Appendix 1

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	West Norfolk Clinical Commissioning Group
Submission Date:	12 May 2014
Title of Report:	Evaluation of Dementia and Complexity in Later Life (DCLL) Pathway Changes in West Norfolk
Purpose of the Report:	Evaluate efficacy of pathway changes to inform next steps
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Sponsor:	Kathy Chapman, Director of Operations

NHS Constitution principles

1. The NHS provides a comprehensive service, available to all;
2. Access to NHS services is based on clinical need, not on an individual's ability to pay;
3. The NHS aspires to the highest standards of excellence and Professionalism;
4. NHS services must reflect the needs and preferences of patients, their families and their carers;
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
7. The NHS is accountable to the public, communities and patients that it serves.

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Appendices

1.0 Introduction

1.1 This report describes the changes to the pathways for people in West Norfolk with dementia and those with functional mental health problems alongside complexities of later life. The new service line is named Dementia and Complexity in Later Life (DCLL)

1.2 The changes were part of the Trust Service Strategy (TSS) implemented from 2013 (see Appendix 1: *About the Trust Service Strategy*).

1.3 The TSS changes to services for people with dementia and complexity in later life are underpinned by a comprehensive evidence base (see Appendix 2: *DCLL: The Evidence Base*). The changes are also aligned with the out of hospital care and closer to home initiatives within the West Norfolk Alliance and Norfolk-wide Better Care Schemes.

1.4 Although the changes were partly necessitated by the requirement for NSFT to reduce its costs by 20% over 4 years, with the necessary re-investment it would be possible to return to the pre-TSS structure.

1.5 However, this report will provide evidence that the piloted changes have greatly increased the service efficacy and that many more people in need of NSFT's DCLL services in West Norfolk are able to receive the support they need.

1.6 No final decisions have been taken about permanently reorganising described services.

2.0 What changes have taken place to enable the new DCLL pathways?

2.1 12 dementia assessment beds on Chase Ward at Chatterton House have stopped being used and the staffing resource enabled the establishment of a Dementia Intensive Support Team (DIST) based at Chatterton House. The DIST provides intensive community support to people with dementia and their carers and those with functional (non-organic) mental health needs with comorbid complexity in later life (CLL).

2.2 An initial DIST pilot in Central Norfolk provided evidence that the demand for DCLL assessment beds would reduce and only those patients with very complex and acute needs would require an inpatient assessment. This indicated that 3 dementia assessment beds would be adequate for the needs of the West Norfolk population and consequently 3 specialist beds in Blickling Ward at the Julian Hospital in Norwich have been designated accordingly.

2.3 For those people with dementia in need of nursing care but who do not have the complexity of need requiring an acute assessment bed, 2 alternative to admission (ATA) beds have been made available at the Paddocks Care Home in Swaffham. The DIST support patients using these beds through in-reach, providing specialist support and treatment advice and prescribing to the Paddocks Care Home staff.

2.4 12 beds for people over 65 with functional (non-organic) mental health problems on Tennyson Ward at Chatterton House have also stopped being used. Many patients who had been admitted to these beds in the past had come from the existing adult service and transferred into the older people's service at age 65 despite no change in their needs on reaching this age.

2.5 People reaching and beyond the age of 65 will now remain with the adult community service to ensure continuity of care. If requiring admission, these patients are admitted to adult acute services and three beds on Churchill Ward at the Femory Unit are designated for people over 65.

2.6 For people with or who develop age related needs or complexities of later (CLL) along with acute functional mental health problems, 2 assessment beds on Sandringham Ward

at the Julian Hospital in Norwich have been designated for patients from West Norfolk.

2.7 Financial support for travel costs to Norwich is available for carers of West Norfolk patients admitted to Blickling and Sandringham Wards.

2.8 The DCLL Community Team based at Chatterton House is a continuation of the previously existing multi-disciplinary Community Mental Health Team for older people. This team receives referrals for people with complexities of later life and functional mental health problems and also for memory assessment and dementia treatment. Although there has been no major change to this service as a result of the Trust Service Strategy, the team are experiencing an increased number of referrals for memory assessment and dementia treatment and are included in this evaluation.

2.9 It is important to note that the beds on Chase and Tennyson Wards were for assessment only and not for longer stay Continuing Health Care (CHC). NSFT has never provided or been commissioned to provide CHC beds in West Norfolk. The Trust's CHC provision has always been provided either at Carlton Court in Lowestoft, or in Norwich which has now been consolidated at Hammerton Court, a new unit at the Julian Hospital. This has contributed to the Julian Hospital being the centre of the Trust's Dementia Academy and set to become a regional and national centre of excellence in the care of people with dementia and complexity of later life. Consolidating the DCLL inpatient assessment provision at the Julian Hospital ensures that the best care and treatment possible is available to all in Norfolk and Waveney.

3.0 Data Analysis Commentary

3.1 Appendix 3: *Data Analysis* provides the full data summarised below.

3.2 The inpatient data provided relates only to patients from the West Norfolk CCG area. When extracting the community activity data it was not currently possible to isolate WNCCG activity from the West+ Locality.

The Trust's informatics department are currently developing the ability to report community activity by CCG.

3.3 An analysis of activity by future CCG area was conducted in 2012 to inform the locality boundary changes implemented during the TSS in 2013. This predicted that WNCCG activity would constitute 72% of the workload for the West+ Locality with the other 28% coming from the practices within the mid-Norfolk region of the North and South CCGs.

As this report is specifically required to inform WNCCG, to provide a more accurate estimation of activity specific to this CCG area, 72% of the total community activity for West+ has been used in Appendix 3.

3.4 Prior to the establishment of the West Norfolk DIST in August 2013, there were two wards for older people, Chase and Tennyson, at Chatterton House with capacity for up to 18 beds, although this full capacity was never needed. Chase Ward provided dementia assessment beds and Tennyson Ward functional assessments beds for people over 65.

3.5 Inpatient services are the most expensive service provided by NSFT, but only used by a small number of patients. Prior to TSS changes that commenced in 2013, at any one time only about 2% of active service users occupied inpatient beds, yet the cost of the these facilities required in the region of 50% of the total spend.

3.6 <u>Inpatient benchmark activity (Appendix 3: 1)</u>

As a benchmark for comparison, activity on Chase and Tennyson Wards for the 6 months from August 2012 to January 2013, before implementation of the TSS, has been used. This shows a total of 38 admissions during this period with an average length of stay of 37 days per episode of care.

3.7 Transition from using the beds on Chase and Tennyson to the new pathways took place gradually between September 2012 to July 13 (see Appendix 3: 2).

3.8 DIST Activity (Appendix 3: 3)

The Dementia Intensive Support Team or DIST became fully operational on 1st August 2013 and provides intensive support to people with dementia and older people with functional (non-organic) mental health problems complicated by complexity in later life. In the 9 months to April 2014 the team have received 240 referrals, averaging 27 per month and maintaining an average active caseload of 33.

3.9 During the same 9 month period the team have undertaken 3,238 recorded contacts. Of these only 3.5% (114) where DNA or cancelled by patient and just under 1% (28) cancelled by practitioners. 96% (3,096) actual contacts have been recorded of which 73% (2250) were face to face with the patient with the remaining 846 mainly telephone contacts.

