A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Item 10**

Date of Meeting: 29th January 2020

Title of Report: Dementia Services Redesign

Presented by: **Caroline Cherry-Head of Service, Older Adults and Community Hospitals**
Julie Lusk-Head of Service, Mental Health, Learning Disability and Lifelong Conditions

The Integration Joint Board is asked to:

- **Note the extensive work carried out by the Dementia Redesign Group to focus on future service provision and pathways.**
- **Approve the recommendation of an Enhanced Community Dementia Team model as the further redesign of dementia services, made by the Transformation Board and SLT with a view to formal agreement in March 2020.**
- **Discuss the future governance of this work.**

1. EXECUTIVE SUMMARY

1.1 This paper reflects the work of the Dementia Services Review Group with a focus on the re-design of dementia services across the Health and Social Care Partnership to meet the challenge of the growth of people experiencing dementia and the impact on carers, communities and services.

1.2 This paper sets out a re-distribution of our assessment, treatment and care from one in-patient assessment resource for the whole area, to an enhanced specialist community resource within our localities.

1.3 The recommended option, following a review of care models and SWOT analysis, is to re-align our services and resources by having Enhanced Community Dementia Teams in each locality with referral to out of area specialist inpatient facilities when required (excluding Helensburgh and Lomond). This re-alignment, enhancing existing specialist community based dementia services, contains a recommendation within it to de-commission Knapdale Ward as a consequence of this redesign.

1.4 The rationale for this recommendation and service redesign is described below. This recommendation was agreed by the Transformational Board on the 7th December 2019.

1.5 It is out with the remit of the Board to revisit all the options but the rationale for the recommended option will be fully outlined. All options

considered in the SWOT analysis are outlined in **Appendix 1** whilst the role and remit of the Dementia Redesign Group is attached at **Appendix 2.**

1.6 Finally given the cross care group and geographical re-design implications, there is a need for the Dementia Redesign group to be reviewed and formalised in its role, function and future membership in order to implement agreed changes in a formal work plan over time.

2. INTRODUCTION

2.1 It is recognised that as the population lives longer the prevalence of dementia will increase. It is estimated that in 2014 there were 16,712 individuals newly diagnosed with dementia in Scotland. By 2020, this number is estimated to increase by 17% to 19,473 (see table 1 below).

2.2 The age group with the most estimated diagnosis of dementia appears to be 80-84 year olds (Scottish Government. 2016). Given that Argyll & Bute's population of adults aged over 75 set to rise by 30% by 2026 it is necessary to ensure that our dementia services are being delivered as efficiently and effectively as possible in order to meet this increase in demand. It is also necessary to ensure we work to the ethos of the national strategy and evidenced based practice.

2.3 Scotland is nearing the end of the third national strategy on dementia 2017-2020. The strategy notes:

"Our shared vision is of a Scotland where people with dementia and those who care for them have access to timely, skilled and well-coordinated support from diagnosis to end of life which helps achieve the outcomes that matter to them."

The emphasis within this strategy continues to be early diagnosis and flexible responses for people on their dementia journey whatever their stage in life.

Our local developments need to reflect progress against the strategic vision for dementia care.

	Projected Number of individuals Diagnosed 2020								
	Total	**Under 60**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**	**90+**
Scotland	**19,473**	**267**	**381**	**861**	**2,170**	**3,460**	**4,876**	**4,503**	**2,954**
Ayrshire & Arran	1,558	17	29	68	177	289	393	359	227
Borders	525	5	10	23	61	97	135	117	77
Dumfries & Galloway	725	6	12	30	78	134	184	169	111
Fife	1,405	18	27	62	166	262	353	311	206
Forth Valley	1,087	15	21	49	127	203	282	241	150
Grampian	2,009	30	40	92	230	346	494	464	312
Greater Glasgow & Clyde	3,703	58	78	164	390	627	928	894	562
Highland	1,399	15	26	62	159	258	347	316	216
Lanarkshire	2,222	32	47	105	253	409	572	504	299
Lothian	2,790	46	56	123	308	482	681	645	449
Orkney	99	1	2	4	10	19	26	21	16
Shetland	87	1	2	4	10	17	21	19	14
Tayside	1,730	20	30	69	185	294	429	412	291
Western Isles	133	1	2	5	14	22	33	31	23

