Kent and Medway NHS
NHS and Social Care Partnership Trust

NHS
Kent and Medway

Improving Outcomes for People with Dementia in East Kent

1. Introduction and purpose of this report

This paper provides an update on the proposals to improve outcomes for people with dementia presented to the Kent Health Overview and Scrutiny Committee (HOSC) in November 2011 and, more specifically:

a) Outlines the progress made in delivering improved outcomes for people with dementia in east Kent.

b) Provides Members with details of options for inpatient care which will be presented as part of a formal public consultation to reconfigure services. This involves reducing the overall number of acute beds for older people, improving the environment and consolidating staff skills and expertise to ensure flexible care is provided which meets the changing needs of patients' and improves their overall experience of services provided by the Kent and Medway Partnership Trust (KMPT).

The aim is to ensure high quality environments which use a therapeutic approach to help people with dementia to maintain their independence and reduce the reliance on the use of medication, such as anti psychotic drugs.

This redesign process is one element of an overall redesign of mental health services for older people and a similar process is being undertaken in Medway.

A separate redesign of mental health services for working age adults and functional mental health services is also being developed. This will be presented to Kent HOSC Members separately and will cover services commissioned across both Kent and Medway. It is this element of service redesign which will require a Joint Overview and Scrutiny Committee (JOSC).

The proposals for people with dementia cover east Kent only. A similar process was undertaken in 2009/10 in west Kent to enhance community support and to reduce and consolidate inpatient provision.

2. Update on service reconfiguration proposals outlined in November 2011 HOSC report

The aim of this redesign process is to improve the outcomes of people with dementia**.** Familiar environment, familiar carers and established daily routines are critical in supporting a person with dementia to keep their independence and to help them to be happy and free from stress or anxiety. Hospital wards in particular are busy clinical environments with lots of different people and set ward routines and procedures. Removing someone with dementia from their familiar environment, whether this is their home or a care home, very often increases their confusion and their levels of anxiety both of which have a direct effect on their wellbeing and their recovery. People with dementia are also much more likely to be discharged to a care home following a hospital admission.

Approximately two thirds of people with dementia live in the community, with or without a carer and one third live in care homes. In the survey, “Support, Stay, Save” (Alzheimer's Society, 2011), 83% of carers and people with dementia said that being able to live in their own home was very important to the person with dementia.

This was also the finding of the National Dementia Strategy,(Department of Health, 2009) which found that most family carers want to be able to provide support to help the person with dementia to remain in their own home, but sometimes need additional help and support themselves.

The proposals are intended to shift the focus of provision from acute mental health beds to community services by:

- Reducing inpatient capacity from 76 to 45 beds.
- Increasing the capacity of the Home Treatment Service for Dementia by 14%.
- Introduction of a dementia crisis service which will be available 24/7.

Inpatient redesign. The Home Treatment service has already had an impact on inpatient services. The older adults’ service has maintained a number of inpatient vacancies over the last 12 months. Between July to October 2011, vacancy rates were between 9.6% to 15% of the total bed stock of 76 beds. To make more effective use of staff and enhance the staffing levels, these vacancies have been consolidated on the St Martin’s site. This means one of the least suitable wards is now empty. The wards on the St Martin’s site are located within a Victorian building with a temporary structure attached. The planning permission for the temporary structure expires in 2013. It is proposed to make this closure permanent.

The current number and location of beds in use is given in the table below.

Cranmer Ward, St Martin’s, Canterbury	Arundel Unit, WHH, Ashford	Thanet Mental Health Unit, QEQM, Margate
15 beds	20 beds	26 beds

Table 1

Home Treatment Service (HTS). This service provides specialist mental health intensive care for people with dementia and their carers when the care situation is breaking down or to support timely discharge from acute mental health inpatient services to the most enabling care environment. Overall the services improve the quality of living for the service users, their family and paid carers. The proposal is to revise service eligibility criteria to enable urgent and emergency referrals to be responded to by a local HTS which will enable them to provide follow up support where the crisis service has been called out. The service will also provide improved and targeted support for residential and nursing care home providers.

