A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 25th March 2020

Title of Report: Dementia Services Redesign-Progress Update

Presented by: Caroline Cherry, Head of Service, Older Adults and Community Hospitals

The Integration Joint Board is asked to:

- **Approve the planned closure of Knapdale Ward, Mid Argyll in order to move to implementation planning of the Enhanced Community Dementia Model, noting that this process may take a year or more to implement.**
- **Approve and ask the Senior Leadership Team to approve the development of detailed implementation plans by way of a Dementia Steering Group, giving the Board assurance that risks are managed as a result of the process of transition.**
- **Note the feedback from the consultation.**

1. EXECUTIVE SUMMARY

1.1 The proposal for the redesign of Dementia Services was brought to the Integration Joint Board in January 2020. After extensive debate, and with the support of Professional Leads, the Board agreed with the rationale of the development of enhanced community dementia model and asked for consultation on the proposed approach. In order to invest in extensive community based models of care, the disinvestment in the assessment ward in Mid Argyll is proposed. This would take place over a period of time to rebalance care and ensure safe pathways are in place across all areas.

1.2 The purpose of this report is to update on the initial consultation and give the Board assurance on the consultation process whilst outlining next steps.

2. INTRODUCTION

2.1 The aim of the initial consultation was to inform why dementia services need to change to meet the challenges of the future, inform detail of the proposed change (including illustrating a before and after model) and to consult on developing an Enhanced Community Dementia Team Model.

Consultation was also sought on the planned closure of Knapdale Assessment Ward-Mid Argyll. The consultation was scoped using the framework developed by the IJB and external critique was sought from the Scottish Health Council. The framework for consultation and engagement is attached at **Appendix 1.**

2.2 It will be important for the Board to be aware of timescales and processes of the initial consultation and reflect on whether the initial consultation is sufficient for progression of the model.

2.3 It will be important for the Board to be aware that after this initial consultation, there will be a period of engagement to develop a Dementia Steering Group which is inclusive and develops a genuine partnership to develop dementia services and community responses to dementia. This group will be developed to support detailed implementation plans for each locality which can be brought to the Board as assurance of the development of safe care. Closure of the ward will not take place until these plans are feasible and in place.

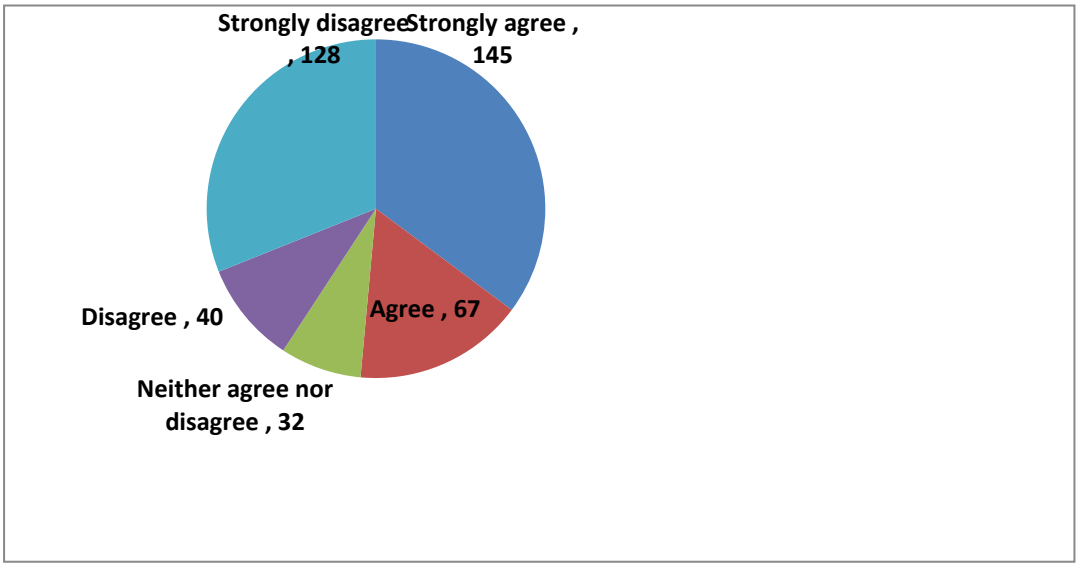
3. DETAIL OF REPORT

3.1 The complete consultation report is attached at **Appendix 2.** There were limitations in terms of island consultation and the general noticing for events. There were a small number of complaints that the consultation seemed rushed, particularly for Bute which was seen as an afterthought. The consultation comprised of an online consultation with over 400 replies and 11 face to face events.

3.2 Events were held in Lochgilphead; Oban; Dunoon; Campbeltown; Islay and Bute, over 250 people attended in total with a mixture of people with dementia, unpaid carers, health and social care staff, third sector services, Elected Members and members of local communities.

3.3 Comments extracted from the online consultation as of the 16th March 2020 were overall in favour of the development of the community model as illustrated below. This is reflective of the community consultation events overall which is explored more in Section 3. There were more negative individual comments than positive attached to the consultation (123 as opposed to 84).

To what extent do you agree with the proposal to disinvest in our Inpatient Assessment Service and reinvest in three locality based Enhanced Specialist Dementia Community Teams?



3.4. **Reflection and Analysis**

The status quo of dementia service provision cannot remain. Upset relatives talked about a lack of pathways, distress at not knowing who to turn to, families being overwhelmed and unacceptable waits for diagnosis. People were keen that the Partnership acknowledges the fragile infrastructure that we are starting from, but the mapping of services in each community and use of these forums to map out potential pathways was useful. There was overwhelming support for a co-production approach to dementia service redesign and a dementia steering group. Over 70 people gave their details to be involved.