Source: ISD Dementia Prevalence rates 2014-2020

https://www.gov.scot/publications/estimated-projected-diagnosis-rates-dementia-scotland-2014-2020/pages/7/

2.4 It has been acknowledged within Argyll & Bute Health & Social Care Strategic Plan for 2019 – 2022 consultation documents that due to the increasing financial constraints we are unable to fully satisfy the public's current expectations of care. In the landscape of an ageing population and increasing health and social care demands, the HSCP is required to

look at alternative ways to deliver care, utilising staff, buildings and money as efficiently as possible.

Historically dementia assessment and care in Argyll & Bute has been delivered via an inpatient model and those with advancing dementia or experiencing distress within their illness were admitted to the Argyll & Bute Hospital in Lochgilphead. In 2010, in response to the changes in national policy, small community dementia teams were established in each locality in order to provide increased community support. The core business of the teams is to support self -management and early diagnosis. The impact of these teams has been shown by the year on year reduction in demand for dementia inpatient beds locally however they are significantly stretched and there is an evidenced level of significant unmet need.

3. DETAIL OF REPORT

3.1 **Scoping Need and Demand**

Post diagnostic support for dementia following diagnosis remains a HEAT (Health Efficiency Activity Target) and NHS Boards are measured on timescales for post diagnostic support being offered. Argyll and Bute have not met the HEAT targets on post diagnostic support for many years.

There is still a lot work to be done around ensuring that those diagnosed with dementia are given access to post diagnostic support services. Figures published by the Scottish Government show that in Highland only 32.5% of those diagnosed in 2016/17 were subsequently referred for post diagnostic support. A comparison of caseloads of the community teams and inpatient unit showed that demand for community services have increased year on year whilst demand for inpatient care has decreased. However as the current community teams were not set up to provide crisis support, nor have capacity to offer this, it would appear that there will be a continuing need to provide inpatient support during times of crisis until community team establishments are increased. This demonstrates unmet need within the community which will only rise in time.

Although there is no comparable data for dementia rates per locality the Alzheimer Scotland dementia diagnosis estimates for 2017 show:
Argyll & Bute – 1982 (total for four localities including Helensburgh)
https://www.alzscot.org/campaigning/statistics

3.2 Current Use of Inpatient Dementia Assessment Beds

Knapdale Ward, the inpatient assessment ward based in Lochgilphead, has 3 adults in situ at present. These adults were never intended to remain long term within the ward.

All adults are delayed in their discharge. Intensive social work assessment is now in place to find appropriate placements. All

placements will be out of area. Families are aware of a changing model but will be updated on any developments. The ward could not be decommissioned until all 3 adults are placed appropriate to their needs.

The admission rate is 1.5 per month over 3 years. This is in the context of a lack of fully functioning enhanced community teams.

Inpatient treatment should be considered when all other treatment options have been exhausted; the risks of admitting someone with dementia to hospital are well documented. In their publication "Ensuring a Human Rights Based Approach for People Living with Dementia" the World Health Organisation state:

"*In many countries people living with dementia are often physically and chemically restrained, even when regulations are in place to uphold their rights*."

When a decision to admit a person to the local inpatient unit the person will be placed in a secure environment. The Scottish Health Service Cost Book (https://www.isdscotland.org/Health-Topics/Finance/Costs/Detailed-Tables/Speciality-Costs/Long-Stay-Specialties.asp) reported that Knapdale ward had the highest pharmacy cost of all dementia units in Scotland for 2017/18. It also reported a cost per occupied bed day for Knapdale of £908, again the highest costing dementia bed in Scotland. There are 15.49 WTE staff in Knapdale (a mixture of registered and non - registered nursing staff) Initially, following organisational policy, all staff would be offered opportunities to be redeployed within community teams with awareness that a skills development plan to support this transition will be required. There will be 16 new posts within the community which should ensure redeployment for in patient ward staff. However the geographical spread of community teams will present understandable challenges to staff relocation and a plan to support this change process for staff will need to be put in place.