3.10 97% of attended contacts were for assessment or treatment, 2% for advice, information and education and 1% recorded for other purposes including complex case conferences and discharge planning.

3.11 Alternative to Admission beds (Appendix 3: 4)

A previous analysis of patients admitted to dementia assessment beds across the Trust showed that many did not require acute hospital admission, but were admitted due to lack of alternative options (e.g. increased community support as now provided by DIST or alternatives to hospital admission (ATA) beds).

3.12 A fundamental element of the change to the pathways is the provision of local ATA beds. 2 ATA beds have been established at the Paddocks Care Home in Swaffham. In the 9 months from August 2013, 16 patients have been admitted to these beds with an average length of stay (LoS) of only 18 days. Total occupancy has been below 85% with occasions when both beds are vacant.

3.13 A qualitative evaluation has taken place to inform this report which shows that service users and their carers are very positive about the use of the Paddocks as an alternative to hospital admission (see Appendix 4).

3.14 Blickling Ward, Julian Hospital, Norwich (Appendix 4: 5)

It has always been acknowledged that a small number of patients with dementia would still require admission to specialist dementia assessment inpatient facilities. For this reason 3 beds are designated for West Norfolk patients on Blickling Ward that provides specialist assessment and dedicated inpatient consultant psychiatrist time.

3.15 In the 9 months since August 2013, 18 patients from the WNCCG area have been admitted to Blickling Ward with an average LoS of 56 days. The trend in admissions and LoS is clearly reducing with far fewer admissions in the second half of the evaluation period. This is likely to be a consequence of the increasing confidence and efficacy of the DIST and confirms expectations.

3.16 Sandringham Ward, Julian Hospital, Norwich (Appendix 4: 6)

2 beds are designated for West Norfolk patients on Sandringham Ward that provides specialist assessment for people with functional mental health problems alongside complexities of later life.

3.17 In the 9 months since August 2013, 12 patients from the WNCCG area have been admitted to Sandringham Ward also with an average LoS of 56 days. The trend in admissions and LoS is also reducing with 9 patients admitted between August and November, but only 3 from December to April.

3.18 Churchill Ward, Fermoy Unit, Queen Elizabeth Hospital, Kings Lynn (Appendix 3: 7).

As referred to in 2.4 and 2.5 above, patients aged 65 and over who do not have age related needs (CLL) will continue to be supported by adult community services and if needing acute care will be admitted to an all age adult acute bed. 3 beds have been designated for people over 65 on the 20 bedded Churchill Ward.

3.19 In the 9 months since August 2013, 8 patients aged 65 and over have been admitted to Churchill Ward. These include patients with complex social care needs with one patient having a LoS of 245 days, increasing the average to 65 despite the majority of patients having considerably shorter inpatient episodes.

3.20 These patients continue to be supported by the adult community services and Crises Resolution and Home Treatment Teams and ATA provision for adults has yet to be established. Consequently the trend in admissions has not changed during the evaluation period.

3.21 Comparison of activity before and after pathway changes (Appendix 3: 8)

Although bed numbers on Tennyson and Chase Wards commenced gradual reduction from September 2012 the lack of demand for these beds had been an established factor prior to this.

3.22 As referred to in 3.6 above, during the 6 months from August 2012 to January 2013, there were 38 admissions to Tennyson and Chase Wards with an average LoS of 37 days per episode of care. This LoS is much less than in previous years as staff were being proactive in ensuring early safe discharge despite the unused bed capacity. There was no DIST during this period.

3.23 During the 6 months from August 2013 to January 2013 the total episodes of care provided was 233, which is a combination of referrals to DIST and inpatient admissions to the Paddocks Care Home, Churchill, Blickling and Sandringham Wards. Although the LoS for inpatient admissions increased to 48, the average LoS per episode of care is only 9. This shows considerably improved efficiency and cost per episode of care.

3.24 The length of stay of inpatients, initially high because of a small number of long stay patients with complex mental and social care needs, is greatly reducing as the Trust focuses on ensuring patients do not remain in an acute inpatient environment for any longer than necessary.

3.25 It is particularly notable that the average length of stay for patients admitted to the ATA beds at the Paddocks Care Home, supported by the DIST, is only 18 days.

3.26 Dementia and Complexity in Later Life (DCLL) Community Team (Appendix 3: 9)

The DCLL Services are seeing a much higher number of referrals than at any time previously. Referrals from November 2013 to April 2014 were 137% higher than the same period in 2012 to 13. The majority of new referrals are for memory assessment and dementia treatment.

3.27 Given the historically lower number of people with dementia identified in West Norfolk compared to expected incidence the increasing number now being referred for assessment is to be welcomed. However, the higher number of referrals compared to discharges is not sustainable and has already lead to seriously high caseload numbers and increasing waiting times.

3.28 The memory assessment function incorporated a shared care agreement with primary care first established in 2004. This facilitated transfer of prescribing for dementia treatment medication to primary care after 4 months and discharge after 10 months. The numbers now being referred, along with the dementia treatment medication becoming available generically, indicates this shared care arrangement is no longer fit for purpose.

3.29 Improving efficiency of the memory assessment and dementia treatment pathway to meet the growing demand evidenced by this data and n accord with demographic projections is a key priority for the West Locality in 2014/15.

4.0 Qualitative Evaluation and Feedback

4.1 Appendix 4: *Qualitative Evaluation Project for DCLL Service in West Norfolk* provides a condensed summary of feedback from randomly selected service users and their carers accessing the new pathways.

4.2 The feedback relates to DIST involvement in care, Sandringham Ward admission and admission to the alternative to admission beds at the Paddocks Care Home. Unfortunately it has not yet been possible to formally capture for this evaluation the feedback from a family member of patients admitted to Blickling Ward.

4.3 Overall the feedback has been positive, most notably in regard to the ATA beds.

4.4 The qualitative evaluation project summarised in Appendix 4 continues and will be informed by further service user and carer feedback over time.

5.0 Conclusion

5.1 This report shows that the DCLL changes NSFT introduced in West Norfolk in 2013 have had a positive impact, greatly increasing the availability of services in the community whilst ensuring that those with the most acute needs continue to have access to specialist inpatient assessment when needed.

5.2 The information in this evaluation now needs to inform the next steps to be taken by WNCCG in collaboration with NSFT. This is likely to include progressing to a public consultation to decide whether the changes described above can become permanent.

5.3 The Trust and the West Norfolk Locality senior management and clinical leadership team look forward to working closely with WNCCG and partner providers in taking forward the West Norfolk Alliance schemes to better meet the needs of the local population as cost effectively as possible.

Appendix 1

About the Trust Service Strategy

The nationally mandated changes to the NHS and more specifically the payment system for mental health, together with the economic pressures requiring a reduction in public spending along with the continued drive to improve outcomes has necessitated the Norfolk and Suffolk NHS Foundation Trust's (NSFT) strategic redesign programme known as the Trust Service Strategy (TSS).

