# Borders NHS Board

Meeting Date: 5 September 2019

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| **Approved by:** | Rob McCulloch-Graham, Chief Officer Health & Social Care |
| **Author:** | Rob McCulloch-Graham, Chief Officer Health & Social Care |

**REDUCTION IN DEMENTIA INPATIENT BEDS AT CAULDSHIELS WARD AND REINVESTMENT IN COMMUNITY SERVICES**

## Purpose of Report:

The purpose of this report is to advise the Board of the direction from the IJB to proceed with the proposal to redesign dementia inpatient services, reducing the number of inpatient beds from 26 to 12 and reinvesting in community services enhancing the care of dementia patients in the community and facilitating the reduction in specialist inpatient beds.

## Recommendations:

The Board is asked to **accept** the direction of the IJB to implement the proposed redesign.

## Approval Pathways:

This report has been approved by the IJB.

## Executive Summary:

The Health and Social Care Partnership, working with Scottish Borders Council (SBC) and NHS Borders, is exploring how together we can respond to the growing demographic of people with dementia. The 'Transforming Specialist Dementia Hospital Care' report developed by Alzheimer's Scotland for the Scottish Government recommends that 50 per cent of acute hospital beds for dementia patients should be transferred to more appropriate residential provision within the community. Following local reviews of dementia care provision within the context of an overarching mental health transformation strategy, and in line with government guidance, we aim to progress a shift in the balance of care for medicine of the elderly in line with our expected objectives from the development work already undertaken.

The proposed redesign of dementia inpatient services will involve reducing the number of inpatient beds from 26 to 12 and reinvesting in community services enhancing the care of dementia patients in the community and facilitating the reduction in specialist inpatient beds. A reserve of £338,000 for the IJB is proposed for the commissioning of additional residential care beds until the impact of the Care Home and Community Assessment Team is ascertained and as a contingency whilst the impact of the dementia services redesign is monitored.

Attached is the report submitted to the IJB on 14 August 2019.

| **Impact of item/issues on:** | |
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| **Strategic Context** | This work has been developed as part of the Mental Health Transformation Programme. The proposed redesign will support the implementation of the recommendations set out in the Scottish Government *"Transforming Specialist Hospital Dementia Care"* report and is consistent with the national and local drive to shift the balance of care from hospital to the community. It will also compliment local ambitions to develop increased suitable housing and support models for people diagnosed with dementia. |
| **Patient Safety/Clinical Impact** | The Scottish government "Transforming Specialist Hospital Dementia Care" report sets out a model of modern specialist hospital units based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care. It also provides an approach to build community capacity to support the safe transition of those who do not have a clinical need to remain in specialist hospitals and can be cared for in more homely settings in the community. The proposed redesign has been developed to support the implementation of the report recommendations. |
| **Staffing/Workforce** | If staff teams are to be reduced, the normal NHS Borders redeployment process will apply. |
| **Finance/Resources** | This project has been brought under the Financial Turnaround Programme. In order to reduce the number of specialist inpatient beds there needs to be reinvestment to develop further community capacity in health and social care services. A net saving of circa £475,000 is expected. |
| **Risk Implications** | A risk assessment has been undertaken as part of the development of the redesign proposal. |
| **Equality and Diversity** | An Equality Impact Assessment will be carried out as part of the project. |
| **Consultation** | Engagement has taken place with staff and dementia patient groups throughout the development of the proposed redesign. |
| **Glossary** | IJB – Health & Social Care Integration Joint Board<br>SBC – Scottish Borders Council |

Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 14 August 2019

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| Report By | Rob McCulloch-Graham, Chief Officer Health & Social Care |
| Contact | Rob McCulloch-Graham, Chief Officer Health & Social Care |
| Telephone: | 01896 828290 |

# REDESIGN OF DEMENTIA SERVICES

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| **Purpose of Report:** | To seek approval for the proposal to redesign dementia services, by investing in community services with a consequent reduction in the need for inpatient beds from 26 to 12, and as a result enhancing the care of dementia patients in the community. |

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| **Recommendations:** | The Health & Social Care Integration Joint Board is asked to:<br><br>a) Approve the reduction of the number of dementia inpatient beds from 26 to 12;<br><br>b) Approve reinvestment in appropriate community resources;<br><br>c) Agree to establish an IJB reserve of £338,000 of recurrent funding. This reserve will be earmarked for the purchase of additional dementia care home beds, as required. Should the beds not be required the balance of the reserve would be used by the IJB to contribute to the delivery of efficiencies within the health arm of the IJB budget;<br><br>d) Agree to review the impact of the new model by no later than March 2021, including the effectiveness of the Care Home and Community Assessment team, the need for NHS Inpatient beds and the ongoing requirement for the earmarked reserve. |

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| Personnel: | If staff teams are to be reduced, the normal NHS Borders redeployment process will apply. |

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| Carers: | Further advice and support for Carers will be available through the Care Home and Community Assessment Team. |

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| Equalities: | An Equality Impact Assessment will be carried out as part of the project. |

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| Financial: | Within the paper, financial consequences and impacts are considered. |

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| Legal: | N/A |

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| Risk Implications: | See attached risk assessment within Cauldshiels mandate (**Appendix 6**). |

## 1 PURPOSE AND SUMMARY

1.1 The Health and Social Care Partnership working with Scottish Borders Council (SBC) and NHS Borders are exploring how together we can respond to the growing demographic of people with dementia. In addition to evaluating current practice within the Borders and commissioning support to provide more accurate predictors for the demographics, officers and members of the Integration Joint Board (IJB) have been examining other models both within the UK and abroad.