3.3 The Case for Change: Enhanced nurse led community dementia team with referral to out of area specialist inpatient facilities when required and the planned de-commissioning of Knapdale Ward

The process of and case for change is outlined. There was unanimous agreement within dementia short life working group that services have to change to meet demand. A high level process mapping exercise was undertaken to identify issues and bottle necks within current pathway.

A & B Dementia Pathway Process Map

Transforming Specialist Dementia Hospital Care – Government commissioned report outlining criteria for admission to dementia units.

Transforming
Specialist Dementia H

01 February 2018 to 31 January 2019 there were 2 routine admissions and 2 planned transfers for Inpatient assessment. This would indicate that less than 0.3% of the population of those diagnosed with dementia in Argyll & Bute required access to a specialist inpatient unit.
Recognition of risks associated with hospital admission for those living with dementia
Reducing demand for Inpatient assessment service
Increasing demand for Community dementia services

Oban Lorn & Isles Dementia Team	**MAKI Dementia Team**	**Cowal & Bute Dementia Team**
Jan 2019 Caseload – **284** (44 pre- diagnosis) **↑ 54 since 07/17 (19%)** <u>Staffing</u> CPN = 1 WTE Dementia OT = 0.8 WTE Alz Link Worker = 2 WTE	Jan 2019 Caseload – **322** **↑ 146 since 07/17 (45.3%)** <u>Staffing</u> CPN = 1 WTE Dementia OT = 0.8 WTE (15 hrs vacant Kintyre) Alz Link Worker = 1.3 WTE	Awaiting Caseload Data <u>Staffing</u> CPN = 1WTE Dementia OT = 1 WTE Alz Link Worker = 2 TBC
Total MAKI & OLI	**606**	
Total Staffing	**CPN = 2 WTE** **Dementia OT = 1.6 WTE** **Alz Link Worker = 3.2 WTE**	

The Inpatient Assessment Ward temporarily closed to admissions since February 2018, for safety of staff and patients. No alternative service model was identified. There is no crisis response service within community to avoid admission to hospital. There is a lack of training, education and support for formal and informal carers as no capacity within existing community dementia teams. Moreover there remains a chronic challenge with recruitment within medical and nursing staff. There is a need to create progressive posts within a contemporary model of care in order to attract personnel to remote and rural areas.

3.6 Detail of the Approach

The enhanced community team option is modelled on the success of NHS Shetlands dementia team nurse based enhanced community service but also follows strategic drivers and evidence based practice.

In scoping dementia redesign activity within other health boards in Scotland the Alzheimer Scotland Clinical Nurse Specialist working in NHS Shetland reported that they currently work within a nurse led dementia service. The service comprises of two specialist dementia nurses working to an advanced nurse practice model. For those requiring a diagnosis, they take referrals for dementia assessment from GPs, hospital consultants and ANPs. They assess, arrive at preliminary diagnoses, and discuss with a Consultant Psychiatrist in Aberdeen via video-link. As a team, they formalise the diagnosis and agree a treatment plan. The nurses are both prescribers, so are able to commence cognitive–enhancing medication. They report swift times from referral to diagnosis, and increasing numbers of new referrals/diagnoses. They have a specific post-diagnostic service (part of a Scottish pilot project), comprising an OT and a post-diagnostic support worker and work closely with them, referring their patients to them.

The nurses also run a rapid-response service to address behavioural symptoms associated with dementia. This utilises advanced nurse practice including prescribing of psychoactive meds, and consultant psychiatrist input if needed. This has been very successful. Shetland does not have a dementia inpatient unit, and have had no admissions to hospital in Shetland for dementia related reasons for around two years, and no off-island transfers to mental health inpatient facilities for a similar timeframe.

