Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 5 June 2019

Somerset Partnership NHS Foundation Trust –

Lead Officer:
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Cabinet Member:
Division and Local Member:

1. Summary

1.1. The purpose of this report is to brief the committee on the enhancements we have made to the community Intensive Dementia Support Service for Somerset. These changes are necessary to ensure we can provide safe, sustainable and quality community services for people with dementia, in line with services for those older people with a non-dementia mental health illness. It enables patients to be assessed, treated and supported seven days a week, within their own home in line with our shared vision to focus care as much as possible in supporting people within their local communities and away from an institutional focussed model of care.

1.2. These changes are informed learning from the service developed in 2017 when Somerset Partnership was forced to close temporarily Magnolia ward, its inpatient dementia ward in Yeovil due to staffing difficulties. As a consequence of the evaluation of that service, we are proposing that alongside the expansion of the IDSS we make the temporary closure of the Magnolia ward permanent.

2. Issues for consideration / Recommendations

2.1. As we have been developing the new IDSS we have been monitoring the demand and need for inpatient beds and the impact of our community based model and our conclusions are:

- While we continue to need a small number of specialist inpatient beds, for most people we can provide better care in community based settings such as IDSS.
- The temporary closure of Magnolia ward has enabled us to establish a much more sustainable specialist inpatient service for the whole county based at Taunton. Should future growth in demand mean we need additional beds, these would be best located alongside the Taunton service as that is where we know we can staff them safely and provide a dedicated and specialist service.
- The IDSS service has produced positive outcomes for patients and carers, and we should be continuing our focus on it and other community services as our core offer for people with dementia

2.2. The Committee is asked to endorse the expansion of the IDSS service and note the consequent proposal to make the temporary closure of the Magnolia ward

permanent, consolidating specialist inpatient services for older people with dementia on to the single site in Taunton. This is fully in line with our shared vision to focus care as much as possible in supporting people within their local communities and away from an institutional focussed model of care.

3. Background

3.1. The number of people with dementia is increasing and presents a significant and urgent challenge to health and social care, both in terms of the number of people affected and the associated cost. Nationally:

- There are approximately 850,000 people with dementia
- Approximately one in six people over the age of 80 have a form of dementia
- The number of people with dementia is expected to double within 30 years
- Whilst dementia is predominantly a condition of later life, there are at least 17,000 people under the age of 65 in the UK who have the illness.

3.2. We know that the demography of Somerset indicates an existing and increasing older population with the consequent likely increase in people with dementia. Services for people with dementia are therefore a key priority for us and it is an area of major rising demand.

3.3. The most effective model of service to support older people with dementia and to maximise their health and wellbeing is to provide community based support and this is the way that the vast majority of people will be helped. Inpatient stays can be very problematic for patients with dementia as they become disorientated in the unfamiliar environment, and have to adapt to a setting with a number of confused – and potentially aggressive - patients all in close proximity which at times can make their own difficulties worse.

3.4. A very small number of people with dementia need the highly specialist service of an inpatient ward – these are the people who:

- are no longer able to be managed safely at home due to challenging and/or aggressive behaviour as a result of significant cognitive impairment, creating a risk to themselves or others; or
- cannot safely live at home due to significant safety risks and vulnerability, as a result of significant cognitive impairment i.e. wandering at night or disinhibition; or
- have been assessed under the Mental Health Act as requiring assessment and/or treatment in an inpatient environment

These patients typically need to stay in hospital for a period of time before being discharged to older people's community mental health services or other care.

3.4 Until June 2017, inpatient services for older people with dementia were provided on two sites in the county – at Pyrland ward 2 in Taunton and at Magnolia ward in Yeovil. Older people with non-dementia mental health issues receive inpatient services at a single site on Pyrland ward 1 in Taunton and support from older people's community mental health services based in ten locations across the county. In June 2017 Somerset Partnership NHS Trust took the decision to temporarily close Magnolia Ward in Yeovil due to a significant risk in terms of

staffing and patient safety. Recruitment of registered staff had become a challenge and the ward had been unable to recruit and maintain adequate and safe staffing levels for a significant period of time, despite active recruitment strategies. There was no indication that the situation would improve. At the time of closing, the number of beds at Magnolia ward had reduced to 8.