1.2 Two major development sessions have been held focussing on the future provision for Health and Social Care within which provision for the elderly is a priority. Details of this work have been discussed at SBC's Corporate Management Team, NHS Borders' Board Executive Team, Strategic Planning Group and the Executive Management Team.

1.3 Previous reviews conducted by external consultants including Anna Evans, Anne Hendry and John Bolton, have identified a need for a step change in the scale and scope of service provision for older people with dementia in the Borders.

1.4 A further report 'Transforming Specialist Dementia Hospital Care' by Alzheimer's Scotland recommended that acute hospital beds for dementia patients should be transferred to more appropriate residential provision within the community.

1.5 In response the Partnership is now developing an overarching Dementia Care Strategy to govern future provision of services. In the meantime, there are a range of early responses which are being advanced in line with the early development work already undertaken and the evolving strategy. These developments aim to progress a shift in the balance of care for medicine of the elderly. The Council invested £500k in securing 7 specialist dementia care nursing beds within Queens House.

1.6 The first opportunity is the transfer of patients currently being cared for in the acute wards of Cauldshiels and Melburn Lodge at the BGH. Provision at Cauldshiels is viewed as being unfit for purpose for dementia care. The unit is currently operating significantly under capacity, with less than 50% of the beds across the two units currently being occupied. Consequently, an opportunity has arisen to transform this service by closing the Cauldshiels ward and relocating patients to the homelier setting of Melbourne Lodge. The closure of Cauldshiels ward and the resetting of the model of care within Melburn Lodge will enable a significant improvement in quality of dementia care facilities, save significant annual revenue resources and avoid the need for substantial investment in the fabric of the Cauldshiels facility.

1.7 The paper outlines in detail how this will be achieved and the necessary investment required to transfer from NHS Borders to SBC, for them to commission

the appropriate provision.

## 2 MAIN REPORT

2.1 **Current Provision -** The current provision of Dementia inpatient care in Scottish Borders is provided across two wards on the BGH site; Cauldshiels (a 14 bed assessment ward) and Melburn Lodge (a 12 bed ward). In addition, Lindean provides a specialist inpatient facility for older adults with acute mental health problems.

2.2 Following investment from SBC, the service is experiencing reduced demand for inpatient beds. We currently have six patients on Cauldshiels (including four delayed discharges) and seven patients on Melburn (including one delayed discharge). Across the 26 beds in the two units, there are currently 13 patients, of which five are delayed discharges and could more appropriately be cared for in an alternative setting.

2.3 A Day of Care Audit (DOCA) (attached **Appendix 3**) was undertaken across all inpatient settings within the Borders, BGH and Community Hospitals in July 2018, and Melburn, Cauldshiels and Lindean in November 2018. The DOCA completed for older adults with an organic and/or functional mental illness, which includes Melburn, Cauldshiels and Lindean, reinforced the national estimation that there is a need for a significant reduction in the number of specialist inpatient beds for this patient group. Locally of the 28 patients included in the audit only seven required a specialist inpatient bed. 21 patients could be cared for in a range of alternative settings such as nursing or residential home or with a package of care at home.

2.4 The DOCA completed in July 2018 for the BGH and Community hospitals identified no patients requiring specialist inpatient dementia care, it also identified that in the Community Hospitals the majority of patients could be managed out of hospital in an alternative care setting or at home with enhanced support.

2.5 The Mental Welfare Commission's (MWC 2014) review of dementia continuing care units identified serious concerns with quality of care, environments, access to multidisciplinary professionals and adherence to legal requirements for providing care.

2.6 Cauldshiels ward has been highlighted in successive Mental Welfare Commission reports as providing an unsuitable physical environment for dementia care. Rectifying this in the long term would require a substantial rebuilding programme and significant capital investment (**Appendix 4** MWC reports and **Appendix 5** Architects report). The estimated cost of doing this work ranges from over £1m to an architect assessed cost of £400k for essential non structural work. This capital cost will be avoided if the ward is no longer required.

2.7 Specialist dementia wards are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family. There is a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia. There is difficulty with transition, resulting in the largest proportion of patients in the specialist dementia wards being those who do not have a clinical need to be in hospital. This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively.