Shetland also achieved a 72.0% post diagnostic support referral rate as opposed to Highlands 32.5%

The population in Shetland is 23,080 and could be equated to most Argyll & Bute localities in population size:
Cowal & Bute = 20,473
Oban Lorn & Isles = 19,996
Mid Argyll Kintyre & Islands = 20,177
Helensburgh = 26164
https://www.argyll-bute.gov.uk/info/population-where-we-live

The Model for the Future

It is a nurse led model of **Community Enhanced Dementia Team** supported by 1 WTE Psychiatrist for Argyll & Bute. There has been a reliance on locum Psychiatrists to provide specialist dementia input for a number of years. This has proved not only costly but de-stabilising for patients and staff. A nurse led model would reduce the reliance on a Psychiatrist for simple diagnosis and prescribing. The model would also create an exciting and rewarding career pathway for a mental health nurse

with a special interest in dementia care. Similarly, although community teams for older adults will be supporting many adults with dementia in the community, a social work focus within a specialist dementia service can support a clear crisis response and multi- disciplinary working.

It has been identified that there is a lack of crisis response and dementia education within the community setting including our care homes. The enhanced community teams would have the flexibility to provide this support. In addition, as part of the model links with developing dementia friendly initiatives in our communities, well established in other parts of Scotland and part of the national strategy, will take place over time. Our response to living with dementia goes beyond a clinical service response. Further work is required to support to further develop community services in line with further redesign of older adult day services.

By enhancing the community team establishments allowing capacity to build a crisis response element to the service with an education remit it would be expected that the current demand for inpatient care would further reduce.

Each team will be led by an Advanced Nurse Practitioner. This member of staff will have the authority to diagnose in less complicated cases and prescribe cognitive enhancers as well as psycho active medication when required. This would reduce the reliance on Psychiatry allowing for 1 WTE Psychiatrist to support all of the teams and provide supervision when complex diagnosis and presentations arise. This is exactly in line with using our resources to the optimum capacity.

Three fully functioning teams are recommended within 3 localities with further refinement on the function.

The team would be one fully integrated team but two components are illustrated below. The exact staff and skill mix needs further refinement by the Dementia Redesign Steering Group.

Enhanced Community Dementia Team

Dementia Clinic Section
Consultant Psychiatrist
Advanced Nurse Practitioner (MH)
Senior Community Psychiatric Nurse
Admin (shared)

Post Diagnostic Support Section
Occupational Therapist
AS Link Worker 2 per team
Band 3 Post Diagnostic Support Worker
Social Worker
Admin (shared)

The Dementia Clinic Section

This part of the team would be responsible for assessment, diagnosis, prescribing of cognitive enhancers and monitoring. They would also lead on crisis prevention and intervention. The ANP in each locality would co-ordinate their diaries to ensure minimal conflicts with each other in order to provide a timely response if a sudden or emerging crisis arose within a community setting. Each team will be led by an Advanced Nurse Practitioner. This member of staff will have the authority to diagnose in less complicated cases and prescribe cognitive enhancers as well as psycho active medication when required. This would reduce the reliance on Psychiatry allowing for 1 WTE Psychiatrist to support all of the teams and provide supervision when complex diagnosis and presentations arise. This is exactly in line with using our resources to the optimum capacity.

Post Diagnosis Support Section

Once the person has received their diagnosis they will then be directly referred internally to the PDS service. This service will provide support with care planning, advice, sign posting, Power of Attorney, peer support, education, cognitive stimulation, social prescribing and carer identification and support. Social work roles would act as a key link with mainstream community teams, identifying and minimising crisis and linking to adult community teams for ongoing care management when required. This role has been tested within Dementia Teams in other parts of Scotland.

The existing teams would remain in situ whilst being part of a wider service. This would reduce variance in practice around Argyll & Bute and allow for cross locality working when required. Each team will be led by an Advanced Nurse Practitioner. This member of staff will have the authority to diagnose in less complicated cases and prescribe cognitive enhancers as well as psycho active medication when required. This would reduce the reliance on Psychiatry allowing for 1 WTE Psychiatrist to support all of the teams and provide supervision when complex diagnosis and presentations arise. There is no local 24hr staffed bed option. Where an emergency bed is required this would be provided within existing locality based services with in-reach support from the enhanced dementia team during normal working hours. As detailed in the Knapdale admission information, 62% of admissions were from another hospital environment. This option would reduce the risk of transitioning someone living with dementia to yet another hospital environment and instead, would bring the specialist support to the adult.