3.5 As a consequence of the temporary closure of Magnolia ward, services for those who patients who needed specialist inpatient support were all located at Pyrland ward 2 in Taunton, which was increased by 4 beds (from 10 to 14) to accommodate the additional patients. In addition, as a temporary measure in 2017/18, while we developed further community services, we also commissioned a small number of other beds in a specialist care home (La Fontana) in Martock.

3.6 Since June 2017 we have been developing a more community focussed model which has included the initial development of an integrated dementia support service (IDSS) in the east of the county. Earlier this year we expanded this service to cover the west of the county following the positive feedback we have had from service users and carers.

3.7 The IDSS is set up:

- to provide an urgent assessment of patients with dementia
- to prevent hospital admissions to mental health inpatient beds through the provision of intensive home support/treatment for patients who may otherwise be admitted.
- to provide in reach to the county's hospitals to support the assessment, treatment and management of patients.
- to support and facilitate early discharge from inpatient beds.
- to provide psychiatric support to patients and their carers in a crisis.
- to provide management of psychotropic medication.
- to provide short term interventions where the situation cannot be safely held within a community mental health team.
- to work collaboratively with community hospitals, integrated teams and the acute Trust to manage complex and challenging patients.
- to supplement with intensive input the Community Mental Health services.
- to work across dementia inpatient and community services to provide the most appropriate intensive service for patients with a diagnosis of dementia presenting with particularly challenging behaviours.
- to offer support and guidance to carers and care home providers to enable their caring roles to be maintained.
- to escalate assessment and transfer to appropriate placement if required.
- to provide signposting to other services.

3.8 The service is staffed by Registered Nurses, Occupational Therapists and Support Workers.

3.9 In the 21 months it has been operating, the IDSS in the east of the county has received a total of 462 referrals. In the three months since it began in March 2019, the IDSS in the west of the county and received a total of 120.

3.10 In the same period the average occupancy rate for Pyrland ward 2 has been 92%. No dementia patients have been placed in inpatient beds out of county during the period the IDSS has been in operation and in March 2019, when the service was established in the west of the county, the contract for the additional

beds at La Fontana Martock was ended as these beds were no longer required to meet the inpatient need.

3.11 The IDSS has therefore seen a significant number of dementia patients who would previously not have received specialist care in the community and may have put pressure on the number of available inpatient beds within the county. At the same time, the requirement for specialist inpatient beds has decreased which has supported the ending of the contract for additional beds in the Martock facility.

4. Consultations undertaken

4.1. An engagement programme was conducted as part of the service evaluation for the service in the east in March 2018. There are challenges with obtaining feedback from service users so the consultation focused on their carers. Learning from this consultation has been used in the development of the enhanced countywide service. A sample of patient stories and feedback is attached as Appendix 1.

4.2. Service users and carers have been involved in the planning for the refurbishment of the Pyrland wards in Taunton.

5. Implications

5.1. The development of the IDSS ensures provision of extended community services for people with dementia, in line with services for those with functional illness. It enables patients to be assessed, treated and supported 7 days a week, within their own home. Patients who require an alternative placement to manage their needs can receive an expedited assessment from the team, without the need for an inpatient admission.

5.2. The service has enabled better support for patients in the community and ensured that beds are available for the very small number of dementia patients who need specialist inpatient services on Pyrland Ward 2.

5.3. We believe this will provide:

- better health outcomes for patients;
- greater staff satisfaction;
- improved patient experience; and
- better value for money

6. Background papers

6.1. An evaluation of the initial IDSS service for the east – March 2018.

Note: For sight of individual background papers please contact the report author

APPENDIX 1

Patient Story 1

Intensive Dementia Support Service (IDSS)

One of the first patients referred to IDSS was a female with dementia and a long standing bi-polar diagnosis. She was referred to us when in Yeovil Hospital and was physically aggressive and declining diet and fluids. She was experiencing religious delusions and was being nursed in a side room because she kept removing her clothing. It was suspected that she may be approaching End of Life due to her not eating and drinking for an extended period. She was reaching the point that a Mental Health Act assessment was being requested due to her current presentation but before taking this course of action it was felt that a referral to the Intensive Dementia Support Service may possibly help avoid a Mental Health in Patient admission. The patient was seen by my team and supported with twice daily visits first at Yeovil District hospital then in one of our NHS funded nursing home beds at La Fontana.