3.5 As noted key infrastructure issues were reflected upon, notably lack of local choice for care homes, differential access to day services, lack of respite care and lack of support to unpaid carers as the key priorities. The Partnership needs to acknowledge that in building this model, the interdependencies of older adult care need to tackled, including care home and housing, care at home and support for unpaid carers.

3.6 Overall, looking at all community events, the community model was favoured by all within local consultations (except Mid Argyll) as the most likely to support people with dementia and their carers locally and the principle of local care was welcomed.

3.7 There were, as the consultation report alludes to, concerns about two key areas beyond the issue of infrastructure-the feasibility of the model and pathways for inpatient care.

3.8 Feasibility refers to issues including recruitment of staff, a note about transparent funding arrangements and concern about implementation. There was a certain amount of scepticism about any changes taking place at pace.

3.9 Pathways need developed for every area of dementia care, but where there is a rare occasion of inpatient assessment care, the geography was less of an issue than reassurance that beds would be available within Glasgow.

3.10 Mid Argyll expressed similar themes regarding lack of infrastructure and feasibility but felt it was short sighted to close an inpatient ward that could assess people with complex dementia needs.

3.11 Mid Argyll expressed concern about the consultation process in itself.

3.12 Mid Argyll argue that Option 4 has not been fully looked at or considered within the original options appraisal. It is also argued that Knapdale Ward has not effectively been developed to fulfil its role.

4. RELEVANT DATA AND INDICATORS

4.1 Noted in 3.1.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 Developing and redesigning dementia services is a strategic aim of the Partnership, in addition this work will have a major impact on development of care homes and care at home.

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

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

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

6.3 This paper went to the Staff Liaison Group in January 2020.

6.4 The redesign of dementia services was presented to the Board in January 2020.

Staff Governance

6.5 The Board requested officers in January 2020 to engage with staff directly affected. Since then there have been fortnightly meetings between the Head of Service, staff, managers and unions.

Clinical Governance

6.6 Any change or service redesign will need to account for risks in the care of adults with dementia.

7. PROFESSIONAL ADVISORY

7.1 Noted and referenced within the report for January 2020.

8. EQUALITY & DIVERSITY IMPLICATIONS

EQUIA and Staff Impact Assessment have been completed.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 No details of any adult's data has been disclosed.

10. RISK ASSESSMENT

10.1 Dementia services in their current state require a Risk Register with mitigating actions likewise a Risk Register is required to accompany an implementation plan.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

11.1 As described within Section 3 of this report and within **Appendix 2.**

12. CONCLUSIONS

12.1 The Board asked Officers in January 2020 to consult on the proposed model of care and the planned closure of Knapdale Ward. During this time, over 250 people attended face to face events and there were over 400 on line responses. Overall the development of the community model was favoured with an understanding that this will be a process of change that will require detailed implementation plans for each area. It is clear that infrastructure, care home choices and unpaid carers are key interdependencies to developing safer provision of dementia care in Argyll and Bute.

13. DIRECTIONS

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

REPORT AUTHOR AND CONTACT

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Appendix 1

Dementia Services Redesign Public Consultation Information Pack

1. INTRODUCTION

Argyll and Bute Health and Social Care Partnership want every person living with dementia in Argyll & Bute to receive high quality care and support that enables them to live independently in their own homes for longer. We want to prevent crisis and avoid unnecessary admissions to hospital.

We have undertaken a review of our Specialist Dementia Mental Health Services in Argyll & Bute and have discovered the following:

- There has been a year on year reduction in demand for in-patient dementia assessment beds.
- Average length of stay is -over double the national average.
- Knapdale ward's physical environment is not conducive to specialist dementia care.
- There has been a year on year increase in demand for our community dementia teams
- The in-patient assessment service that is least used takes up the bulk of the total financial dementia service resource
- Unpaid Carers are under pressure in our community settings such as community hospitals, care homes and private residences.
- We need to find better ways to prevent, support and manage crisis in the community
- We are working within a reactive model of care rather than focussing on preventative strategies.
- There is no framework to provide dementia education, training and support in a consistent and accessible way for all stakeholders in care.
- People in Argyll & Bute are experiencing challenging lengths of time to receive a diagnosis of dementia.
- Our model of care has remained unchanged for a decade despite the knowledge and understanding of the appropriate treatments for those living with dementia moving forward at pace.

2. CURRENT SITUATION IN ARGYLL AND BUTE

Analysis of the admissions to our inpatient assessment ward between February 2016 – January 2019 showed that there were 55 people admitted to the ward. Of these admissions, 40 people were already in a place of care prior to admission with 15 coming from a private residence. Only 6 admissions were recorded as emergency with 49 recorded as either routine or planned.

What this tells us is that at least 40 people who were already in a care environment may have been prevented from enduring an unnecessary transition to another place of care had we been working within a model that allowed the

specialist support to reach them and maintaining them within their own localities. There could have been a further reduction in admissions to hospital had we provided specialist support at the onset of crisis.

Analysis of our community team caseloads showed that Oban, Lorn & Isles team had an increase of 19% in their case load in an 18 month period bringing their case load to 284. In Mid Argyll, Kintyre & Islay caseloads rose in the same period by 45.3% bringing their caseload to 322. Our teams are small in each locality with 1 full time Dementia Community Psychiatric Nurse and 1 part time Occupational Therapist focussing on assessment (with the exception of Cowal & Bute who have a full time Occupational therapist) and 2 Alzheimer Scotland Link Workers providing post diagnostic support.