The Service Strategy sets out how NSFT's services and support functions will operate in an environment where the key challenges are:

- The continual need to improve outcomes for service users and carers;
- The national economic situation and its impact on public finances, which will reduce NSFT's funding in real terms by 20% over four years;
- The need for NSFT to be able to respond quickly to change, in the light of the changing environment in the NHS;
- The introduction of competition to mainstream healthcare, leading to tendering exercises for services that were traditionally part of NSFT's remit;
- The shift of responsibility for commissioning to the Clinical Commissioning Groups (CCGs), making GPs the customer for most of NSFT's services.

In setting out the changes, the Strategy ultimately aims to give stability and certainty to staff, service users, and carers over the future direction and development of services.

The Trust has adopted an overarching strategic approach to service provision and quality whilst recognising that local and national commissioning arrangements mean that models within the strategy will differ between localities and counties. With the advent of more locally focussed CCGs we expect these differences to increase as clinicians work together with CCG clinical staff to develop more local models.[1]

The development of the new Service Lines and pathways within the TSS were clinically led and involved wide consultation with service users, stakeholders, commissioners and staff throughout 2012. This included an analysis of caseloads across Norfolk and Waveney in 2011/12 Q4 and culminated with the new structures being agreed in 2012/13 Q3. The implementation phase then commenced and progressed throughout 2013.

During TSS implementation, that inevitably required challenging workforce and service changes, concerns have been raised about the robustness of NSFT's approach to TSS communication as well as stakeholder and public engagement. This has been compounded by the major changes to commissioning structures in 2013 that increased the risk of lack of continuity in the engagement of commissioners and other partners and stakeholders. It is therefore essential that the collaborative approach to the TSS established in 2012 is further developed throughout 2014.

[1] Extract from *Norfolk and Suffolk NHS Foundation Trust: Service Strategy 2012-16.* NSFT product code: 13/085. Available from Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE. Or via Internet: http://www.nsft.nhs.uk/PageFiles/4479/TSS_FINAL.pdf

Appendix 2

Dementia and Complexity in Later Life: The Evidence Base

The evidence base for the DCLL service proposal is founded upon a wealth of national data, evidence and strategy and further supported by Operating Framework priorities and the Prime Minister's Dementia Challenges.

The clinical interventions are based upon NICE Guidelines.

Publications that have informed the service design include:

- Alabady et al NHS Norfolk (2010) Norfolk Dementia Needs Assessment : How dementia affects older people in Norfolk – Joint Strategic Needs Assessment
- Alzheimer's Society (2007) Home from Home. Quality of care for people with dementia living in care homes
- Alzheimer's Society (2009) Counting the Cost: Caring for people with dementia on hospital wards
- Alzheimer's Society (2012) Mapping the Dementia Gap: Progress on improving diagnosis of dementia 2010-2011
- Audit Commission (2000) Forget me not. Mental health services for older people
- Carers UK (2007)Carers UK & Leeds University. Stages and Transitions in the Experiences of Caring.
- Care Services Improvement Partnership / Royal College of Psychiatrists (2005) New Ways of Working for Psychiatrists
- Department of Health (2001) National Service Framework for Older People
- Department of Health (2005) Supporting people with long term conditions. An NHS and social care model to support innovation and integration
- Department of Health (2005) Securing better health for older adults
- Department of Health (2007) Continuing Care Framework
- Department of Health / CSIP (2006) Everybody's Business. Integrated mental health services for older adults: a service development guide
- Department of Health (2009) Living Well with Dementia: The National Dementia Strategy
- Department of Health (2010) "Nothing Ventured, Nothing Gained: Risk Guidance for people with dementia
- Department of Health (2009) The use of antipsychotic medication for people with dementia: Time for action
- Kitwood T (1997) Dementia reconsidered. The person comes first.
- Knapp M et al (2007) Dementia UK: Report to the Alzheimer's Society
- Knapp M et al (2007) Dementia: International comparisons. Report to the National Audit Office
- National Audit Office (2007) Improving services and support for people with dementia
- National Audit Office (2010) Improving dementia services in England
- National Institute for Health and Clinical Excellence (2006) Dementia. Supporting people with dementia and their carers in health and social care
- North West Public Health Office (2007) Indications of public health in the English regions 8: Alcohol
- Royal College of Psychiatrists (2005) Who cares wins. Improving the outcome for older people admitted to the general hospital

- Royal College of Psychiatrists (2006) Raising the standard: Specialist services for older people with mental illness
- Stewart R (2002) Vascular dementia: a diagnosis running out of time. British Journal of Psychiatry 180: 152-156
- The National Council for Palliative Care (2009) Out of the Shadows: *End of life care for people with dementia*

The National Dementia Strategy (NDS) was supported by a full economic impact assessment and it contains 17 objectives. Those objectives that are relevant to mental health services have formed the basis of the DCLL service proposal's objectives:

For people with dementia, the key objectives of the DCLL service proposal are:

- Maintenance of functioning, independence and quality of life of people with dementia (PwD) for as long as possible
- Prevention of admissions to acute and mental health care hospitals
- Prevention of or delaying admission of PwD to care homes
- The above will deliver huge financial savings to the local health and social care economy.

These key objectives will be met as a result of:

- Early identification of people who might have dementia (NDS objectives 1 and 2)
- Early assessment and diagnosis (NDS objective 2), leading to
- Early treatment (NDS objective 2) and
- Access to care, support, information and advice for people with dementia and their carers (NDS objectives 3, 4 and 5)
- Routine advanced care planning (NDS objectives 2 and 12)
- Routine proactive reviews of PwD and their carers (NDS objectives 2, 6 and 7)
- Timely and appropriate support for carers (NDS objective 7)
- Enhanced support for PwD and their carers who are in crisis, at risk of admission or who are already admitted to an acute hospital (NDS objectives 8 and 9).

The radical changes to the current services to deliver the above are:

- Greatly increased integrated working between DCLL practitioners and primary care and general acute services, social services and the third sector
- Roll out of Dementia Intensive Support Teams (DIST) to cover the whole of Norfolk and Waveney and provide in-reach services to acute hospitals to aid safe and early discharge
- Further enhancing the skills of DCLL practitioners in order to improve quality and productivity of the services.

In the area covered by NHS Norfolk and Waveney there are over 15,000 people with dementia but less than half of them are in receipt of a diagnosis. In other words more than half of the people with dementia locally have no diagnosis and therefore no access to treatment that can prolong their quality of life and independence, delay expensive institutionalisation, and help prevent expensive episodes of unplanned care.

<u>Dementia Intensive Support Teams (DIST)</u>

The Julian Hospital in Norwich (serving the North, City and South localities) had 36 acute dementia assessment beds until August of 2009 when they were reduced to 22. However there was a constant occupancy of 100% and many outliers such that occupied beds for the central Norfolk localities was averaging 30.

The pilot DIST became operational in June 2010, initially only taking referrals from the North and South community teams. By October/November of 2010 bed occupancy had reduced to between 13 and 16, and currently the bed occupancy is around 12.