2.8 There is a lack of integration between these specialist hospital environments and the wider health and social care systems. This results in specialist dementia hospital units sitting in isolation, without the same focus on discharge to more appropriate care environments that are the case with acute hospitals. This often results in the window of opportunity being missed for safe transition to a more appropriate community setting to enhance quality of life.

2.9 Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.

2.10 **Proposed Redesign -** The Scottish government "Transforming Specialist Hospital Dementia Care" report (**Appendix 1**) sets out a model of modern specialist hospital units based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care. It also provides an approach to build community capacity to support the safe transition of those who do not have a clinical need to remain in specialist hospitals and can be cared for in more homely settings in the community.

2.11 Specialist dementia hospital care is required for people with dementia who have an acute psychological presentation as a result of dementia or co-morbid mental health illness. The clinical needs of this group can only be met in a hospital environment. Whilst a psychological presentation may necessitate being admitted to hospital, the person will also have additional physical, emotional and social care needs. This requires a highly skilled multi-disciplinary workforce that can deliver therapeutic interventions, care and treatment; with the appropriate level of multi-disciplinary professional input to support those providing day-to-day care.

2.12 Most people with dementia can be cared for in the community throughout the illness. This requires a multi-disciplinary coordinated and planned approach to support those providing day-to-day care. There will be a small number of people with dementia who have acute clinical care needs that require specialist hospital care for a period of time. It is estimated that up to one percent of people with dementia will require management in a specialist dementia hospital environment at any one time. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

2.13 The Scottish Government report recommends a 50% reduction in specialist dementia inpatient beds for all Health Boards. Melburn lodge already provides an appropriate environment to support the above recommendations for an inpatient "centre of excellence" for dementia care and will therefore require little alteration. Melburn provides 12 inpatient beds approximately meeting the estimated requirement for an overall 50% reduction in specialist dementia inpatient beds. Due to the physical environment on Cauldshiels ward not being fit for purpose, closing this ward would allow a suitable reduction in line with the national recommendation.

2.14 Day of care audits for Borders General Hospital, the Community Hospitals and specialist dementia in patient wards confirm that the local demand for beds supports the reduction in inpatient beds by 50%.

2.15 In line with recommendations made in the Scottish Government report, the Health and Social Care Partnership should reduce the number of dementia inpatient beds from 26 to 12 and reinvest in appropriate community resources (**Appendix 6** Cauldshiels Mandate). The proposal is to phase the reduction in inpatient beds in Cauldshiels whilst developing the community services to facilitate this shift in the balance of care. The current assessment function undertaken in Cauldshiels will

be incorporated into Melburn.

2.16 Preliminary bed modelling has been undertaken, this indicates that the number of inpatient dementia beds can safely be reduced through the existing changes and the development of the Care Home and Community Assessment Team without the need to purchase additional specialist dementia beds in the community. The report is contained in **Appendix 7**.

## 3 NEXT STEPS

3.1 The Health and Social Care Partnership are in the process of developing a local Dementia Strategy and our Mental Health Services are in the midst of a transformation programme. It is clear that reducing inpatient beds and reinvesting in community resources is consistent with the National and local drive to shift the balance of care from hospital to the community and the Scottish government report "Transforming Specialist Hospital Dementia Care". It will also compliment local ambitions to develop increased suitable housing and support models for people diagnosed with dementia.

3.2 A local Dementia Strategy is likely to include the redesign of services and the development of an appropriate commissioning strategy. It is clear that reducing inpatient beds and reinvesting in community resources is consistent with the national drive to shift the balance of care from hospital to the community and the Scottish Government report. It will also compliment local ambitions to develop increased suitable housing and support models for people diagnosed with dementia.

3.3 A project team has been established to take forward this proposal which will be part of the Mental Health Transformation Programme, but will also work alongside the NHS Borders Financial Turnaround Programme.

3.4 This proposal includes the introduction of a Care Home and Community Assessment Team. Modelling suggests that this team could reduce the number of admissions from care and nursing homes by 50%. If this modelling is correct, the additional 5 specialist Dementia Nursing Beds might not be required. It is therefore proposed that the £338k identified for the specialist beds be ear marked as an IJB reserve until the actual impact of the Care Home and Community Assessment Team is realised or not. This reserve would therefore be utilised if the pressure for admissions to acute services remain at a level which would jeopardise the ability to cater for people with high level dementia needs.

3.5 The Cauldshiels steering group will monitor progress across both wards in Cauldshiels and Melburn Lodge. A review will be produced for the IJB to determine the impact of the ward closure.

3.6 Investment in additional social work capacity (£45,000) has also been identified as a key requirement to ensure continued flow through the inpatient bed capacity and maintenance of the reduced level of specialist inpatient beds. This will be funded from the disinvestment from Cauldshiels.

## 4 IMPLICATIONS

### 4.1 Financial

The proposed recurring reinvestment, funded by the reduction in Cauldshiels beds will enable: -

(a) Development of a Care Home and Community Assessment Team to support patients in the community.