We have looked at these services and feel we could be using our financial and staffing resource in a better way that supports more people. We are therefore recommending that the inpatient assessment service is de-commissioned and the money reinvested into community services.

3. THE PROPOSED NEW DEMENTIA SERVICE

We are proposing that we disinvest in our inpatient service and reinvest in enhancing our specialist community teams. These teams would be led by Advanced Nurse Practitioners who will have the capability in most cases to diagnose and treat people with dementia in a timely manner. These teams would be supported by a Consultant Psychiatrist. The teams would have the capacity to be flexible and responsive to the needs of our increasing older population. They would provide in-reach to existing services as well as peoples own homes. Our vast remote and rural geography with island populations calls for this flexibility in our specialist services. Moving away from investing in buildings and instead investing in the service itself. This model would ensure equity of service amongst our localities and ensure the right support is available at the right time.

This model would double the number of Community Nurses in each team, increase the hours for Occupational Therapists, introduce 1 new Social Worker role along with 3 new Senior Health Care Support Worker roles and 1 full time administrative worker supporting the 3 teams. In total this would create 16 new posts within specialist community dementia services.

Whilst most people with dementia will live well with their illness, we acknowledge that there may be a small number of people each year who will require admission to a specialist dementia unit. These individuals will have exhausted all means of support and be experiencing very severe behavioural and psychological symptoms of dementia. As with most other complex health conditions we would have arrangements in place with Greater Glasgow & Clyde Health Board in order to access a bed within a specialist contemporary unit. Our enhanced community teams would retain oversight of this admission and work with families and carers to facilitate discharge back to the person’s locality as timely as possible. Respite support would usually take place in care homes.

4. WHY ARE WE PROPOSING TO DECOMMISION THE CURRENT INPATIENT SERVICE AND INVEST IN COMMUNITY SERVICES?

THERE ARE A NUMBER OF REASONS WHY WE THINK THAT WE NEED A DIFFERENT KIND OF SERVICE:

- We now have clear guidance from the Scottish Government of who should be admitted to a specialist dementia unit
- We now have clear guidance from the Scottish Government on what a specialist dementia unit should look like
- We recognise that we do not have the demand to build such a unit
- We are aware of the risks involved to the person with dementia when they undergo transitions in their care environment
- Many other Health Boards and Integration Joint Boards are working hard to transform their dementia services to keep pace with the changing demands of our populations.
- Our current model of care is not fit for purpose
- Our current community teams are under established and unable to meet the increasingly complex needs of our population living with dementia and those who care for them.
- By enhancing our community teams and creating capacity to provide in-reach we believe we can increase partnership working between existing agencies to provide a more streamlined, efficient, effective and person centred service.
- Our re-established focus on dementia will translate to consideration of developing Dementia Friendly Communities, getting all types of services, businesses and communities being inclusive of people with dementia and their carers
- We are experiencing significant recruitment challenges and want to offer staff progressive contemporary posts in order to attract bright, ambitious individuals to work in Argyll & Bute and compete with other areas with our recruitment and retention.

5. NATIONAL DRIVERS FOR CHANGE

Scottish Government Dementia Strategy 2017 - 2020
Dementia has been a national priority for the last ten years; significant progress has been made in the areas of diagnosis rates, post diagnostic support and improving the care experience for those living with dementia and their carers. These achievements have been made possible by the commitments laid out in the Scottish Governments three dementia strategies.

The Health and Social Care Delivery Plan (2016) sets out the plan to enable Scotland to have a Health & Social care system that is focused on prevention, anticipation and supported self-management. Its aims include providing the highest quality and standard of person centred care wherever the setting. The plan also aims to ensure that people can return to their home as soon as appropriate with minimal risk of re-admission.

Integration of Health and Social Care and Primary Care Transformation. The transformation work within community services is providing opportunities to better support those living with dementia in their home and community. A focus of this work is to improve anticipation of people's needs in order that fewer people are inappropriately admitted to hospital or long term care.

National Clinical Strategy (2016) sets out a framework for developing services in Scotland over the next 10 – 20 years. Its fundamental aim is to change the work of acute and hospital services with greater emphasis on primary and community care.

The Public Bodies (Joint Working) Scotland Act 2014 sets out a framework for integrating adult health & social care services. The Health and Social care partnerships have a responsibility to meet 9 national health and well being outcomes

Transforming Specialist Dementia Inpatient Care Report (2018) A Scottish Government commissioned report that sets out a model of specialist hospital care for people with dementia who have intensive and complex clinical care needs.

6. OTHER OPTIONS WE LOOKED AT

We also looked at other options:

- We looked at doing nothing and letting the service continue as normal with reduced inpatient beds that reflected the current demand. This was not recommended as we recognise the need to transform our service to meet the needs of the population of Argyll & Bute.

- We looked at enhancing the community teams and retaining two beds within an existing hospital or care home. This was not recommended as the patient would not receive the specialist holistic service that they would require in order to meet their needs. Essentially they would receive a single professional model of care which goes against best practice guidance. We believe that if a person is experiencing complex and extreme distress within their dementia they should have swift access to a multi-professional team within an appropriate enabling environment. We believe that extreme and enduring distress in dementia deserves to be given equal importance as any other complex health need and access available to a care environment designed to meet this need. We do not have the demand in Argyll & Bute to build such a facility and as such with any other complex, serious health conditions; specialist treatment should be sought within the central belt for the very few people who will require it.

