are arguably at the leading edge of reform.

24. However, there are other parts of the report which we find more problematic. Specifically, it recommends the development of specialist dementia units, to support the very small number of individuals which the report projects will require hospital care because they have an acute psychological presentation of dementia or co-morbid mental health illness. When this proposal is situated within a large population group and covers the sort of territory that some mainland Health Boards span, then it may have a role in the wider range of services provided; but in an area like the Western Isles, with a small, dispersed rural population, and a correspondingly small mental health budget, this recommendation is wholly impractical to implement. It is therefore suggested that we do *not* build this into our own redesign proposals and if at some future juncture mainland specialist capacity is developed which would augment our local system, then we look at that when it becomes available.

25. The report further recommends that there should be no financial detriment for families as part of the decommissioning of hospital based care, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board. Again, it is recommended that the Joint Board does *not* implement this, not just because we're already more than half way through a process of service redesign, not just because we won't have a budget line to accommodate the lost income, but because in essence it would be fundamentally unfair: it would result in a person with dementia who is discharged from Clisham to a care home not being charged for care, while someone in similar circumstances discharged from the medical wards would be. To that end, it is recommended that we simply note the preference of the Scottish Government but continue to align ourselves to the national regulations which allow us to charge for community care services.

26. Members of the Joint Board should therefore consider the content of the report on specialist dementia care but note that in giving effect to its broad ambition, we will not commit ourselves to implementing every recommendation. The Joint Board is empowered to come to that view in that the letter from the Scottish Government asks only that we give consideration to implementing the recommendations and in any event the Joint Board is able to fall back on existing statute and regulation to implement our service redesign proposals as we had intended.

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Appendix 1:

Recommendation	Local Commentary
That specialist NHS dementia care is modernised, providing high quality, human rights based care, specifically for individuals who cannot be cared for in the community.	A human rights based model sits at the heart of our model of care and is referenced in our local dementia strategy
Integration Joint Boards develop a transition plan and a local engagement strategy with their partners, including NHS Boards and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop further community capacity in health and social care services.	This work has been undertaken as part of the mental health redesign process. However, our intention is to invest liberated capacity in community mental health services and community care rather than in a specialist dementia unit which would be unsustainable within a small partnership area.
That the Scottish Dementia Working Group and National Dementia Carers Action Network provide the representative groups for this local engagement.	Engagement process have been robust to date but if we can strengthen these further then we will give full consideration to the offer
Integration Joint Boards and NHS Boards assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings.	This work is being actioned already through the assessment of the patients in Clisham
The Alzheimer Scotland National Dementia Nurse Consultant provides expert guidance at both a national and local level.	We have had specific discussion with Alzheimer Scotland, noting our broad agreement with the thrust of the report but outlining where we will be unable to deliver on the recommendations
Integration Joint Boards and NHS Boards build strong and strategic local engagement on: any necessary de-commissioning and re-directing of resources to the development of specialist dementia hospital units and building further community health and social care services.	Both the mental health redesign process and the redesign of residential care have been subject to full and extensive public engagement
NHS National Procurement to commission the design of a blueprint for a specialist dementia unit that can be implemented by each NHS Board.	For reasons outlined above, it is unrealistic to operate a specialist dementia unit within the island boards.
There should be no financial detriment for families as part of the decommissioning process, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board.	We are unable to implement this because we have already set out on our reform, we have not made financial provision for lost income and believe it to be unfair on other people who have to pay for community care.
The legal status of patients being transitioned to the community is reviewed and the appropriate legal documentation put in place.	This is being considered as part of the assessment and discharge process.
The creation of modern specialist dementia units that will provide centres of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.	For reasons outlined above, it is unrealistic to operate a specialist dementia unit within the island boards.

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