(b) Investment in a dedicated Social Worker to ensure flow through hospital into the community.

(c) The proposed £338,000 initially identified for the commissioning of five specialist dementia beds in the community to be ear marked as an IJB reserve and only to be invested in nursing beds should this be required.

4.2 The table below summarises the saving anticipated from the closure of Cauldshiels, and proposed reinvestment in new dementia services. This will require the redirection of resources by the IJB from acute services funded by NHS Borders to community settings funded by SBC. In the process a net saving of £474,202 will be realised, please see **Appendix 8** for further breakdown:

| **Cauldshiels Savings** | **Recurring £ (Excl MHOAT)** |
|---|---|
| Total Budget for Cauldshiels Ward | 1,102,455 |
| **Total Funding** | **1,102,455** |
| | |
| **Total estimated investment (excl beds)** | |
| Staffing (inclusive of Care Home and Community Assessment Team and 1 FTE Social Work post) | 266,253 |
| Travel | 24,000 |
| Cost of new provision (excl beds) | 290,253 |
| **Interim Saving (excl beds)** | **812,202** |
| | |
| **Ear Marked Investment for 5 Specialist Beds** | **338,000** |
| | |
| **Forecast Savings (incl beds)** | **474,202** |

4.3 In order to reduce the number of specialist inpatient beds there needs to be reinvestment to develop further community capacity in health and social care services (estimating this at £1,300 per week per patient, a reduction of 14 beds on Cauldshiels ward would equate to a reinvestment of £946,400 pa). With this in mind our Health and Social Care Partnership has already agreed to: -

- Develop a Care Home and Community Assessment Team to provide specialist support to Community Hospitals and the Care Home sector to

reduce the need for hospital admission. This should be operational by September 2019. This will support more robust community resources to provide outreach to care homes and Community Hospitals which would be flexible and responsive to individual needs.

- Commission 5 specialist Dementia Nursing Beds to accommodate existing inpatients suitable for discharge from inpatient care or to prevent such an admission.
- Place a concerted focus on timely discharge, we have experienced a reduced demand for suitable admissions to Cauldshiels ward.

4.4 As a result, we have chosen to staff the ward to meet demand reducing the number of beds from 14 to 10. Currently we have six patients on Cauldshiels ward of which four are delayed discharges. As the demand has reduced further we are now considering reducing beds to six from the end of September 2019. Melburn ward has also seen a reduction in demand and currently has seven patients with one delayed discharge (on a ward with 12 beds).

# Transforming Specialist Dementia Hospital Care

Alzheimer Scotland
Action on Dementia

Scottish Government
Riaghaltas na h-Alba
gov.scot

This report is part of the consensus-based stakeholder response to the Mental Welfare Commission's report into specialist NHS dementia care in 2014. It is an independent review of the sector commissioned by The Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. This work was led by Alzheimer Scotland's National Dementia Nurse Consultant, a post that was jointly funded by Alzheimer Scotland and the Scottish Government.

The development of this report was led by Maureen Taggart, Alzheimer Scotland National Dementia Nurse Consultant

This report was researched and written by:
Maureen Taggart and Lindsay Kinnaird, Research Manager, Alzheimer Scotland

Report design by Andrew Palfreyman, Alzheimer Scotland

Please cite as: "Transforming Specialist Dementia Hospital Care, Alzheimer Scotland, 2018"

Published June 2018

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**With grateful acknowledgment to:**
Our NHS colleagues who made this unique insight possible
Alzheimer Scotland colleagues
Alzheimer Scotland Carers Reference Groups
Care Inspectorate
Health Care Improvement Scotland
Knowledge Services, NHS Lanarkshire
Mental Welfare Commission
National Dementia Carers Action Network
National Nurse and Allied Health Professionals Consultants Group
NHS National Education for Scotland
Scottish Dementia Working Group

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# Executive summary

## Introduction:

- This report sets out a model of specialist hospital care for people with dementia who have intensive and complex clinical care needs that require high level expert care.
- Specialist dementia hospital care is required for people with dementia who have an acute psychological presentation as a result of dementia or co-morbid mental health illness. The clinical needs of this group can only be met in a hospital environment.
- Whilst a psychological presentation may necessitate being admitted to hospital, the person will also have additional physical, emotional and social care needs. This requires a highly skilled multi-disciplinary workforce that can deliver therapeutic interventions, care and treatment.
- It also provides an approach to the safe transition of people who do not have a clinical need to remain in hospital and can be cared for in more homely settings in the community, with the appropriate level of multi-disciplinary professional input to support those providing day-to-day care.
- The findings and recommendations of this report were made possible by the overwhelming enthusiasm of staff working in this area to welcome the Alzheimer Scotland National Dementia Nurse Consultant to visit their unit and share their practice. This included staff within the specialist dementia units, mental health leads for quality excellence in specialist dementia care, executive directors of nursing and allied health professionals, consultant psychiatrists and psychologists, pharmacology and social work.
- This collaborative approach also included people with dementia and their families, Chief Nursing Officer's Directorate, Commitment 11 Excellence in Specialist Dementia Care Group of the National Dementia Strategy and the Mental Welfare Commission.