- We looked at developing our existing inpatient service to allow for 5 beds, respite facilities, day hospital facilities along with a support and information hub as well as housing an enhanced community team. We found that:

- This model for respite and day care was now outdated as we no longer bring people to a clinical environment for these services.
- The model was heavily weighted to the population of Mid Argyll rather than equitable throughout Argyll & Bute
- We did not have evidence to support the need for 5 beds along with an enhanced community team.
- The proposed establishment was not in line with current staffing recommendations for a specialist dementia unit.
- The HSCP already financially support our carers centres to provide support and information hub, this would be a duplication of services.
- The existing clinical environment is not fit for purpose as is and would require extensive building work to extend the footprint to house this proposed model.
- The proposals were unaffordable

7. WHY YOUR VIEWS ARE IMPORTANT

It is important to the Argyll & Bute Health and Social Care Partnership that the views of people who use our dementia services, their families and carers are carefully considered; as well as feedback from other stakeholders. Whatever the outcome of the consultation please let us know if you want to be involved in future developing our services for people with dementia.

8. HOW TO HAVE YOUR SAY

8.1 Open Public Consultation

You are invited to give your views on the proposals for the Enhanced Community Team Model. You can do this by using the Online Response Form at:
The Information pack and response form are available to download and print from the
If you require a paper copy of the Information Pack or Response Form please contact
You can also email your response directly to
Please also contact us if you require the Information Pack and response form in any other format.
Please return paper Response Forms to
****

The consultation is open now and closes on 17th March 2020

8.2 Consultation Events

Public consultation events have been arranged in each locality. Times and dates are below.

Area	Venue	Date/Time
Mid Argyll	Baptist Church Hall Lochgilphead	Tuesday 10th March 2pm – 4pm 5pm – 7pm
Oban	Fire Station	Wednesday 11th March 2pm – 4pm 5pm – 7pm

Dunoon	Queens Hall, Meeting Room 1	Thursday 12th March 2pm – 4pm 5pm – 7pm
Rothesay	Lay Hall	Monday 16th March 4pm - 6pm
Campbeltown		
Islay		

At these events you will be able to

- Find out more about the new services that we would like to set up
- Talk to Health & Social Care staff
- Pick up a paper copy of the Consultation Information Pack and Response form.
- Find out how to get involved

Appendix 2

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Dementia Redesign Consultation 2020

Authors:

Caroline Cherry, Head of Service, Older Adults
Lora White, Specialist Dementia Nurse

Dementia Redesign Community Sessions 2020-Key Themes Consultation Process

Positive views:

The way that the sessions were organised with the presentation then case studies went well in most areas, it allowed us to focus on the person and not the service. The format was not followed in Mid Argyll where people wanted to ask questions and make comment.

Sessions were attended by people with dementia, unpaid carers, third sector services, health and social care staff and members of the public. Afternoon sessions were better attended than evening sessions with the exception of Mid Argyll. Over 250 people attended 9 sessions. There was clear enthusiasm for a dementia steering group and developing more of a co-production approach driven by a wider stakeholder group, over 70 people gave their contact details for more information and to be involved. This will form one of the key recommendations.

Areas of concern:
Some people felt the whole consultation process seemed rushed, there were complaints about lack of clear notice for the events, times for the events were sometimes not in local papers. There was a real criticism as to the lack of involvement of people with dementia throughout the whole process. There was a request to write to care homes specifically seeking the views of people with dementia. Third Sector colleagues said they felt that they had been left out of the process.

Infrastructure of Older Adult Care

Positive views:

We agreed that if we want to develop dementia services we need to map what currently exists, what's working well, what isn't, within each area. This would be a good place to start.

Areas of concern:

Although the consultation was primarily about dementia services, the reality was that there was a great deal of discussion about services for older adults and the themes will be discussed below. However there was an overwhelming issue about the lack of infrastructure/joined up care surrounding older adult care in general and the perceived difficulty of adding on dementia teams to an already fragmented situation. This seemed particularly marked in Cowal where many people said small third sector services were holding critical situations together and carers said they were reliant on these services for help. In Bute the lack of psychiatry input and care home provision were noted as critical issues.

Themes of service gaps:

- **Unpaid Carers-**many carers attended and they felt their needs were often not addressed
- **Respite**-this came up in every session. Flexible available respite for unpaid carers was seen as patchy and expensive
- **Day Services**-the cost and availability of day services are prohibitive, having good available day services would assist carers greatly with stress
- Lack of choice regarding **care homes**, particularly the lack of nursing care beds in Oban and Bute
- General concerns on the quality and coverage of **care at home services**
- The lack of investment in the **Third Sector**
- Managing **distress and crisis**, families reported just trying to manage as best as they could with little clarity on who to contact when there is a crisis, this would support the community model
- There were questions surrounding the real figures of those needing **inpatient care,** with one family disclosing their relative had been in an assessment ward for two years out with Argyll and Bute
- **Pathways** for dementia at whatever stage are significantly lacking

Recruitment

Positive views:

In general more localised support and staffing was welcomed, noted that taking anyone to appointments with dementia was extremely challenging and pointless, noted that models would have to in-reach to homes.

Areas of concern:

People really had concerns about the feasibility of the plan in terms of recruitment of staff, so even if they agreed in principle they wondered if it was going to happen. A Psychiatrist advised it would be difficult to recruit a Dementia specific psychiatrist. Most people felt that there needed to be more detail as to how new services could be implemented.

Comments on the Model

Positive views:

Everyone agreed that the status quo for dementia services is not sustainable. There were moving and emotional stories from families in crisis. In general, the principles of enhanced community support locally was welcomed as a positive model that would support local dementia care and reinvigorate local models of older adult care. In reach to care homes and local health and social care teams was welcomed. In Cowal, Bute and Islay, there was little or no awareness of Knapdale Ward.

The main concerns of the model (with the exception of Mid Argyll) was lack of clarity on some key issues of implementation and process. People wanted a guarantee that the money would be ring fenced if there was a move of model of care. Financial transparency is required for each area.