Argyll and Bute will be working with GGC to confirm the future pathway for specialist assessment and this will be concluded once this process is complete.

4. RELEVANT DATA AND INDICATORS

4.1 Noted in 3.1.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 This forms part of mental health redesign work but also supports the development of effective community services for older adults.

5.2 This work underpins the main strategic aim of the Partnership, to support adults to remain living well at home within their own communities.

6. GOVERNANCE IMPLICATIONS

6.1 The imperative of this redesign is to get the right support to the adult at the right time. **Appendix 3** highlights the budget breakdown and costs associated with the potential new model as opposed to the existing model. Costs are indicative and need further refinement however there are anticipated efficiencies.

6.2 As part of the Transformational work streams, the options appraisal was discussed and an agreed option was recommended in December 2019.

6.3 This paper went to the Senior Leadership Team for discussion in January 2020.

6.4 This paper went to the Staff Liaison Group in January 2020

6.5 Staff Governance

This paper went to the staff liaison group in January 2020. Further discussion with existing staff affected is required.

6.6 Clinical Governance

The Dementia Redesign Group will be reformed with an explicit terms of reference, role and remit. It will report to the Mental Health Redesign Steering Group.

7. PROFESSIONAL ADVISORY

The professional leads are supportive of a remodelling of how dementia care is delivered in Argyll & Bute and an enhanced community model of care in line with the aspiration of the Dementia Strategy and our Strategic Plan.

They recommend strong professional leadership involvement in the implementation phase to include risk identification and mitigation, workforce modelling and establishment settings in line with service delivery needs.

8. EQUALITY & DIVERSITY IMPLICATIONS

EQUIA is attached.

Dementia Redesign
EQIA Draft 2 (1).docx

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Not relevant.

10. RISK ASSESSMENT

Risks are outlined in the SWOT analysis, see **Appendix 1.** There are risks associated with the transition period, sourcing Advanced Nursing Practitioners and ensuring effective skills development. These risks can be mitigated in part by a detailed implementation plan.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The working group included the views of carers.

It is proposed that a formal consultation should take place between the January and March Board seeking views on the proposed changed model using the agreed IJB consultation process.

12. CONCLUSIONS

The dementia short life working group undertook an options appraisal to determine the preferred option for the future of dementia care in Argyll and Bute. Currently, the HSCP is not meeting post diagnostic targets, there is no effective pathway or service response other than diagnosis or referral to Knapdale for assessment.

The enhanced community dementia team emerged as the most appropriate service for the future of dementia care delivery within Argyll and Bute. This genuinely shifts the model of care to supporting adults with dementia within their own localities. However this needs embedded within developing pathways.

As a result the Transformation Board accepted the recommendation which includes the planned de-commissioning of Knapdale Ward.

IJB is asked to support the recommendation and proceed to next stage of stakeholder and public engagement on the preferred model to inform the final delivery model with all stakeholders. It is acknowledged that more detail is required on the model and this will be developed by the Dementia Services Redesign Group.

The Dementia Services Redesign Group is recommended as the vehicle to plan implementation of any future model and that the membership, role and remit of this group be fully reviewed to implement the proposed changes.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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APPENDICIES

Appendix 1

SWOT Analysis of all options considered

Option 1 Retain Existing Model of Care with reduction to 3 Inpatient Assessment Beds

STRENGTHS	WEAKNESSES
• Reduced cost	• No community team development • Lack of admission criteria - increased risk of avoidable admissions • Risk to patients in a hospital environment i.e. infection, falls. • Several highly distressed patients confined in a small area. • Majority of patients out with their own locality • Limited ability to recognise physical illness – no RGNs • Risk of delay in discharge • Ward environment not focussed on enabling – no patient kitchen, patterned floor covering, locked doors.... • Reduced demand for service • High cost associated with agency nursing staff/locum psychiatry cover. • Inefficient • Centralised service • Lack of integration with wider health and social care systems • No local specialist inpatient service