## Background:

- The Mental Welfare Commission's (MWC 2014) review of dementia continuing care units identified serious concerns with quality of care, environments, access to multi-disciplinary professionals and adherence to legal requirements for providing care.
- A roundtable discussion[a] was hosted by Alzheimer Scotland in 2014 following on from the above report to develop a better understanding of the issues and challenges and identify what could be done to remedy these.
- The key outcome of this roundtable was the appointment of an Alzheimer Scotland National Dementia Nurse Consultant to undertake a review of NHS specialist dementia care environments. This post was jointly funded by Alzheimer Scotland and the Scottish Government.
- Ten NHS Boards were included in this review, with 63 individual specialist care environments visited from a total of 92 with the purpose of 1) evaluating the quality

a Chaired by Professor Graham Jackson and attended by representatives from Scottish Government, NHS Health Boards and Royal College of Psychiatrists

and appropriateness of specialist hospital care in dementia and 2) developing an understanding of the issues around transition and discharge from hospital.

- During these visits staff demonstrated how they were delivering person-centred care within challenging circumstances and environments. These challenges included unsuitable buildings, design and layout that hindered the delivery of person-centred care, lack of access to multi-disciplinary professionals and the needs of patients ranging from acute psychological symptoms to end-of-life care.
- The Alzheimer Scotland National Dementia Nurse Consultant also brought her own in-depth understanding of the context of these environments and the needs of people who require specialist dementia hospital care. This specialist knowledge and understanding, combined with the extensive consultation enabled the Nurse Consultant to provide the recommendations within this report.

## Issues with current provision:

- The Alzheimer Scotland National Dementia Nurse Consultant found:
  - Specialist dementia wards are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family.
  - There is a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia.
  - There is difficulty with transition, resulting in the largest proportion of patients in the specialist dementia wards being those who do not have a clinical need to be in hospital.
  - This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively.
  - Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.
- There is a lack of integration between these specialist hospital environments and the wider health and social care systems.
- This results in specialist dementia hospital units sitting in isolation, without the same focus on discharge to more appropriate care environments that is the case with acute hospitals.
- This often results in the window of opportunity being missed for safe transition to a more appropriate community setting to enhance quality of life.
- Most people with dementia can be cared for in the community throughout the illness. This requires a multi-disciplinary coordinated and planned approach to support those providing day-to-day care.
- There will be a small number of people with dementia who have acute clinical care needs that require specialist hospital care for a period of time.

- It is estimated that up to one percent of people with dementia will require management in a specialist dementia hospital environment at any one time[b]. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

## Moving forward:

- This report sets out a model of modern specialist hospital units based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care.
- It also provides an approach to build community capacity to support the safe transition of those who do not have a clinical need to remain in specialist hospitals and can be cared for in more homely settings in the community.
- Going forward, the Advanced Dementia Practice Model (Alzheimer Scotland 2015) provides the integrated and comprehensive evidence-based approach to support people in the community and ensure that people with dementia do not remain in hospital unnecessarily.
- Based on the evidence presented in this report, there is an urgent need for widespread redesign of specialist dementia hospital provision across Scotland. This will enable current resources to be used more effectively.
- The decommissioning and re-design process can be delivered as a one-time transformational change.

## Recommendations:

- That specialist NHS dementia care is modernised, providing high quality, human rights-based care, specifically for individuals who cannot be cared for in the community.
- Integration Joint Boards develop a transition plan and a local engagement strategy with their partners, including NHS Boards and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop further community capacity in health and social care services.
- That the Scottish Dementia Working Group and National Dementia Carers Action Network provide the representative groups for this local engagement.
- Integration Joint Boards and NHS Boards assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings.
- The Alzheimer Scotland National Dementia Nurse Consultant provides expert guidance at both a national and local level.
- Integration Joint Boards and NHS Boards build strong and strategic local engagement on:
    - Any necessary de-commissioning and re-directing of resources to the development of specialist dementia hospital units and
    - building further community health and social care services.

**b** Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

- NHS National Procurement to commission the design of a blueprint for a specialist dementia unit that can be implemented by each NHS Board.
- There should be no financial detriment for families as part of the decommissioning process, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board.
- The legal status of patients being transitioned to the community is reviewed and the appropriate legal documentation put in place.
- The creation of modern specialist dementia units that will provide centres of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.

  The estimated 45[c] specialist dementia units required across Scotland will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver highly skilled therapeutic interventions.

  Promoting Excellence Framework the foundation for evidence based care for all practitioners.  Leaders and senior practitioners ensuring that everyone working within the unit are trained at the appropriate level to ensure a high quality therapeutic approach.