Whilst there was a lack of any preference for the situation of an inpatient ward or pathway out with Mid Argyll (Islay and Cowal had a clear preference for Glasgow), there was a lack of confidence or clarity about out of area models for those small number of people with very complex needs. The geography was not as much of an issue as a guarantee that the beds would be available if they were required. There was a fear that the ward would close without notice and with no planning.

There was more than one suggestion that the report to the IJB should acknowledge the gaps in care that currently exist and note that implementation would take a long time to build up teams. In terms of performance, people wanted to know waiting times for diagnosis and services for dementia and have explicit targets.

One adult with dementia summed up the views of many-*"Support for adults at every stage".*

Areas of concern:

The presentation made note of the model not being developed for financial reasons, however some people noted the budget consultation had as a saving for dementia of £200k and so they felt this was disingenuous. There was real critique of the planned closure of Knapdale Ward from Mid Argyll. Critique centred on flaws with figures with people in the ward, noting referrals were made to the ward and apparently rejected; there was critique on why option 4 had not been considered; there was negativity about the consultation process; the loss of a ward when a new hospital had been built only a few years before; critique on beds going out of the area; an argument that the ward has been deliberately run down for two years. There was an argument regarding the use of the Shetland model with a note that this model was reliant on an infrastructure of effective care homes and day services to an extent that Argyll and Bute doesn't have.

Wider Comments

There was discussion on the stigma of dementia and the lack of status of the illness.

There was discussion on early onset dementia and a presumption that dementia developments are focused solely on older adults.

Localities Feedback - Three Key Themes from each area

Mid Argyll

Inpatient beds

There was a sense of loss and anger around the potential of losing a resource that is situated locally. There was also a perception that the ward provided a respite/service.

- *Future provision of inpatient and out of hours care – where would this be provided*
- *How will we care for people in crisis?*
- *Knapdale is not a local resource it covers all of Argyll & Bute. Travel from other areas is long and stressful*
- *Knapdale ward environment – very clinical*
- *What is the crisis pathway for complex patients who need inpatient care?*

Infrastructure to Support New Model

The lack of respite, Day Care and Care Home provision in the Mid Argyll area was highlighted on several occasions.

- *Respite for carers*
- *Not enough Care Home beds locally*
- *Have housing models of care been considered?*
- *Distressing for person with dementia and family when moved to a care home out of area.*
- *Look at other models for respite*
- *Where do we recruit staff from for new model?*
- *We will never recruit to an old fashioned model of care*

Proposed New Model

There was little objection to the proposal to increase the community team establishments, however there were some questions around this which are mirrored in the themes of the report.

- *Contact point/person for crisis prevention*

Home Care providers can give care at designated times with little or no flexibility – will this be augmented?
Programme/timetable to transform to new service?
Current model is not person centred

Kintyre

The consultations in Campbeltown drew three key priorities.

Diagnosis

Rapid access to diagnosis is important to many individuals

Joined up services with good communication

- *Important to ease and speed up the process of obtaining a diagnosis.*
- Many found the current services confusing and hard to navigate
- *Very exciting way forward*
- Some services unaware of what the other can provide

Right people at the right place to give support at the right level

- Some reported that after the initial post diagnostic support they were left feeling unsupported and alone within their caring role.
- Third sector workers are feeling unsupported by the HSCP, workloads increasing and experiencing financial challenges.

Islay

Key themes drawn from consultation on Islay were

Inpatient Services

- *Community here would already use or expect input from Glasgow, not Knapdale ward. Flights to Glasgow and transport links much better and regular than to Lochgilphead.*
- *No accommodation in Lochgilphead. No taxis to get to hospital.*
- *I would want the specialist unit in Glasgow not Lochgilphead*

Many of our family already live in Glasgow and Edinburgh so would be easier.

New model of Care

- *This needs to be a community service*
- *Experienced and qualified staff are the key*
- *A community team would allow us to build a relationship and they would get to know us really well.*
- *We have been considering moving to the mainland to be near our children in case we need their support. If this service was in place we could stay on Islay.*
- *We need support on the Island and our own homes*

Current Infrastructure

We miss the sheltered housing wardens
Near me clinics could be used more

Oban

Infrastructure to Support New Model

The lack of respite and Care Home provision in the Oban area was highlighted on several occasions.

- *Respite beds are difficult to access in this area. Many are our of area and causes distress.*
- *Consider healthy village model of in reach support to villages*
- *Severe lack of home care, need more time to build relationships with people*
- *Psychiatry posts – mixed psychiatry and dementia post more the norm*
- *Working in rural areas now more valued and popular, recruitment improving, better quality of life.*
- *Affordable housing needed to support recruitment*

New Model

- *Currently a long wait for psychiatrist referral, new model would address this*
- *Link to other services to increase referrals eg dementia resource centre*
- *To keep people at home there needs to be appropriate support for carers and a well-resourced third sector.*
- *Currently challenging to access GP this is distressing for patients new model would improve access re prescribing and monitoring*
- *Carer centres are good but in home support required large rural population, community model would be more beneficial*
- *Bring the service to the patient*
- *This model will bring the ability to focus on the person with dementia's skills and experience to design therapy around this*

Inpatient Beds

- *Will inpatient beds be commissioned from Glasgow?*
- *Instead of wards consider hospice type area*
- *Glasgow for assessment only and have a specialist team locally, then we would be better placed to support families and carers through the dementia journey*