From September of 2011 DIST began an in-reach service to NNUH predominantly to prevent admission to the in-patient wards and reduce length of stay. The evidence to date demonstrates that the DIST in-reach service does indeed achieve these goals, but only when DIST is working with people on the Medical Admissions Unit or very early in their admission. This can be replicated by a liaison service with practitioners able to incorporate DIST ways of working. There is very clear evidence that the DIST service has helped many people with dementia return to their own homes on discharge from the acute hospitals by providing intensive follow-up and prevented these people from being discharged to a residential home.

The DIST has also begun bed management for the dementia admission ward at the Julian Hospital to try to capture the patients that have been admitted without being known to DIST.

In the proposed service model, the central DIST team will deliver services to the whole of the new Central locality (ie including the city community that is not presently covered) and there will be new DIST teams set up in the West Locality and the GY & Waveney locality.

Primary Care Liaison and Integrated Working

Drawing on the experience of the Primary Care Dementia Practitioner (PCDP) pilot, the new DCLL teams will have the majority of the Band 6 practitioners aligned to specific surgeries. The PCDP pilot demonstrated that this way of working has not only facilitated integrated care but has also raised the dementia diagnosis rates in the surgeries they have been attached to. However there was not universal coverage in the pilot and many surgeries had no access to a PCDP. In the proposed model, every surgery will have a named Band 6 DCLL practitioner. Depending upon the size of the surgeries, they may be shared between two or more surgeries.

Older adults with functional illnesses

In the proposed service model older adults with functional illnesses will be taken on either by adult services or by DCLL services. The choice of service will be on the basis of need, not age, as is required by age discrimination legislation. Service users seen by the DCLL service will have complex age-related needs such as physical frailty, multi-system pathology, and very poor mobility. They will be able to access the same range of services that are available in the adult service but delivered by a team that is expert in managing the complexity of later life.

The evidence base for the interventions for older adults with functional illnesses is provided in the adult service evidence base.

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January 2013

Appendix 3: Data Analysis

IMPORTANT NOTE

The inpatient information in this analysis specifically relates to West Norfolk CCG patients only. However, it was not possible in time for this report to identify only West Norfolk community activity from West+. The pre-TSS benchmark information estimated that WNCCG community activity would be 72% of the total for the West+ Locality. Therefore, as this report is specifically for the WNCCG, only 72% of the reported activity for West+ has been used. Due to the increasing trend in the number of referrals for people with dementia from the WNCCG these figures are likely to be a conservative estimate. Work continues to ensure accurate reporting of activity by CCG.

1. Benchmark Admission Data

August 2012 to January 2013 (26 weeks)

	Chase Ward	Tennyson Ward
Total Admissions:	**12**	**26**
Shortest LoS	**10**	**1**
Longest LoS	**145**	**183**
Average LoS	**86**	**40**
Total Bed Days (est.*)	**373**	**1040**
Total combined	**1413**	

* Total admissions x average LoS

This table shows the total number of episodes of care (admissions) to the two older persons 12 bedded wards at Chatterton House in Kings Lynn. At this time there was no Dementia Intensive Support Team.

2. Inpatient Bed Change Timeline

The following table details the transition of beds as follows:

Chase Ward (12 beds), transitioned to: 2 x Alternative to Admission (ATA) beds at the Paddocks Care Home, Swaffham + 3 x Dementia Assessment beds at Blickling Ward, Julian Hospital in Norwich.

Tennyson Ward (12 beds), transitioned to: 3 x non-complexity in later life beds on the all age acute admission Churchill Ward at the Fermoy Unit, Queen Elizabeth Hospital, Kings Lynn + 2 x complexity in Later Life beds at Sandringham Ward, Julian Hospital in Norwich.

Chase Ward (Dementia assessment for people over 65)					
No of Beds	18	12	8	6	3 (t ransferred + ATA) [1]
Date	Up to 12/09/12	From 13/09/12	From 13/12/12	From 15/01/13	Transferred from 30/06/13 – Ward closed
Tennyson Ward (Functional assessment for people over 65)					
No of Beds	18	12	8 [2]	6 [2]	4 (transferred) [2 3]
Date	Up to 21/09/12	From 22/09/12	From 19/10/12	From 03/06/13	From 30/06/13 – Ward closed
Churchill Ward (Acute assessment for 18-65 to all age, non-CLL)					
No of Beds	24	24+4 [2]	Gradual reduction from 24+4 to 17+3 [2]		
Date	Up to 19/10/12	From 19/10/12	From 24+4 March 13	To 17+3 Aug 13	

[1] 3 x Dementia Assessment beds provided at Blickling Ward, Julian Hospital;
2 x Alternative to Admission (ATA) dementia beds provided by Paddocks Care Home.

[2] Gradual transfer of beds from Tennyson to Churchill providing 3 beds for non-CLL older people (65+).

[3] 2 x Complexity in later life (CLL) beds provided by Sandringham Ward, Julian Hospital.

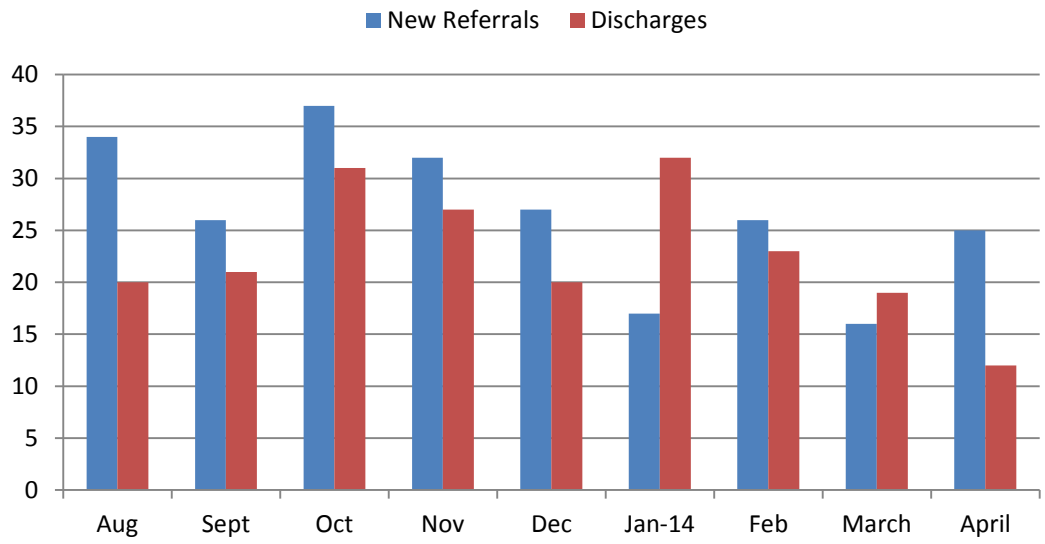
3. Dementia Intensive Support Team

Note: Totals for the West+ Locality have been reduced by 72% to provide a conservative estimate of actual West Norfolk CCG activity.

The Dementia Intensive Support Team (DIST) is a key component of the changes to the bed provision for the population of West Norfolk, enabling intensive community support to either prevent admission, access the alternative to admission beds at the Paddocks Care Home or when necessary support admission for the minimum period necessary to the dementia and CLL assessment beds at the Julian Hospital.