  They will be underpinned and supported by the Charter of Rights for People with Dementia and their Carers in Scotland, the Promoting Excellence Framework, the AHP Framework Connecting People, Connecting Support and the Standards of Care for Dementia in Scotland.
- The timeframe for this process will extend beyond the end-point of Scotland's 2017-2020 National Dementia Strategy

c This is based on an estimated 560 people with dementia who require care and treatment in a specialist dementia unit.

# 1. Introduction

## 1.1 Introduction

This report is part of the consensus-based stakeholder response to the Mental Welfare Commission's report into specialist NHS dementia care in 2014. The independent review of the sector was commissioned by the Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. This work was led by Alzheimer Scotland's National Dementia Nurse Consultant, a post that was jointly funded by Alzheimer Scotland and the Scottish Government.

Most people with dementia can be cared for in the community[d] throughout the illness. This requires a multi-disciplinary, professional, coordinated and planned approach to support those providing day-to-day care[e]. There will be a relatively small number of people with dementia at any one time who have acute clinical care needs that require specialist hospital care for a period of time. This will result from severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition.

However, an estimated 60 percent of current patients with dementia do not have this clinical need and could be more appropriately cared for in the community. This means the specialist dementia hospital population has a wide range of needs that cannot be appropriately accommodated alongside each other. It also results in resources being used inefficiently and does not facilitate skilled practitioners to deliver highly specialised interventions for people with an acute clinical need.

This report sets out a model of a modern specialist hospital unit based on quality of care for people with dementia who have intensive and complex clinical care needs and require high level expert care. It also provides an approach to building community capacity to support the safe transition for those who do not have a clinical need to remain in hospital and can be cared for in more homely settings in the community.

Going forward, the Advanced Dementia Practice Model (Alzheimer Scotland 2015)[f] provides the integrated and comprehensive evidence-based approach to support people in the community and ensure that people with dementia do not remain in hospital unnecessarily.

**d** Continuing to live at home or in a care home

**e** This includes family carers, care homes, care at home service and day care

**f** Alzheimer Scotland (2015) "Advanced dementia practice model: understanding and transforming advanced dementia and end-of-life care" https://www.alzscot.org/campaigning/advanced_dementia_model

## 1.2 Background to report

The Mental Welfare Commission's (MWC 2014)[g] review of dementia continuing care units identified serious concerns with quality of care, environments, access to multi-disciplinary professionals and adherence to legal requirements for providing care. A roundtable discussion[h] was hosted by Alzheimer Scotland in 2014 following on from this report to develop a better understanding of the issues and challenges and identify what could be done to remedy these.

The key outcome of this roundtable was the appointment of an Alzheimer Scotland National Dementia Nurse Consultant to undertake a review of NHS specialist dementia care environments. Ten NHS Boards[i] were included in this review, with 63 specialist care environments visited from a total of 92 with the purpose of:
1) evaluating the quality and appropriateness of specialist hospital care in dementia; and
2) developing an understanding of the issues around transition and discharge from hospital.
The Nurse Consultant also carried out extensive consultation with key stakeholders, including people with dementia and families, as part of this process. The findings from this review are presented in full in Appendix 1 of this report.

The recommendations of this report are based on the findings of the review by the Alzheimer Scotland National Dementia Nurse Consultant. Improvements since the review have been explored in a smaller number of NHS Boards and are incorporated into the recommendations within this report.

The recommendations are also informed by the improvement programme of work from the Commitment 11 Quality and Excellence Specialist Dementia Care Group. This work has been ongoing since September 2014, with NHS Boards submitting their self-assessment and improvement plans to the Commitment 11 Group. This work has been continued through a programme led by Focus on Dementia[j] that is working with four individual specialist dementia hospital units across Scotland. Additional improvement has been delivered through the Promoting Excellence Framework (2011), with the Dementia Specialist Improvement Leads Programme being introduced to cascade enhanced and expert education and training to support change and improvement.

g Mental Welfare Commission (2014) "Dignity and respect: dementia continuing care visits" http://www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf
h Chaired by Professor Graham Jackson and attended by representatives from Scottish Government, NHS Health Boards and Royal College of Psychiatrists
i Review took place between April 2015 and March 2016 and included Ayrshire and Arran, Dumfries and Galloway, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, Scottish Borders and Tayside.
j Health Improvement Scotland

## 1.3 Context and legal framework for specialist dementia hospital care

The National Dementia Strategy for Scotland[k] is underpinned by the "Charter of Rights for People with Dementia and their Carers in Scotland" (2009)[l]. This includes ensuring that the human rights of people with dementia are respected, protected and fulfilled. The Charter also stipulates that people with dementia have the right to health and social care services provided by people with an appropriate level of training on dementia and human rights.

The Promoting Excellence Framework (2011)[m] takes this forward into practice through outlining the knowledge and skills required by health and social care practitioners. This is set out in four different levels of skill and knowledge determined by a practitioner's role and level of responsibility. There has also been focused attention and improvements in specialist dementia hospital provision through the Commitment 11 Group of the National Dementia Strategy (2013 to 2016)[n].