Dunoon

Current Model of Care

- *Nurses are expensive admin workers*
- *Case load numbers not taking in to account social work caseloads – Dementia many more in community*
- *Travel to Lochgilphead is not practical*
- *People waiting over one year for assessment and diagnosis*
- *No support for those with early onset dementia in this area*
- *Lots of gaps in service, needs to be more joined up.*

Inpatient Beds

- *Cowal and Bute residents are using Inverclyde Hospital for inpatient beds just now*
- *I would prefer to go to Inverclyde or Glasgow than Lochgilphead*
- *Knapdale provides assessment and treatment. Difficult to keep these people in the community.*

New Model

- *Value and support for care homes*
- *Clearer pathway needed*
- *Need local service*
- *Joint training opportunities*
- *Clear pathway between team and GP with shared treatment plans*
- *Need to ensure information sharing with families when patient is out of area*
- *All services are under pressure so less time to communicate and share information. This model looks more positive*

Bute

Infrastructure to Support New Model

- *Need more local Care Homes and access to local respite*
- *Existing local services need more support*
- *Limited choice of services on the island*

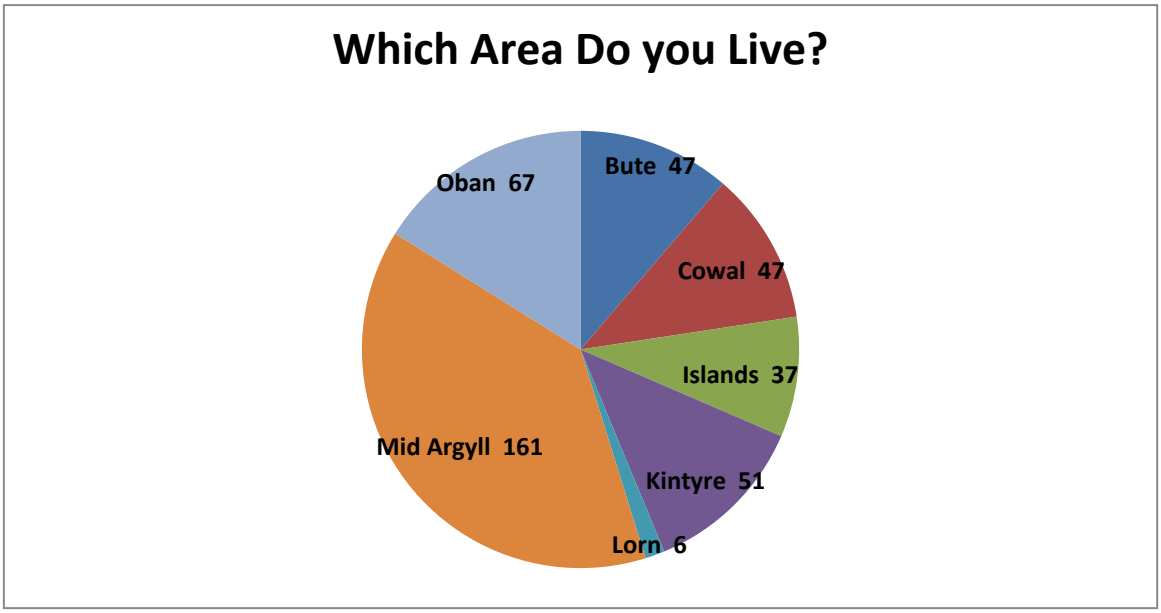
Current Model

- *No Psychiatrist cover since before Christmas*
- *Lack of services overall*
- *Feel like the Cinderella of Argyll and Bute*
- *Hard to access service to get a diagnosis*