The revised specification has been developed and performance indicators to measure the delivery of outcomes are being finalised The Kent and Medway Partnership Trust (KMPT) is in the process of recruiting to the new posts. It is anticipated that the extended service will be in place by 1 May 2012.

Crisis Service. This service will be available 24/7 for people with dementia and their carers and will support home treatment and therefore avoidance of inappropriate hospital admission. This will be modelled on the service already provided in west Kent which provides support to people with dementia and their carers. The service is provided by three domiciliary care agencies, with support from statutory services. The service provides support to service users and carers where an emergency response is needed, which could be to the service user or to the carer where the caring situation has broken down.

The first year of the west Kent service has been evaluated and has indicated that it has prevented 25 admissions to acute trusts and prevented 44 admissions to mental health beds. It also prevented a number of admissions to care homes. It has also supported a number of carers and prevented a breakdown in the caring situation.

A joint procurement process led by Kent County Council (KCC) has commenced for this service. The funding will be transferred to KCC via a section 256 agreement. The section 256 will clearly set out what outcomes are required and the performance indicators that will be used to determine if outcomes have been achieved. These will be based on best practice and evidence from the west of the county. A provider forum was held in December 2011 where potential providers of the service were invited to find out more about the proposed service and tendering process. This was well attended by a range of providers, so it is anticipated that there will be a good response to the tendering process.

Both the HTS and the crisis service will initially be funded from non-recurrent monies, The services are being established in advance of the bed closures to support the transition from inpatient to community services. Recurrent funding will be made available from the savings realised from the reduction in acute beds.

Case Studies

Home Treatment Service Case Study

Kathryn Davis believes it is thanks to the home treatment team that her mother Gwen was able to remain independent in her home for an extra year. Gwen Davis, 87, who served in the land army during the Second World War, was diagnosed with vascular dementia two years ago.

Kathryn, 48, said, “She was fiercely independent and had lived on her own since my dad died in 1997. It was at a goodbye party for my sister, who was going to live in Australia, that we first noticed she was acting differently. I remember her putting a strange combination of food on her plate, mixing chocolate and salad, and behaving oddly. At first, we dismissed it. To be honest, we just thought she’d had a bit too much to drink.”

Gwen’s mother had dementia, but she had always refused to talk about it, so alarm bells didn’t start to ring for Kathryn until things got worse. “She used to play chess and loved flower arranging, but just started to lose interest. She had my phone number in her purse. I started to get calls from people saying they had found her sitting on the pavement in the village.”

Gwen’s GP, Dr Thaker, diagnosed her with vascular dementia and prescribed her aricept to slow down the disease.

Kathryn said, “There was a small improvement at first but then she started to go down hill. Her personality started to change. She was really sharp with me, and became rude and irritable. She kept falling out with her friends.” Kathryn, who works full time, and her daughter Emily, 16, decided to draw on the support of a local care agency. “My mum would refuse to stay in when the carers came to visit, sometimes she wouldn’t even let them in. I couldn’t be there at the end of the day to make sure she was eating the food they left. She stopped looking after herself and wouldn’t change her blouse or clothes and was forgetting to wash. In the end she became very dehydrated.”

The Home Treatment team was called in to see if they could help. “They were amazing, they had such a great softly, softly approach, which worked. They quickly figured out what made situations escalate and what worked. For example, she’s of a strip wash generation which was much better, and they would lay her clothes out for her to put on. It was more about suggesting things to her. I definitely think they prevented her from going into hospital.”

In September, after a number of falls, Kathryn decided it was safer that Gwen moved to a care home, and chose Elliott House, in Reculver. “The Home Treatment team helped us with getting mum to understand and helped with the transition. It was a difficult decision but I was comforted by the fact we had been able to give her that extra year in her own home.”