Specialist hospital care in dementia sits within the principles and provisions of the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act[o]. The review by the Alzheimer Scotland National Dementia Nurse Consultant found that only a small number of patients are subject to a compulsory treatment order under the Mental Health (Care and Treatment) (Scotland) Act.

Whilst legislation and guidelines provide the framework for staff to work within, there is also a need for ongoing training and support in ethical decision making. There is unlikely to be a single right answer in any given situation and staff within specialist dementia hospital care require support in the complex ethical dilemmas that can arise (Nuffield Council on Bioethics 2009)[p].

**k** The first National Dementia Strategy was published in 2010, with subsequent updates published in 2013 and 2017

**l** "Charter of Rights for People with Dementia and their Carers in Scotland" (2009) https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf

**m** NHS Education for Scotland and Scottish Social Services Council (2011) "Promoting Excellence Framework" http://www.gov.scot/Resource/Doc/350174/0117211.pdf

**n** Commitment 11: "We will set out plans for extending the work on quality of care in general hospitals to other hospitals and NHS settings."

**o** Mental Health (Care and Treatment) (Scotland) Act 2003 and updated provisions in Mental Health (Scotland) Act 2015.

**p** Nuffield Council on Bioethics (2009) "Dementia ethical issues" http://nuffieldbioethics.org/wp-content/uploads/2014/07/Dementia-report-Oct-09.pdf

## 1.4 Outline of report

### Section 2: People with dementia who need specialist hospital care

This section provides an understanding of when people with dementia may require specialist hospital care. It also presents current data on the number of people with dementia in specialist hospital environments and an outline of the Advanced Dementia Practice Model (Alzheimer Scotland 2015).

### Section 3: Current approaches to specialist dementia hospital care

This section provides an understanding of current approaches to specialist hospital care in dementia. It provides a summary of the key findings of the review by the Alzheimer Scotland National Dementia Nurse Consultant. It also provides a synopsis from recent findings from the Mental Welfare Commission's visits to specialist dementia hospital environments.

### Section 4: Transforming specialist dementia care

This section takes forward the issues and challenges outlined in the report and presents a blueprint for a specialist dementia unit through outlining the core specialisms and approach required. It also puts forward a case for a one-off transformational change through decommissioning and re-design of specialist dementia care across Scotland.

### Section 5: Conclusion and recommendations

This section provides the concluding remarks and sets out a series of recommendations to guide the decommissioning and transformation process.

# 2. People with dementia who need specialist hospital care

## 2.1 Introduction

This section will demonstrate that most people with dementia can continue to be cared for in the community throughout the illness. It will show that only a small proportion of people with dementia require specialist hospital care. As the number of people with dementia increases, recognising and responding to these factors will be of key importance in reshaping dementia hospital provision with the essential component of specialist community support to ensure resources are used efficiently.

## 2.2 People with dementia who will require specialist hospital care

The experience of dementia is unique to each individual and dependent on factors relating to underlying health, personality, biography and social context. As dementia progresses, the physical nature of the illness becomes more to the fore – the influence of social and psychological aspects will also continue to be prominent.

People will often have co-morbid physical or mental health conditions that will combine with dementia in a complex way. The possible range of physical, psychological and social issues in dementia requires a bio-psychosocial holistic approach in providing appropriate care and treatment for the individual.

Health care practitioners will have a key role in responding to the increasing physical nature of advancing dementia, the impact of co-morbid conditions and supporting psychological wellbeing. This specialist support can be provided in the person's current place of residence[q] for most people with advanced dementia. Section 2.4 outlines how people can continue to be supported in the community to avoid unnecessary hospital admissions.

There will be a small proportion of people who will require specialist dementia hospital care and treatment. This group will experience very severe and persistent psychological distress and behaviours that would be too challenging to be managed in mainstream settings, irrespective of how much specialist support is provided.

The types of issues include aggression and physical violence, self-harm, high risk to self and/or others and ongoing extreme disinhibited behaviours, with lack of recognition of inappropriateness. They will often be physically mobile and possibly younger. It also includes people with dementia who have acute mental health conditions such as psychosis, schizophrenia and severe depression with suicidality.

This group will also have complex physical health care needs, along with the requirement for meaningful occupation and social stimulation. This requires a multi-disciplinary professional approach in addition to the nursing and specialist clinical care support who will provide day-to-day caring.

Brodaty et al (2003)[r] provide a "seven-tiered model of management of behavioural and psychological symptoms of dementia". They estimate that up to one percent of people

q Continuing to live at home or in a care home

r Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

will be within the highest tiers and require management in a psychogeriatric or neuro-behavioural unit. This will include people with acute psychiatric illness and severe behavioural problems complicating their dementia.

The intensity of experience is likely to continue for a relatively short period of time until the presentation changes. This may be ongoing for a period of around 18 months and will diminish as the illness progresses and physical robustness reduces. The person can then be safely transitioned to being cared for in a community setting, once this clinical need to remain in hospital no longer exists.