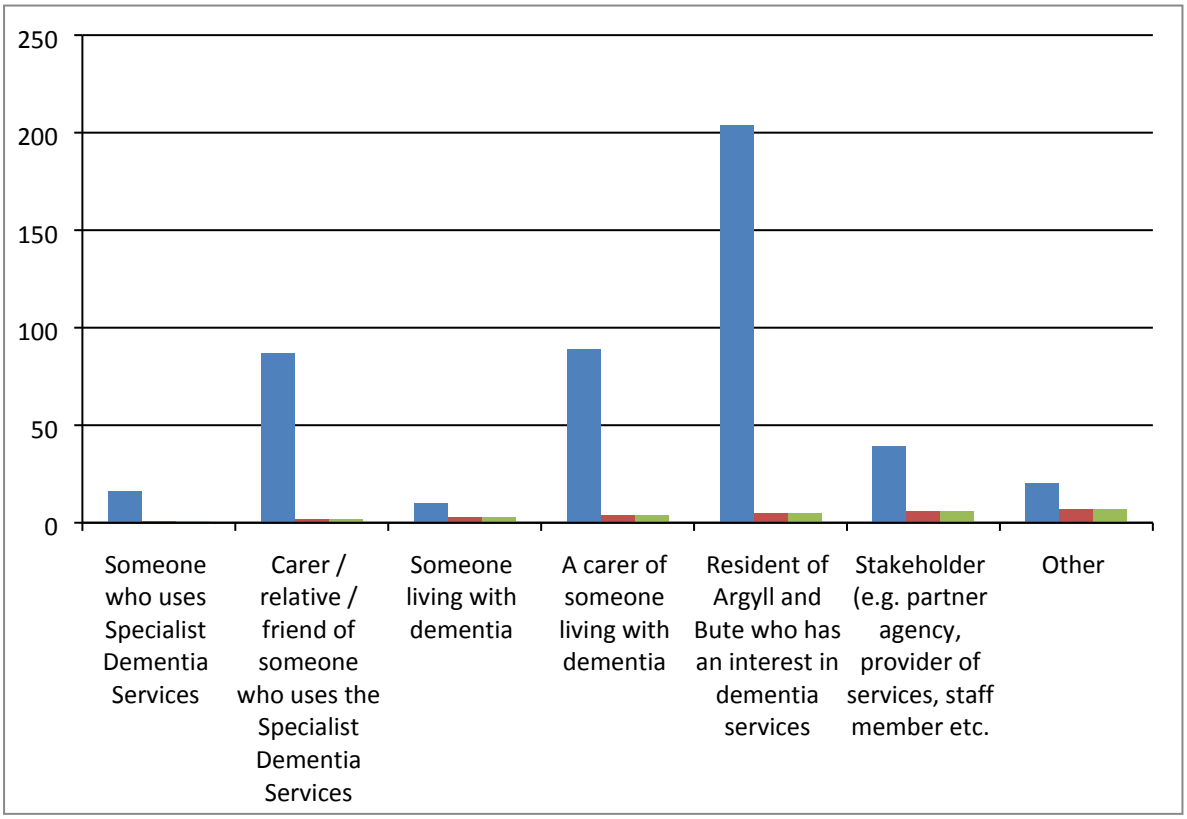
New Model

- *More local service needed*
- *Visible and responsive service would be welcomed*
- *Need assurity that the money would be invested in our community*

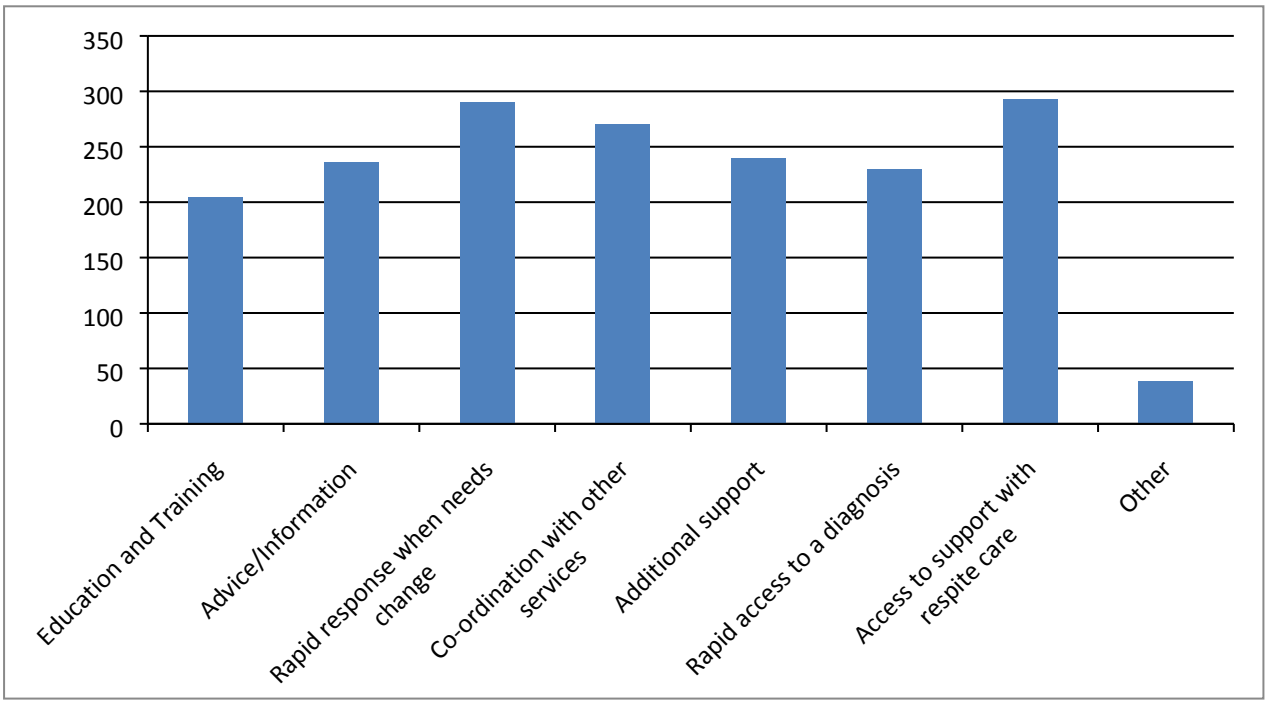
On Line Feedback (as of 16.03.2020):
420 responses to the online consultation