West Kent Crisis Service Case Study

A referral was made to the crisis service from Social Services Duty Team on 9th February 2012 to respond to an emergency situation. Mr P who cared for his wife with dementia had been taken to hospital following a fall which resulted in a head injury. Mr P was admitted to the acute trust. Mrs P who has significant cognitive impairment and confusion was being cared for at home by a friend. The dementia crisis team responded immediately and relieved the friend. Mrs P was unable to remain safely at home without continuous support. The dementia crisis team provided round the clock support until Mr P was discharged from hospital the following day.

The dementia crisis service prevented Mrs P from being admitted to an emergency hospital bed or to a temporary care home placement. Mr P was able to be discharged from the hospital with crisis support allowing an earlier discharge.

3. Improving the overall quality of care

It has long been recognised that extended periods of inpatient care have a detrimental impact on patients’ long term capacity. Therefore timely treatment and discharge to familiar environments are vital to prevent institutionalisation. Familiar environment, familiar carers and established daily routines are critical in supporting a person with dementia to keep their independence and to help them to be happy and free from stress or anxiety.

KMPT have a target average length of stay of 49 days and a target occupancy rate of 85-90%. Occupancy rate is within target (87.8% in December 2011), but average length of stay is consistently over target. This is usually a result of a small number of patients with an excessive length of stay which impacts on the average.

In order to validate the proposed number of beds, a number of scenarios have been created. These were developed using data provided by KMPT for the older people's mental health beds for the period August 2010 – July 2011. The data was used to create various scenarios, ie

- Occupancy rates with a maximum length of stay of 42 days with 45 beds.
- Occupancy rates with a maximum length of stay of 42 days with 61 beds.
- Occupancy rates with a maximum length of stay of 49 days with 45 beds.
- Occupancy rates with a maximum length of stay of 49 days with 61 beds.

It was also assumed that anyone with a length of stay of less than seven days would be supported in the community in the future with additional community support.

The length of stay of 42 days has been utilised as it mirrors a similar piece of work which was undertaken in Medway.

The scenarios show that with a bed stock of 45 beds it would be possible to manage the current volume of admissions over 7 days of duration if the average length of stay was reduced to 42 days. It also shows that there is capacity to manage for most of the year should the length of stay be nearer to 49 days average.

The information provided by KMPT also showed a significant number of admissions came from care homes and had a longer length of stay when compared to people admitted from their own homes. This is shown in the table below.

	Care Home Residents		**Non Care Home Residents**	
Length of Stay	**Number**	%	**Number**	%
<7	14	4.3	15	4.6
7-12	17	5.2	33	10.2
22-42	30	9.2	39	12.0
42-60	29	8.9	27	8.3
60+	78	24.0	43	13.2

Table 2

The Home Treatment Service helps to facilitate individual discharges to care homes and also supports care homes to manage individuals who develop challenging behaviours. Part of their enhanced role will be to provide support and training to care homes in a more systematic way to enable care homes to appropriately manage these more challenging patients and reduce the need for a hospital admission. It is therefore expected that there will be a decrease in admissions from care homes and a reduced length of stay following admission.

The additional community capacity was also calculated and this has resulted in the conclusion that the reduced bed capacity will be sufficient to meet demand in east Kent, providing the additional capacity of and investment in the Home Treatment Service and the Crisis Response service is sustained.

4. Increasing prevalence of older people with dementia.

Dementia is one of the main long term conditions of later life and it has a huge impact on capacity for independent living. Dementia is estimated to cost £17 billion per year in the United Kingdom and it is predicted that there will be a doubling, possibly trebling of the number of people who have dementia in the UK.

The risk of developing dementia doubles every five years, with a 65 year old having a 1.3 % chance of having dementia and a 95 year old having 32.5% chance. In east Kent the highest levels of dementia can be seen in the 85 plus age range.