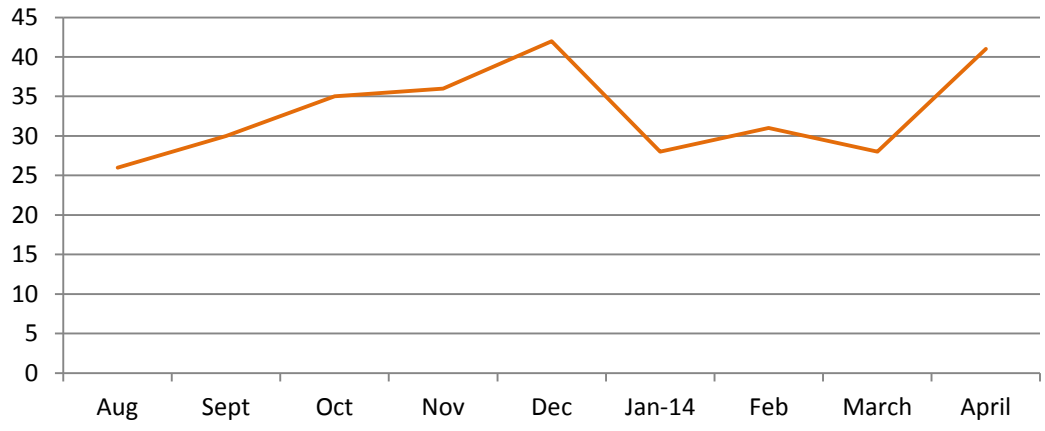
The DIST team provide support to people in their own homes, care homes and acute and community hospitals.

3 a) New referrals and Discharges by month (August 2013 to April 2014)



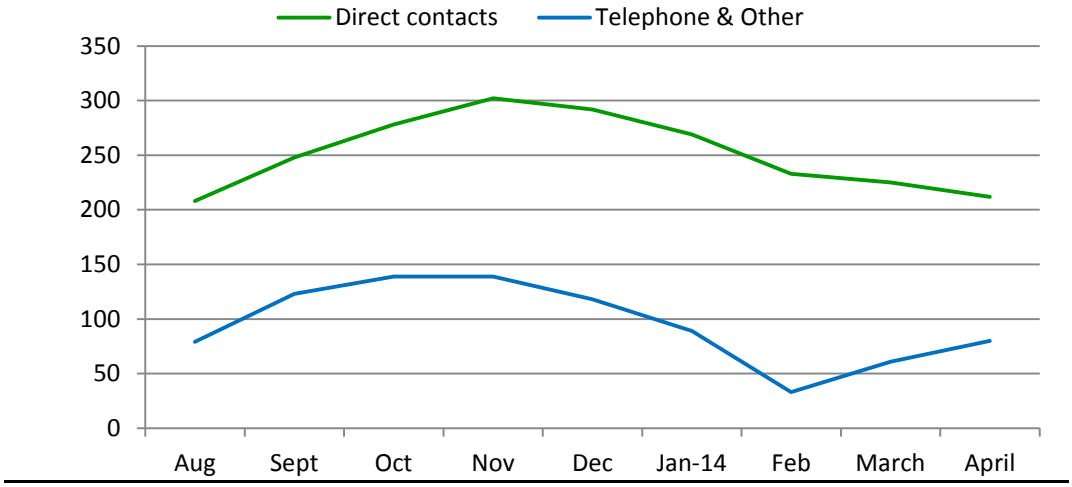
3 b) Caseload (open referrals) by month (August 2013 to April 2014)

The DIST team have a target caseload capacity in the region of 30 to 35 which gives capacity to deliver periods of intensive home or in reach support and treatment.



3 c) Clinical (patient) contacts by month (August 2013 to April 2014) = **3,096**

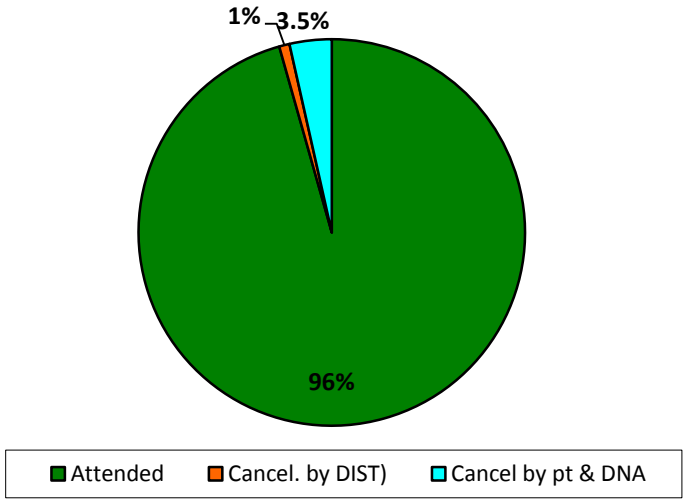
These figures only represent direct actual contacts with service users and those acting in a proxy role, but do not include the large number of DIST contacts with GPs and other health and social care professionals.



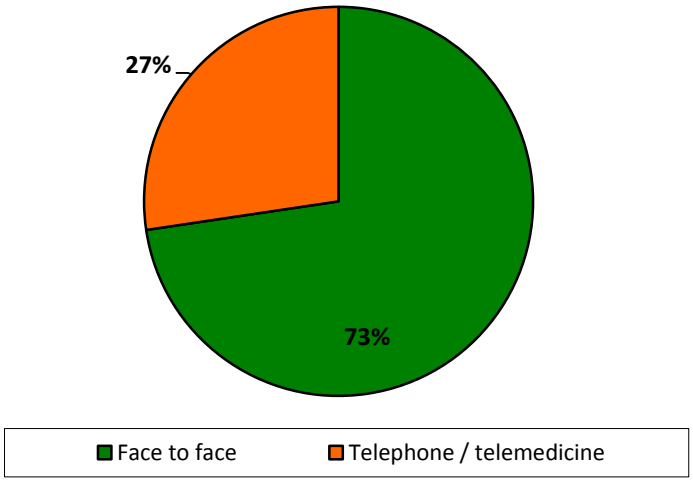
3 d) Contact Analysis (August 2013 to April 2014)

The analysis of contacts by the DIST shows remarkable effectiveness with a very low number of cancelled appointments and a high proportion of direct face to face contact with patients.