IDSS Staff engaged with her and built a good relationship to the point she started eating, drinking and taking her medication. They also engaged with her sister who was her next of kin and also with her CPN who had known her for some time. Staff from the IDSS team visited her sister to gather some background history and personal information about the patient so that we could provide personalised care to her.

On arrival at the nursing home the lady wasn't eating or drinking, was not able to stand or walk and was hostile on personal care interventions. The team persevered and provided continuity with the staff that went into the home to support her. They also demonstrated and role modelled to the nursing home staff the approach to use with this patient. They encouraging her to take her medication and to at first drink then eat. We established foods and drinks she liked and offered her these. She then became more mobile and sociable in the nursing home. She also started taking her medication consistently and became less preoccupied and less distressed. We asked the manager from the residential home to come and assess her and she was assessed as being able to return there to live.

With all these people/professionals working together the patients presentation improved to the point she could be discharged back to her residential care home where she had lived for many years.

This patient story helps to show the value of the Intensive Dementia Support Service as prior to its set up there was no existing community resource that could provide the level of care this lady needed in order to recover and improve to a level that she could be discharged back to her residential care home. For the patients this was the best outcome and meant she could live back near her sister and maintain her contact with her. This was also a very rewarding experience for staff who say the significant improvements in this lady's health and wellbeing.

Emma Norton IDSS manager

Patient Story 2

Patient J

Referral source: Acute hospital
Duration of IDSS team involvement: 43 days

J was referred to IDSS by the Acute Hospital due to an increase in confusion and psychosis. She had a long standing diagnosis of bi polar disorder and a more recent diagnosis of dementia. At the point of referral, J was presenting as agitated and delusional. She was neither eating nor drinking, was aggressive towards staff attempting to provide care and was being nursed in bed in a side room on the ward at the Acute hospital due to persistent shouting/screaming and reluctance to wear clothing. J was also non-compliant with medication and it as felt at this time that we were heading towards needing to consider that a palliative approach.
IDSS provided a review of prescribed medication focusing on pain management and management of level of agitation through reintroducing a low dose anti-psychotic medication. Staff visited J whilst on the ward at the Acute Hospital to build a rapport with J and support staff with personal care interventions, medication administration and encourage food and fluid intake. We then quite quickly transferred J to one of the IDSS NHS assessment beds at our local Older Persons Mental Health Nursing Home providing regular visits to achieve a rapport that allowed us to support with meaningful activities and provided support to allow the gradual build-up of nutritional intake and eventually support J to mobilise again, regaining her former level of independence. J was then able to return to her previous residential placement which had been her home for the last 16 years.

Patient Story 3

Patient R

Referral source: CMHT
Duration of IDSS team involvement: 36 days

R was referred to IDSS by a Doctor in the CMHT in attempt to prevent hospital admission under the Mental Health Act due to carer burnout and R having repeatedly been declined by respite options due to previous mental health ward admission and historic risk. R was reliant on his wife as able to initiate but not complete tasks there were instances of paranoia escalating into shouting, and on one occasion R raising his hand. R sustained a head injury following a fall from a ladder and had developed a dementia which increased his dependency on his wife.

Over the course of our involvement, IDSS staff established a rapport with R alongside his existing care interventions (specialist day care and a care provider) providing additional support to his wife/main carer. IDSS' therapeutic interventions enabled R to accept a period of intensive assessment within one of the IDSS NHS assessment beds at our local Older Persons Mental Health Nursing Home, where we assessed risks to himself and others and his compliance with respite. R's period of assessment in the Older Persons Mental Health Nursing Home was successfully completed and an updated assessment document was produced. Involvement of IDSS prevented a MHA assessment and subsequent potential for admission to hospital. It also provided evidence that R was not a risk to other vulnerable residents.