The table below provides the estimated numbers of dementia patients in Kent between 2006 and 2026 by Local Authority District in east Kent.

	2006		2026	
	Est. number	Est. prev	Est. number	Est. prev
Kent	**17,400**	**1.3%**	**30,100**	**1.9%**
Ashford	1,300	1.2%	2,500	1.6%
Canterbury	2,100	1.4%	2,900	1.9%
Dover	900	1.0%	1,700	1.3%
Shepway	1,500	1.5%	2,600	2.5%
Swale	1,400	1.1%	2,600	1.8%
Thanet	2,100	1.6%	3,000	2.2%
NHS Eastern and Coastal	**9,200**	**1.3%**	**15,300**	**1.9%**

Source: Dementia UK prevalence estimates applied to South East Plan Strategy-based forecasts (July 2010), Research & Intelligence, Kent County Council.

Due to projected changes in the age structure of the population, the local authorities expected to experience the greatest increases in the prevalence of dementia are Shepway and Swale.

This increasing demand is seen in the context of a health and social care community which is seeing its resources increasingly under pressure. It is therefore essential to identify opportunities to redesign services to improve quality outcomes for individuals by lengthening the time people maintain their independence, so delaying and reducing the need for health and social care intervention.

This will be achieved by the following developments:

- **Memory Assessment.** Currently, KMPT provide all memory assessment clinics across Kent and Medway. However, the prospect of managing increasing demand within existing resources means that new ways of working need to be identified. It is therefore proposed to work with KMPT and Clinical Commissioning Groups (CCGs) to agree how primary care may be able to diagnose and manage people with dementia in primary care.

- **Improve awareness and diagnosis of dementia in an acute hospital setting.** A significant number of older people admitted to acute hospitals have dementia or some level of cognitive impairment. This fact, plus the recent reports on the quality of care received by some older people in acute hospitals, has resulted in this area being made a priority in the Operating Framework for 2012/13. Liaison psychiatry services have a key role in helping to support acute hospital staff in the management of people with dementia. This service is already in place in east Kent and is being implemented in Medway and plans are being developed to implement this service in west Kent.

  Co-production. This is a process where communities are engaged with and asked about what the issues are for them in relation to the delivery of services for dementia. It is intended to act as a two way dialogue with people as active contributors towards the design, delivery and review of public services. This work is being led by Kent County Council's (KCC) Social Innovation Lab, Kent (SILK) and some work has already been undertaken which has identified a number of themes which will be useful in helping to design future dementia services.

- **Peer support groups and dementia cafés.** A tendering process in currently in progress to establish peer support groups and dementia cafés across Kent. Peer support groups are aimed at people who in the early stages of dementia and allows them to receive help and support. Dementia cafés are aimed at people with dementia and their carers.

These developments also need to considered alongside other workstreams, e.g.

- Proposed intermediate care review.
- Enhanced support to care homes,
- Health and social care integration programme.
- Co-ordination of care for end of life.

5. Developing the options for a reconfigured inpatient service

In order to develop the options for the public consultation a full options appraisal was undertaken. It was commissioned from an independent consultant who specialises in NHS option appraisals and it followed a tried and tested process of rigorous appraisal.

The full options appraisal is made up of three elements:

- Non financial appraisal.
- Economic and financial appraisal.
- Risk analysis.

The results of the three appraisals have been combined to determine which options should be taken forward to consultation. The full report is attached (annex 1).

Non Financial Appraisal

In order to develop the options to be included in the consultation process, a non financial appraisal workshop was organised in December 2011 which was facilitated

by an external consultant using a well recognised process. The workshop was attended by a range of stakeholders and the list of participants can be found at Appendix A of the attached report.

The objectives of the workshop were to:

- Ensure there was an understanding of the options to be evaluated.
- Rank the evaluation criteria in order of importance.
- Weight the criteria.
- Score the options against each criterion to reflect how well the option performed.
- Agree any sensitivity tests where alternative markings, weights and scorings were considered important.
- Review the overall outcome to ensure the results accurately reflected the views of the participants.