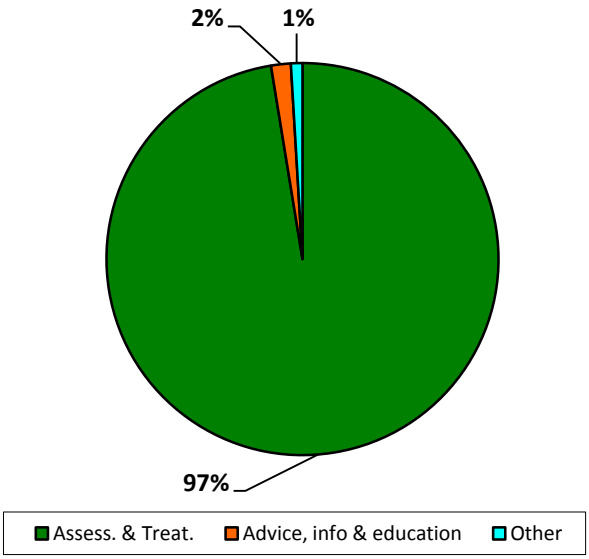
i) Attendance



ii) Attended contacts: Type

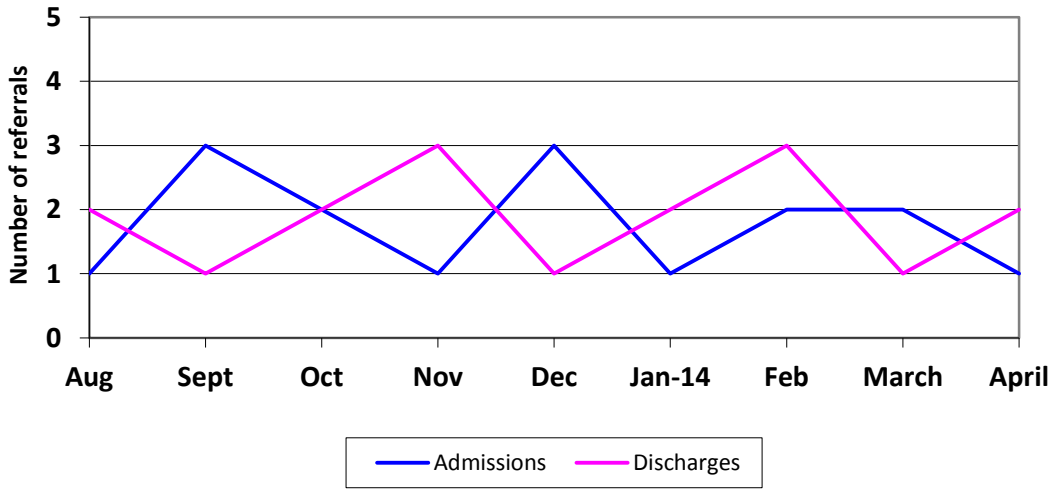


iii) Attended contacts: Purpose



4. Paddocks Care Home (Alternative to Admission) Bed Usage

Admissions & Discharges (August 13 to April 14)



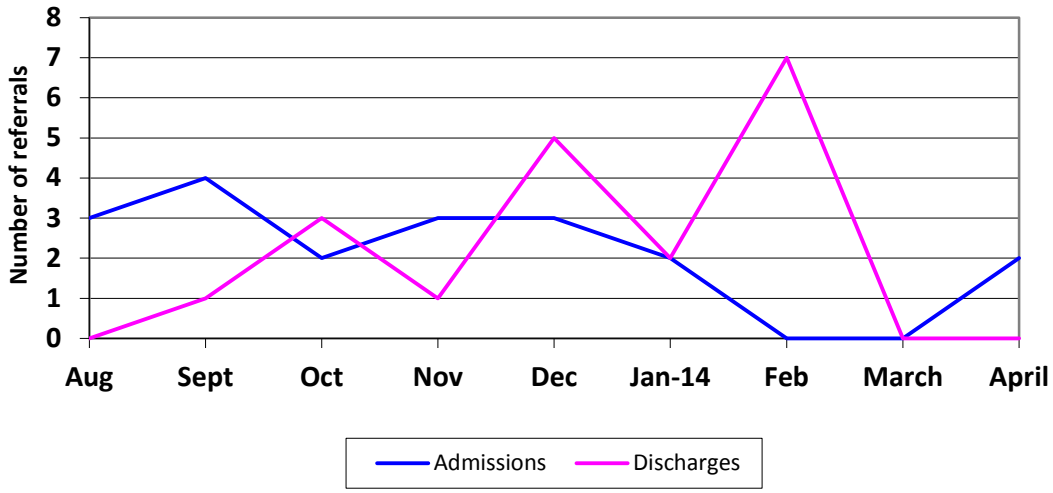
	Paddocks
Total Admissions:	**16**
Shortest LoS	**1**
Longest LoS	**63**
Average LoS	**18**
Total Bed Days (est.*)	**288**

* Total admissions x average LoS

5. Blickling Ward, Julian Hospital, Norwich (Dementia Assessment)

In August 2013 there were a number of patients transferred to Blickling Ward with protracted lengths of stay. These patients have been successfully discharged, subsequent admissions have required considerably less lengths of stays and the demand for beds has continued to reduce.

Admissions & Discharges (August 13 to April 14)



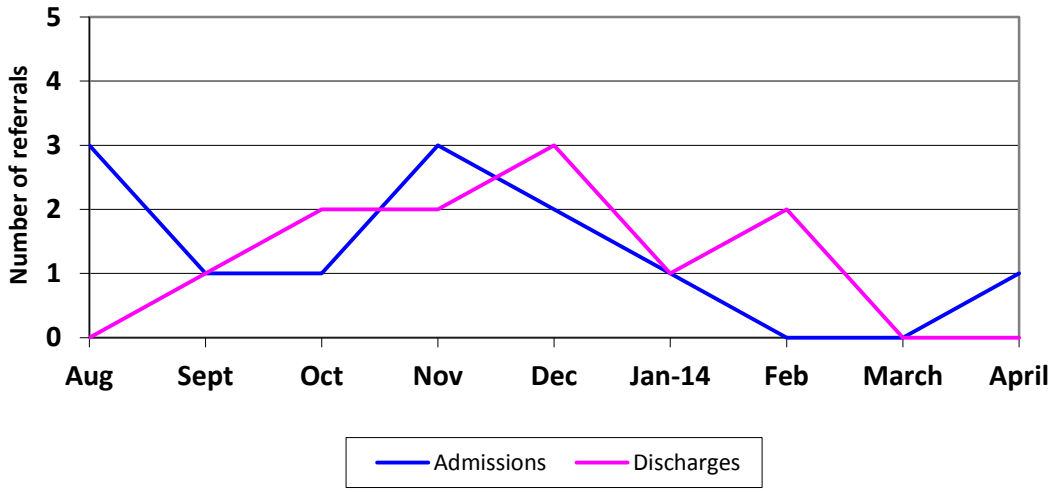
	Blickling
Total Admissions:	**18**
Shortest LoS	**5**
Longest LoS	**172**
Average LoS	**56**
Total Bed Days (est.*)	**1008**

* Total admissions x average LoS

6. Sandringham Ward, Julian Hospital, Norwich (CLL Assessment)

In August 2013 there were a number of patients transferred to Sandringham Ward with protracted lengths of stay. These patients have been successfully discharged and subsequent admissions require considerably lower lengths of stays and the demand for beds has continued to reduce.