Patient Story 4

Patient C

Referral source: CMHT
Duration of IDSS team involvement: (96 days)

C was a lady in residential placement referred to IDSS by the CMHT due to a decline in her mental health and her behaviour becoming challenging in the form of being intrusive of other residents' personal space and rooms and becoming physically aggressive towards staff on interventions. It was increasingly difficult to maintain therapeutic benefit of medication for C due to poor compliance, which continued even with covert administration being in place. At the point of referral, the residential home in which she resided were unable to meet her care needs and her behaviour was reaching the point that a MHA was being considered for admission to hospital.

Alongside ongoing review of medication, IDSS provided twice daily visits to support with personal care and advise staff on encouraging medication compliance, offering support and advice to staff in techniques to manage challenging/aggressive behaviour. In order to avoid hospital admission, IDSS maintained this increased level of support whilst alternative and more appropriate placement was sourced and provided support to C during transfer and settling period once moved through daily visits and then reducing to telephone support as C became familiar with her new surroundings and staff. Following a review we then discharged C from our service back to the care coordinator in the Older Adult CMHT. IDSS successfully prevented hospital admission thus reducing the number of moves for C.

Patient Story 5

Patient P

Referral source: Older Persons Mental Health Ward
Duration of IDSS team involvement: (69 days)

P was admitted to YDH in September 2017 with acute confusion which escalated to aggression and physical attacks on staff; this led to mental health act assessment and subsequent admission to the Trust's Older Persons Mental Health Ward under section 2 of the Mental Health Act 1983, on the 28 September, where he quite quickly settled. P was referred to IDSS by the ward on 9 October 2017 to support/facilitate safe, timely period of section 17 leave (13 – 16 October) and subsequent discharge (16 October), minimising length of stay on inpatient unit (19 days inc. 4 on Section 17 leave), and provide continued assessment and support to P in his home environment.
IDSS supported P with twice daily visits to assess and monitor his needs, where necessary providing support with ADLs and in attending appointments. This facilitated completion of up to date assessment document which identified need to provide a twice daily care package, now in place and P remains in his home environment (supported by a care provider).

Patient Story 6

Patient D

Referral source: Adult Mental Health Ward
Duration of IDSS team involvement: (52 days)

D was informal admitted to one of the Trust's Adult Mental Health Wards from the Acute Hospital via the Crisis Team due to his increased hallucinations and paranoia; he was diagnosed with dementia during his admission. He was referred to IDSS to assist with facilitating supported timely home leave (24 – 28 July) and subsequent discharge (28 July 2017) from the ward, minimising length of stay on inpatient unit (19 days inc. 5 on leave), and provide continued assessment and support to D his home environment. IDSS provided twice daily visits around re-engaging him in his voluntary work and for monitoring and support in relation to his mental health, ongoing medication review and supported D to move into extra care housing from his own flat and subsequently discharged forward to the CMHT.

Patient Story 7

Patient R

Referral source: CMHT
Duration of IDSS team involvement: (43 days)

R was referred to IDSS by Dr in CMHT due to increased carer strain in response to some challenging behaviours and aggression, particularly towards her husband/main carer of whom she became increasingly demanding, persistently seeking his reassurance. She had a diagnosis of dementia. Alongside medication review, IDSS provided twice daily visits to the home address to support R with personal care and to focus and engage R in some meaningful activity in order to alleviate some of the strain on her husband as carer and support him in continuing to care for his wife until placement was sought and move facilitated.

Patient Story 8

Patient J

Referral Source: Nursing Home
Duration of IDSS team involvement: (24 days)

J was referred to us directly by the matron at an Older Persons Mental Health Nursing Home where he had recently been moved to following escalation of behaviour at home and a previous failed placement. J had a diagnosis of Alzheimer's. Soon after arrival at the Older Persons Mental Health Nursing Home, J was aggressive, kicking windows and trying to leave, also wandering at night and difficult to settle. He was quite variable in his presentation and irritable particularly towards females. Alongside medication review, IDSS provided an assessment, follow up and review visits to support staff with challenging behaviours which enabled the Older Persons Mental Health Nursing Home to maintain safe care of J and for him to remain in that placement without further move or hospital admission.