A draft list of eight options was presented to the workshop participants for discussion with the objective of deriving a short list for further assurance and evaluation. The options were based on national and local best practice and were worked up over a number of months by clinicians and mangers, with input from commissioners and service users and carers.

Benefits Criteria

The options were assessed against a list of high level criteria with sub definitions which were agreed with the workshop participants. The high level criteria are given below and the sub definitions are detailed in annex 1.

- Clinical quality and integration.
- Access.
- Sustainability and flexibility.
- Operational and environmental suitability.
- Efficiency.
- Staff recruitment, training and development.

The criteria were then ranked by the workshop participants in order of importance and weighted. The full process is described in the attached report.

The Options

The outcome of the non financial appraisal indicated that three of the seven options evaluated performed consistently better than the other options and these are summarised below.

	Canterbury	Thanet MHU	Ashford
Option 1	One ward. 15 beds	One ward. 15 beds	One ward. 15 beds
Option 5	One ward. 15 beds	Two 15 bedded wards	
Option 6		Three 15 bedded wards.	

Table 3

The Kent and Medway Partnership Trust estate in the west has been largely purpose built and the therapeutic environments have been developed to offer personal accommodation and bathrooms, shared living space such as lounge rooms, dining rooms, and activity areas, as well as quiet rooms and walking space together with safe outdoor areas. It is understood that the trust is looking at a phased capital investment programme to improve the living environments for older people's services over the next three years. Their ambition is to provide flexible, environments which can offer a high quality of care.

Economic and Financial Appraisal

The options which were subjected to the economic and financial appraisal and risk analysis were the four highest scoring options from the non financial appraisal, plus the 'do nothing' option which was used as a benchmark. These are the options outlined in table 1 above, plus the fourth scoring option (option 4) and option 8 (the 'do nothing' option) in table 4 below.

	Canterbury	Thanet MHU (Woodchurch)	Thanet MHU (Sevenscore)	Ashford (Winslow)
Option 4 Separate Functions Mixed Gender	Organic		Functional	Functional
Option 8 Do nothing	Functional	Functional	Organic	Mixed Organic and Functional

Table 4

The financial appraisal deals with both the capital and revenue cost of each of the options. The capital costs are broadly similar across all the options.

The centralisation of all services in Thanet in option 6 indicates the greatest yield of revenue savings, whereas the other three options are within a closer banding of savings. However, the actual savings to be achieved will be dependent on the final option, following public consultation.

The economic analysis shows that option 6 has the lowest equivalent annual cost and demonstrates the lowest economic cost out of all of the options. This arises from the service being provided from one site with the savings in associated running costs and more efficient staffing costs.

Risk Analysis

A qualitative risk assessment of the short listed options was undertaken and the approach adopted involved firstly identifying potential risk areas such as operational, finance and project risk. Each of the options was scored against each risk on two counts:-

- impact of risk on the service should it occur; and
- the likelihood of the risk occurring.

The risk assessment of the options indicates that option 5, has the lowest level of risk overall. This is due to a number of factors but more notably the fact that this option operates from two sites rather than three, has one site co-located with an acute hospital and would be regarded as reasonably accessible to patients, visitors and staff.

The 'do nothing options' came second which was due to the negligible risk associated with refurbishment and project management risks. If these risks were excluded from the overall score, it would be the highest level of risk overall.

Conclusion

The appraisal has assessed five options (the four highest scoring options from the non financial appraisal and the do nothing option) from which to select a minimum of three to include in the consultation process. Based on the full analysis, it is recommended that the 'do nothing' option should not be taken forward. It does not address the requirements of the new patient pathway nor does it deliver any revenue savings which is a key requirement so that the community based services can be expanded and sustained.