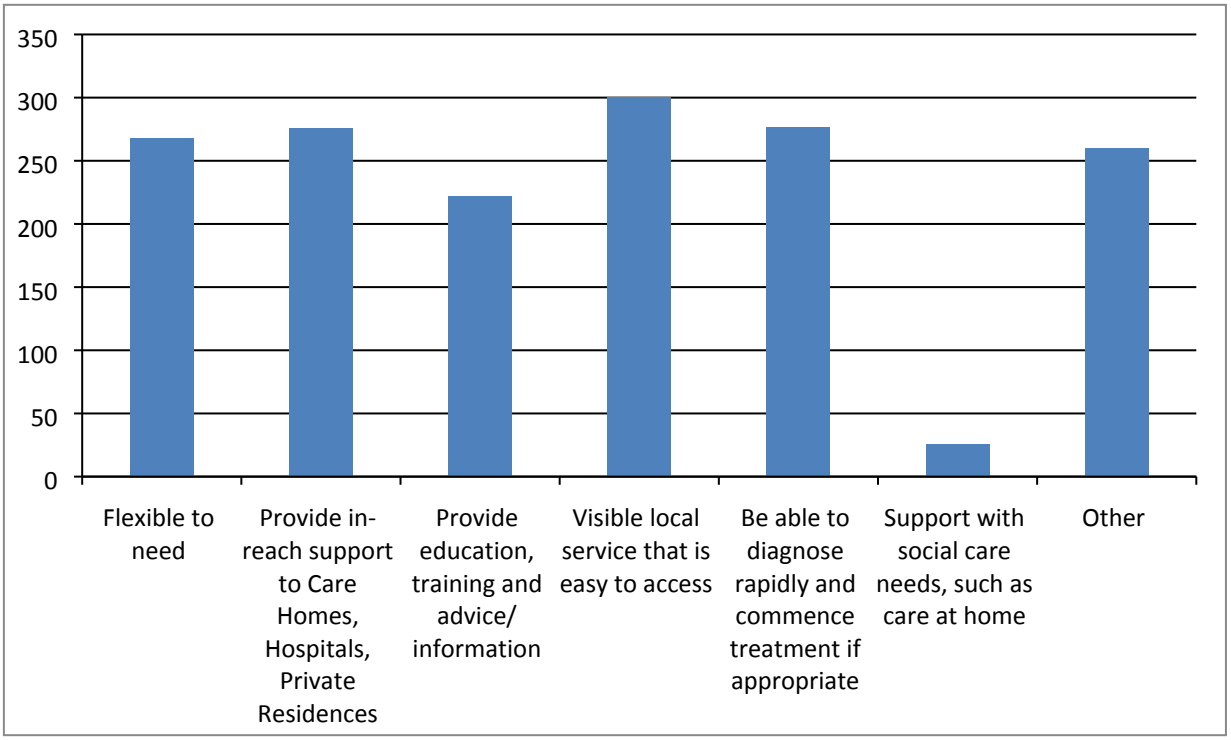
Please state your interest in Specialist Dementia Services



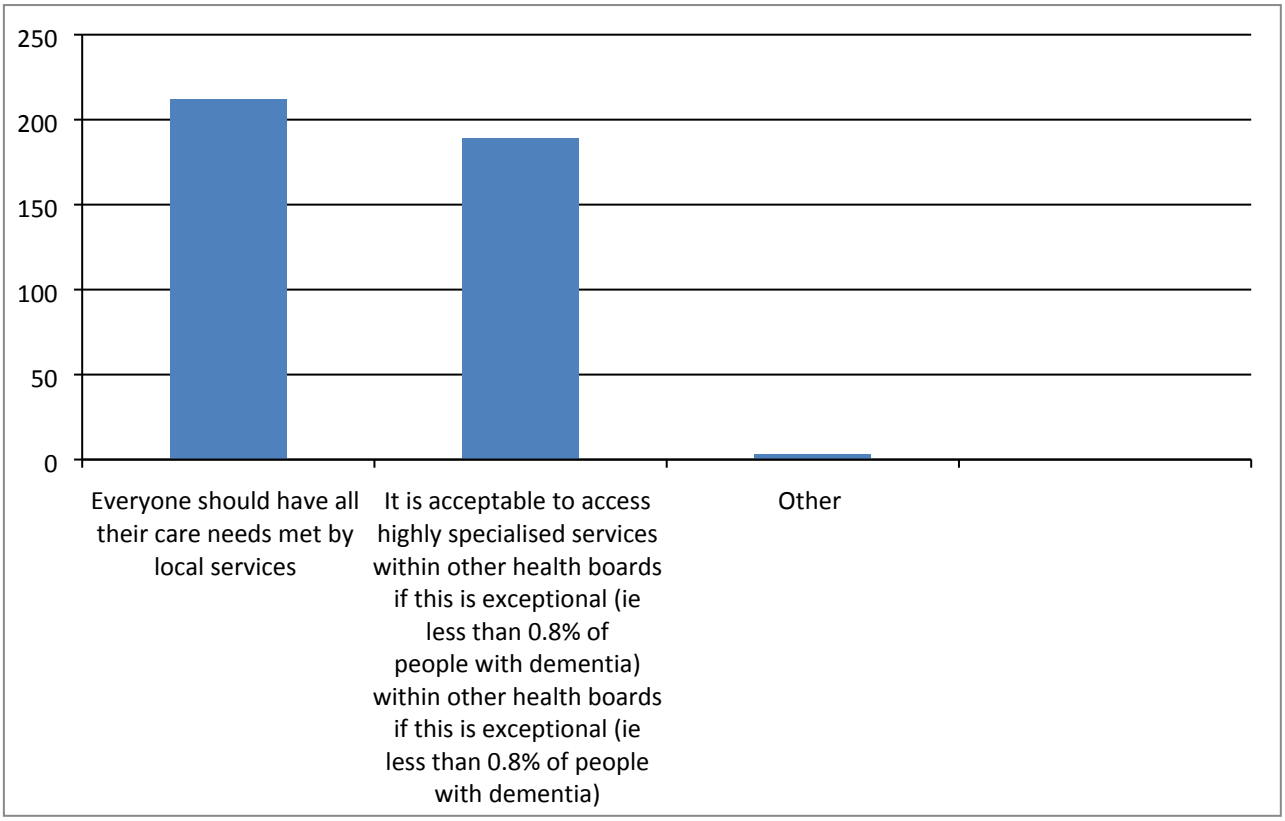
What support do you think is needed for you and your family from local Specialist Dementia Services?



What could Specialist Dementia Services look like in your area?



What are your views about using Glasgow to access Specialist Inpatient Dementia Assessment for people with serious and complex needs?


250
200
150
100
50
0
Everyone should have all their care needs met by local services
It is acceptable to access highly specialised services within other health boards if this is exceptional (ie less than 0.8% of people with dementia) within other health boards if this is exceptional (ie less than 0.8% of people with dementia)
Other