Admissions & Discharges (August 13 to April 14)



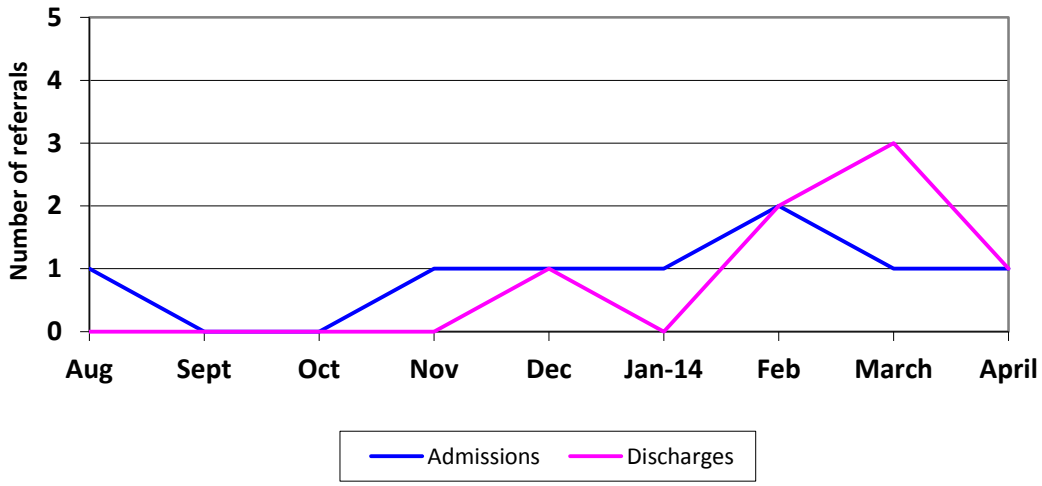
	Sandringham
Total Admissions:	**12**
Shortest LoS	**13**
Longest LoS	**160**
Average LoS	**56**
Total Bed Days (est.*)	**672**

* Total admissions x average LoS

7. Churchill Ward, Fermoy Unit, King's Lynn (non-DCLL older people)

There is one older patient on Churchill Ward who had an exceptionally long length of stay due to nature of their clinical presentation. If this patient is not included in the LoS figures the average reduces to 40 days.

Admissions & Discharges (August 13 to April 14)



	Churchill (65+)
Total Admissions:	**8**
Shortest LoS	**1**
Longest LoS	**245**
Average LoS	**65**
Total Bed Days (est.*)	**520**

* Total admissions x average LoS of discharged patients

8. Comparison Tables

8a) August 2012 to January 2013

	Chase	Tennyson	DIST	Church.	Paddocks	Blickling	Sand.
Admissions / referrals	**12**	**26**	**-**	**-**	**-**	**-**	**-**
Total Bed Days (est.)	**373**	**1040**	**-**	**-**	**-**	**-**	**-**
Combined bed days	**1413**		**-**				
Total episodes of care	**38**		**-**				
Bed days per episodes of care (average)	**37**		**-**				

8b) August 2013 to January 2014

	Chase	Tennyson	DIST	Church.	Paddocks	Blickling	Sand.
Admissions / referrals	-	-	**190**	**4**	**11**	**17**	**11**
Total Bed Days (est.)	-	-	-	**316**	**209**	**952**	**616**
Combined bed days	-	-	-	**2093**			
Total episodes of care	-		**233**				
Bed days per episodes of care (average)	-		**9**				

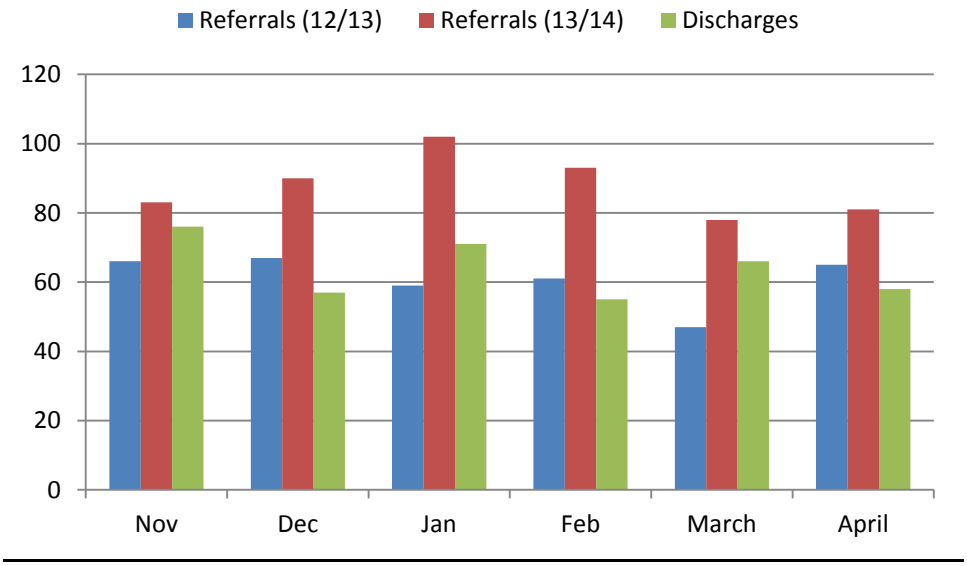
The length of stay figures continue to fall as community teams work closely with acute services to ensure inpatient episodes of care are no longer than necessary. For example, the LoS for people over 65 on Churchill Ward, averaging 79 in the above table, has more than halved to 36 for patients admitted since January 2014. In addition the demand for inpatient admissions is less than anticipated at this stage with very effective use being made of the Alternative to Admission beds at the Paddocks Care Home.

9. Dementia and Complexity in Later Life (DCLL) Community Team

Note: Totals for the West+ Locality have been reduced by 72% to provide a more accurate but conservative estimate of actual West Norfolk CCG activity.

The following information shows estimated WNCCG activity for the 6 months from November 2013 to April 2014. The referral activity from August to October contains greatly increased number of transition referrals from West+ (non-WNCCG) practices during the 3 months following commencement of the new Locality boundary and has therefore not been incorporated as would obscure West CCG area activity.

9a) New referrals and Discharges by month (November 2013 to January 2014, with referrals from November 2012 to January 2013 for comparison)

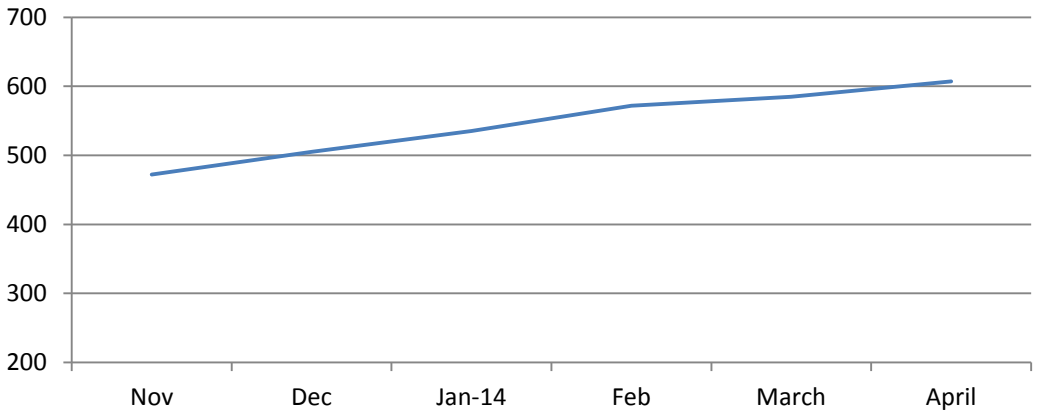


The13/14 referral figures have been adjusted to more closely reflect WNCCG activity. Those for the corresponding months in 12/13 were the old West Locality that was coterminous with the current WNCCG area.