OPPORTUNITIES	THREATS

• Develop robust admission/discharge criteria	• Recruitment and retention of appropriately skilled Medical and Nursing Staff
	  • National and local policy moved toward community based models of dementia care.
	  • National recognition of limited need for inpatient treatment.
	  • Lack of care home provision and timely access to care packages in Mid Argyll
	  • No community based crisis response to prevent avoidable admissions

OPTION 2 - Enhanced Nurse Led Community Team – with inpatient provision (2 beds) located within existing adult services, staffed by RMN/HCA 24/7 for short term safety and stabilisation – SLA for longer term Specialist Dementia Inpatient Care with NHSGGC

STRENGTHS	WEAKNESSES
• Local beds for emergency short term care • Phased approach to change • Investigations completed as inpatient – CT, ECG, bloods. • Patients have access to a local specialist dementia service at all stages of illness • Service is flexible to changing needs of population • Enhanced service has capacity to provide education and training to stakeholders • Clear roles for staff allowing right care at the right time • Enhanced career pathway for nurses • New roles and opportunities • Reduced reliance on psychiatry – cost effective • Reduced waiting time for non-complex diagnosis • Reduced waiting time to start treatment and access post diagnostic support • Enhanced communication pathway for all stakeholders in care • In reach service will provide support for care homes, care at home and local hospitals. • Enhanced support to facilitate a more rapid discharge from	• If care home beds ?Quality of care staff • Out of area specialist beds leading to increased travel (excl Cowal & Bute) • Approximately 2 years to train an Advanced Nurse Practitioner • Cost associated with staff up skilling • Risk of delay in discharge leading to lack of bed availability for unmanageable crisis in the community. • Major service change – anxiety in public and staff • Inequalities with bed availability (centralised service) • No local specialist inpatient service

acute care. • No requirement for out of area referral for short term treatment • Clear pathways of care, swifter access to appropriate service • Improved access • Improved staff competence and skill • Optimising resources	
OPPORTUNITIES	**THREATS**
• New roles • Greater collaboration with provider partners in both primary, secondary care and the independent sector • Improve recruitment and retention by providing an enhanced career pathway for staff within a developing service. • Enhance public confidence in service • Relocate • Redesign • Bring services in line with local and national policy • Reduce hospital admissions • Provide human rights based care • Attract highly skilled, ambitious practitioners • Provision of skilled therapeutic interventions	• Financial constraints in NHS and beyond • Recruitment and retention of appropriately skilled Medical and Nursing Staff • National and local policy moved toward community based models of dementia care. • Lack of care home provision and timely access to care packages in Mid Argyll • Staff stress • Capacity to support inpatient admission within existing acute inpatient services

Option 3 - Enhanced Nurse Led Community Team Only with SLA for longer term Specialist Dementia Inpatient Care with NHSGGC

STRENGTHS	WEAKNESSES
• Skill mix • Community focus • Enhanced teams • Specialised care • Appropriate environment • Reduced length of stay in hospital/cost effective • Enhanced career pathways • New roles and opportunities • Equitable service throughout Argyll and Bute • Service has capacity to provide education and training to stakeholders • Clear roles for staff allowing right care at the right time • Enhanced career pathway for nurses • New roles and opportunities • Reduced reliance on psychiatry – cost effective • Reduced waiting time for non-complex diagnosis • Reduced waiting time to start treatment and access post diagnostic support • Enhanced communication pathway for all stakeholders in care • Community based crisis response – reducing inappropriate admission to hospital	• Idealistic • ?Not reality based • Major service change • Anxiety in public/staff • Out of area specialist beds leading to increased travel (excl Cowal & Bute) • Approximately 2 years to train an Advanced Nurse Practitioner • Cost associated with staff up skilling • No local 24hr mental health supported care • Requirement for out of area referral for short term inpatient treatment • Reduced access to inpatient services