Of the remaining options the analysis indicates that options 1, 5 and 6 should be taken forward as the relative benefits of each varies depending on benefits delivered, costs and levels of risk. Given the relatively poor performance of option 4 compared with the other change options it is recommended that this option is not included in the consultation process. This has been accepted by the Boards of NHS Kent and Medway and Kent and Medway Social care Partnership NHS Trust so we propose to take only three options forward for wider consultation with staff, stakeholders and the public.

6. Engagement and Consultation

It is proposed to commence the formal consultation from the middle of March for a period of 13 weeks. This process will be conducted using a number of approaches which are outlined below. The communications and engagement strategy is attached (annex 2).

Clinical advocates and champions
KMPT and commissioners has a panel of both commissioners and providers including clinicians, who will listen to views and explain the improvements that are being planned at public events, in community forums, or by speaking with the media.

Public meetings and events
A small number of public meetings and events will be organised, tailored to best meet local circumstances and stakeholder expectations in terms of the number, location, format and content; supported by core materials and suitable spokespeople from the PCT and KMPT and other advocates. Recognising that this is a particularly vulnerable group of service users and that carers have pressures on their time, it is intended to visit those organisations or events in venues they know and feel comfortable using, to meet people within their local community and hear their views such as the dementia cafés, pensioner forums, carer events.

Public events will be extensively promoted through the media, targeted distribution of leaflets and posters, and through partner stakeholder channels and followed up through proactive media relations, in staff communications and in updates to stakeholders.

Media relations
Key media will be identified and briefed on the consultation before it launches. Following the consultation launch we will maintain a regular flow of proactive media stories to promote and report on consultation events. Existing media monitoring arrangements will be employed to keep abreast of any media coverage and to ensure that any inaccurate or adverse coverage is addressed immediately.

Consultation documentation
A full consultation document and a summary document will be produced. Documents and summaries will be clear, person centred and accessible following best practice in terms of plain English, font sizes and colour schemes. They will be made available in alternative formats and will offer advice in the most common community languages on how to receive more detail in other languages.

Websites
Detailed consultation materials (including reference material such as national policy frameworks, clinical evidence etc) will be hosted on KMPT and the relevant PCT's website, along with updates, latest information on events and opportunities to provide feedback and get involved. Both the PCT website and KMPT website will feature core information about the overarching plans, providing links to the other consultation materials and enabling partner organisations to flag the consultation on their website and provide enabling links.

Social media will be used to promote active engagement for those utilising different forms of virtual discussions: tweets, blogging, etc.

Response handling
A wide range of mechanisms to capture consultation responses (or the use of existing, where possible) in each PCT, including:
• Freepost address
• E-mail address
• Online response form

Informal Consultation and Approval Process

In advance of the start of the formal consultation process, the proposals have been presented to a number of groups and committees. Discussions have taken place with Clinical Commissioning Groups (CCGS) who have supported the proposals in principle.

Extensive discussions have also been undertaken with KMPT clinical staff who have been key in working up the future options. Service users and voluntary organisations were also involved in the options appraisal process.

7. Timetable

As indicated above, it is proposed to commence consultation from the middle of March 2012. An overview of the approval process is given below and a full timetable is attached (annex 3).

December 2011	Stakeholder option appraisal
January 2012	Finance and risk assessment Presentation to east Kent Commissioning Committee.
February 2012	Briefing MPs, SHA assurance meetings, report to Boards for approval
March 2012	HOSC presentation
March – June 2012	Consultation
July 2012	Analysis
September 2012	Board decision

Following the consultation all responses will be analysed and considered in conjunction with the full options appraisal. This process will result in a recommended option which will be presented to the relevant committees and Boards for approval, i.e.

- NHS Kent and Medway Board.
- KMPT Board.
- CCG Boards.

This will be undertaken before reporting back to the HOSC on the outcome.

8. Recommendation

The Committee is asked to note

a) The progress made in delivering improved outcomes for people with dementia in east Kent.

b) Note the recommendation to proceed to public consultation with options one, five and six.