The month on month higher rate of referrals compared to discharges is unsustainable and requires urgent remedial action currently being planned and implemented.

9b) Caseload (open referrals) by month (November 2013 to April 2014)

The upward trend in caseloads numbers directly corresponds to the differential between discharges and referrals in the above chart.



Appendix 4

Qualitative Evaluation Project for DCLL Service in West Norfolk

Introduction

In line with the NSFT recent service reconfiguration, a qualitative study has taken place to evaluate the service model so far. Service users and carers who have either been admitted to one of the wards at the Julian Hospital, or admitted to one of our alternative to admission beds at a local care home, or have been receiving a service from our dementia intensive support team (DIST) have been interviewed and notes taken on their experiences.

This is a work in progress and further data will become available as time progresses and more service users are seen. The collection of the following data has been somewhat problematic due to the complexities around the service users being part of a mental health service. Although the data has been collected at random, there have been some people who have not been able to be included, for example, if the service user has since passed away, if they are deemed to lack capacity to consent and there is no carer, or if their current mental health is in a state of crisis and it is felt that to be conducting the interview at this time would lack sensitivity.

All people interviewed have had the same set of questions asked of them, with the wording altered very slightly depending on which part of the service they have been part of. A typical interview spine is detailed in appendix 4A.

Data

To date 5 service users/carers who have received care from DIST have been interviewed. One carer of a service user who was admitted to Sandringham Ward has been interviewed.

Key themes

DIST involvement:

One person was unable to remember or comment on their experience.

One person was referred to the DIST by their community nurse – this person appeared to be confusing the DIST and community team during the interview.

Of the remaining 3, all apart were referred by their GP and then seen directly by the DIST. All reported positive experiences of the DIST team. This included comments regarding the staff being ‘very good’ and ‘on time’. All reported that the DIST staff explained their role, how the service operated and why they were involved with their care. All reported the team to be ‘helpful and useful’ in terms of having someone to talk to and someone who gave them strategies to help with care. All reported that the discharge process was explained to them and that they were aware of what they would need to do should they need to be seen again in the future. two reported this process took place via a telephone call, which one reported feeling ‘disappointed with’ and another reported feeling ‘happy’ about this.

The family and friends question was rated as ‘extremely likely’ by 3 people and ‘likely’ by one person. Comments made to explain this included people being ‘pleased with the service’, that’s staff were ‘helpful and caring’, and that ‘if you needed help now you would know what to do’.

In terms of any changes for the better, two people said ‘nothing they could think of’, another commented on advertising, in terms of people not being aware the team existed, and another said they waited a long while to be seen and that this could have been shorter.

Sandringham ward admission

One person was able to be interviewed regarding their family members admission to Sandringham ward. They reported a long contact with mental health services prior to this time, dating back a number of years. This current admission was as a result of physical health problems and an admission to the acute hospital, which had resulted in mental health medication being discontinued and a subsequent destabilisation of the presenting mental health problem. The family member reported a very positive experience of the liaison consultant who was said to be ‘amazing’ and who arranged the admission. The reason for the admission and the process itself was fully explained to them and they were happy with this. They reported the care on the ward to be good, the staff were

'brilliant' and the place was 'awesome'. They felt that the staff working on the ward were responsible for getting their family member better again. They described how they were flexible with visiting hours, to fit in with the travel from Kings Lynn. Prior to the discharge process, they were told it would be planned and were aware of the arrangements and were happy with how this was done.

The family and friends question was rated as 'extremely likely', and the comment made that they 'could not fault the place or the mental health team'.
In terms of anything changing for the better, they reported that they were initially worried when they were told it was going to be in Norwich, but actually found the ward environment good and the staff really helpful so felt happy about this. The travelling to and from the ward was their only gripe.

Blickling ward admission

Unfortunately it has not been possible so far to interview any family members whose loved ones have been admitted to this ward.

Alternative to admission beds

13 admissions to the ATA beds at the Paddocks Care Home are included within this project. Of these, so far, 4 carers/family members have been interviewed. Two feedback sessions have also been held, one with staff from the care home, the other with staff from the Dementia Intensive Support Team (DIST).

The key themes from the interviews with both sets of staff are as follows:

> The experiences of the project from both sides are generally positive. Both teams described initial anxiety, apprehension and concerns about the project, but these have now been resolved. Changes have been made to paperwork which has allowed for improvements to the project and the relationships between the two teams are building. Both teams describe feeling supported by each other. Both teams also report that sticking to the admission criteria for patients being admitted as part of the project, has helped with smoother running of the project. The monthly meetings are also reported to be helpful. There have been some issues with communication on both sides, some related to problems with paperwork, also telephone systems at the care home making it harder for DIST staff at times to keep in contact with the care home staff. The staff at the care home have been reported by the DIST team, to be friendly and helpful and welcoming to the project. The care home staff themselves report that the project has promoted the care home. DIST staff report that the care that the staff at the care home are providing appears to be good, and that there has been some positive benefits for patients admitted, but there have been some concerns regarding the environment not being ideal.

Of the 4 family members interviewed, the following themes have been found:

> The staff at the care home are consistently reported to be 'friendly', 'lovely' 'helpful' and 'fantastic'. It was reported that 'nothing is too much trouble' for the staff there. The manager was reported to be 'brilliant'. Families liked that they could visit when they liked and always felt welcomed.
>
> There was consistent praise for the fact that it is a care home and not a hospital, with families saying it was 'better than a hospital' environment and that they felt 'relief' when they found it wasn't a hospital. However there were also numerous comments that the environment seems 'dated', 'confined', 'drab' and 'dirty'.
>
> There were consistent comments around the care, with families describing that they 'could not fault the care' and that the care was 'good'.
>
> There was also consistent praise for staff from the DIST, as being good at keeping families informed of what was happening.
>
> In response to the families and friends question, of the 4 family members, two rated this question as' **extremely likely'**, both because it was a non-hospital environment, which was unpressurised for the patient and family. One rated it as '**likely'** again because it was a non-hospital environment, the reason they didn't rate it as extremely likely was due to the location. The final family member rated the question as '**unlikely'** due to the environment.

Appendix 4A

Patient and carer interviews

Interview spine:

- 1st contact with the service
- Experiences of their contact with the services up to the point of admission (or team contact)
- Explanation of the admission (or team) process
- Process of the admission (or team involvement)
- Experiences during the admission (or contact with team); care staff, environment, DIST involvement
- Process of discharge

Final questions to be asked at end:

In accordance with the Trust ethos of ensuring people remain close to home your recent care has been provided at the care home instead of in hospital. We would like you to think about your experience of this approach.

"How likely are you to recommend this approach to friends and family if they needed similar care or treatment?"

Response scale: 1 Extremely likely 2 Likely 3 Neither likely nor unlikely 4 Unlikely 5 Extremely unlikely 6 Don't know

"Please can you tell us the main reason for the score you have given?"

"Please can you tell us why you would/would not recommend this approach to your Friends and Family?"

Is there anything we could change for the better?