• In reach service to provide support for care homes, care at home and local hospitals. • Enhanced support to facilitate a more rapid discharge from acute care. • Clear pathways of care, swifter access to appropriate service • Improved access to community based services • Improved staff competence and skill • Optimising resources	
OPPORTUNITIES	**THREATS**
Social Worker added to team Closer working with TEC enabled care Mixed speciality (RCP view) New roles Greater collaboration with provider partners in both primary, secondary care and the independent sector Enhance public confidence – higher visibility of service Services in line with national direction Skilled person centred therapeutic interventions. • Improve recruitment and retention by providing an enhanced career pathway for staff within a developing service. • Relocate • Redesign	Recruitment and retention of appropriately skilled Medical and Nursing Staff

• Reduce hospital admissions • Provide human rights based care • Attract highly skilled, ambitious practitioners • Provision of enhanced support for carers	

Option 4 - Development of Knapdale Ward to provide Inpatient Assessment/Respite/Day Care/Outpatients/Information Hub & Community Team Base. Development of Enhanced Community Teams

STRENGTHS	WEAKNESSES
• Planned Admissions • Joined up concept • (Strengths of enhanced community team element captured in previous options)	• Stepping back in service delivery (NHS day care/respite) • Knapdale unsuitable layout and design for a dementia unit • Very busy environment if all services accommodated • Uni-professional approach to inpatient/day service/respite • No identified access to specialist dementia unit • No data/evidence to back suggested bed numbers
OPPORTUNITIES	**THREATS**
• ?Government funding (no clarity on what this means)	• Cost • Recruitment • Lack of identified need for inpatient assessment service

Appendix 2

Remit of the Mental Health and Dementia Services Development Steering Group

TERMS OF REFERENCE

Meeting Title: Mental Health and Dementia Services Development Steering Group

Meeting Remit
As directed by the Argyll and Bute Service Transformation Board, ensure the progression and delivery of transformational change, and redesign of the mental health and dementia services. **This will be achieved by providing:** • **Development and implementation of Argyll and Bute's mental health and dementia services strategy.** • **Recommendations for change to the Service Transformation Board** • **Support for the redesign and development of Mental Health and Dementia services within Argyll and Bute.** • **Accountability to the Service Transformation Board** • **Supporting the resolution of any HR or organisational change issues.** **The work plan will include:** • **Monitoring delivery of savings and best value in line with the Quality & Finance Improvement Plan** • **The review and future development and implementation of the Community Mental Health Teams within Argyll and Bute.** • **The review and future development and implementation of Mental Health in patient services.** • **Supporting the statutory requirement of MHO duties within the services.** • **Consideration of educational needs with the services** • **The review and future development of dementia care in Argyll and Bute, including in patient and community services.** • **To be responsible and accountable for the allocation of new resources to mental health services in Argyll and Bute.** • **Supporting and approving the application of PDSA improvement methodology to the development of these services.** • **Determine method of engagement for service users and carers** **The steering group will direct and support this work, via locality implementation/short life working groups.** • **Mental Health Inpatients (Nicola Gillespie)**

- **Community Mental Health Review (Gillian Davies)**
- **Dementia Inpatient & Dementia Community Services (Lora White/Mhairi Will)**
- **Psychological Therapies (Lucia Swanepoel / Ishbel Dumughn)**
- **Transition to Mental Health Services (Maggie Young / Karen Campbell)**
-

The Steering Groups will achieve the above by building on positive relationships, effective, open and honest communication.

The Mental Health & Dementia Steering Group will adhere to the HSCP Values of "CIRCLE".

We will demonstrate these shared values through the following agreed expectations for the meetings:

- **Start and end meetings on time.**
- **Stay on track**
- **Listen to others and don't interrupt-you will have a chance to speak.**
- **Accept that there will be differences of opinion.**
- **Show mutual respect.**
- **Leave egos at the door.**
- **Challenge ideas, not individuals.**
- **Be free to speak without fear of reprisal.**
- **Encourage contribution of the whole team.**
- **Do what you say you will do.**
- **Keep appropriate confidences.**
- **Make decisions based on clear and accurate information.**
- **Make decisions based on an integrated approach to care.**
- **Silence is viewed as agreement.**

Reporting and Accountability
Argyll and Bute HSCP Adult Services Management Team **Argyll and Bute HSCP SLT.** **Argyll and Bute HSCP IJB.** **Argyll and Bute Service Transformation Board**

Membership	
Designation	**Name**
Interim Head of Service & Professional Leadership-Social Work (Exec Lead)	Phil Cummins
Locality Manager- MAKI & Mental Health (Chair)	Donald Watt
Head of Adult Services West	Lorraine Paterson
Professional Leadership -Nursing	Liz Higgins
Professional Leadership-AHP's	Carrie Hill
HR -Council	Jo McDill
HR-Health	Trudy Kennedy

Staff side-Health	Fiona Broderick
Staff side-Council	
Finance-Health/Council	Denise McDermott
Consultant Nurse Mental Health	Gillian Davies
LAM-Mental Health	Nikki Gillespie
LAM – Mid Argyll (Knapdale)	Kate MacAulay
LAM – Cowal & Bute	Jane Willaims
Alzheimers Scotland	Sarah Burgess
Acumen	Rachel McLean
Clinical Lead	Dr Tammy Burmeister
Clinical Nurse Specialist	Mhairi Will
Psychological Therapies	Lucia Swanepoel / Ishbel Dumughn
Advanced Nurse Clinical Education	Wendy O'Ryan
Practice Education Facilitator	Lora White
Alzheimer Scotland Dementia Nurse Consultant	Ruth Mantle
CAMHS Team Lead	Maggie Young
Mental Health Officer	Jacq Osborne / Julie Cameron
Service Improvement Officer	Colin Willis
Scottish Care Integration Lead	Margaret McGowan
Scottish Care Integration Lead	Janice Cameron

Quoracy
A minimum of six members in attendance

Agenda Setting
1 week before meeting.

Administrative Arrangements
Cheryl Stewart

Work Programme		
Date	**Regular Business**	**Special Items**

Date TOR Agreed: **Review Date:**

Appendix 3

Financial Information

		Existing Funded Establishment			Enhanced Community Dementia Team	
Inpatient Service - 12 Beds Knapdale Ward, Mid Argyll Hospital		**Wte**	**£**		**Wte**	**£**
Psychiatric Nursing		9.80	480,000			
Health Care Assistants		12.25	430,000			
		22.05	**910,000**			
Medical						
Consultant Psychiatry		1.00	140,000			
		1.00	**140,000**			
Community Dementia Service						
Psychiatric Nursing		3.00	150,000			
Occupational Therapy		2.52	130,000			
		5.52	**280,000**			
Alzheimer Scotland Link Workers		6.00	200,000			
		6.00	**200,000**			
Dementia Clinical Function						
Consultant Psychiatry					1.00	140,000
Psychiatric Nursing					6.00	350,000
Total Memory Clinic					**7.00**	**490,000**
Post Diagnosis Support Function						
Occupational Therapy					3.00	160,000
Social Worker (incl. Travel)					3.00	155,000
Health Care Assistants					9.00	280,000
Alzheimer Scotland Link Workers					6.00	200,000
Admin					1.00	30,000
Total Post Diagnosis Support Team					**22.00**	**825,000**
IT						5,000
Travel			20,000			30,000
Total Non Pays Costs			**20,000**			**35,000**
Total		**34.57**	**£ 1,550,000**		**29.00**	**£ 1,350,000**

Total Existing Funding			**£ 1,550,000**			**£ 1,550,000**
Remaining Budget			**£0**			**£ 200,000**

Analysis excludes potential protected earnings costs arising from closure of Knapdale Ward

Notes

Potential Costs of Out of Area Dementia Inpatient Referrals to NHS Greater Glasgow and Clyde for Information				
GG&C Cost per Inpatient Bed Day	Based on Average Length of Stay (Weeks)	Cost per Admission	No. of Admissions per Annum	Cost
£		£		£
350	8	£ 19,600		
			6	£ 117,600
			8	£ 156,800
			10	£ 196,000