## 2.3 Specialist dementia hospital population

There were 1,886 NHS Old Age Psychiatry specialist beds for people with dementia in Scotland in June 2014[s]. The work carried out by the Alzheimer Scotland National Dementia Nurse Consultant suggests that this number is likely to have reduced to some extent since the audit was carried out.

Official statistics provide approximately 1,850 as the number of NHS Old Age Psychiatry beds in 2016 (ISD 2017)[t]. Official statistics also show that there are 4,400 Geriatric Medicine beds in 2017. These official statistics includes people with an organic illness (dementia) and those with a functional illness (mental ill health conditions such as depression, bi-polar and schizophrenia). It is therefore difficult to provide a precise number of patients with dementia, given the frequency of co-morbid conditions and under-diagnosis of dementia.

## 2.4 Advanced Dementia Practice Model and Advanced Dementia Specialist Team

Those providing day-to-day support require specialist support in responding to the complex physical, psychological and social issues that occur in advanced dementia. The Advanced Dementia Practice Model (Alzheimer Scotland 2015) provides an integrated and comprehensive approach to respond to this most complex phase of the illness and support people to remain in the community.

The Advanced Dementia Specialist Team provides the specialist input required to support those already providing care. They will provide expert assessment, medical interventions and guidance on skilled, person-centred approaches to care. These specialist practitioners are located within this team on a full, part-time or consultancy basis. It includes specialist consultants, psychologists, allied health professionals and mental health and general nursing practitioners.

The care plan provides a planned and coordinated approach to support the person through advanced dementia and end-of-life. It will identify the practitioners required to support the person's care, bringing in specialist support where this is not already being provided. This approach will enable most people to remain within the community. It will also provide the multi-disciplinary professional team necessary to enable people to safely transition from hospital to the community when they no longer have a clinical need to remain.

**s** Scottish Government audit of NHS Boards for National Dementia Strategy Commitment 11 Working Group

**t** 1,160 long stay beds and 3,235 in units other than long stay https://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

## 2.5 Current practice

Current practice is not consistent with this optimum approach to specialist care in dementia. The following section will demonstrate that people are currently being admitted to hospital who can be cared for in community settings and are then unable to be safely transitioned out because of lack of appropriate care in the community.

# 3. Current approach to specialist dementia hospital care

## 3.1 Introduction

This section provides an understanding of current approaches to specialist hospital care in dementia. Evidence presented comes from the extensive and in-depth review by the Alzheimer Scotland National Dementia Nurse Consultant[u]. This review included consultation with a wide range of key stakeholders such as practitioners and people living with dementia. It outlines the key problems in the quality and appropriateness of provision. It also highlights that many people do not have a clinical need to be in hospital, but that challenges with transitioning from these environments means that the number of people remaining in hospital is much higher than necessary.

A synopsis of the findings of the Mental Welfare Commission's reports[v] in specialist dementia care environments is provided. The good practice examples from the review by the Alzheimer Scotland National Dementia Nurse Consultant are then presented along with an understanding of some of the improvements since that time.

## 3.2 Findings of review by the Alzheimer Scotland National Dementia Nurse Consultant

### 3.2.1 Hospital population

Admission to assessment units was often not because of clinical need to be in hospital. It could broadly be defined as relating to a lack of appropriate care and support in the community. This included the lack of an appropriate care plan for the person to remain in their current place of residence, and distress in dementia not being adequately supported by specialists in the community. The range of needs within specialist units and transition units varied widely from psychological symptoms of dementia and co-morbid mental health illness to end-of-life. Occupancy levels varied across the NHS Boards. Low occupancy was noted in three Boards with occupancy levels around 70 percent.

### 3.2.2 Workforce skills and knowledge and access to multi-disciplinary professionals

The skill mix and ratio of professional staff in these environments was lower than that of all other mental health areas. In most areas there was a lower ratio of registered mental health nurses to clinical support staff. A small number of NHS Boards had higher ratios of professional staff, with 55 to 60 percent registered mental health nurses.
Access to multi-disciplinary professionals in assessment units was at a higher level compared with specialist dementia units. However, the level varied between NHS Boards. Only two wards had dedicated social worker time, with all others having a referral system. Most of the specialist and transition units for people with complex needs associated with

u A full report on the review is provided in Appendix 1
v Inspections that took place during 2016 and 2017

advanced dementia had no access to the multi-disciplinary professional team including psychology, pharmacy and allied health professionals.

Half of the assessment units had access to allied health professionals and there was very limited access to pharmacy and psychology. The specialist and transition units had virtually no access to these professionals – access to pharmacy was minimal and they were not participating in medication management or multi-disciplinary reviews. Access to other professionals could be available through a referral approach, but length of waiting time was an issue. Due to increased referrals from community teams, very few people with dementia in the specialist and transition units were supported by the psychological service.

The cost of beds varied widely. Higher costs did not equate to quality of care and access to a greater number of specialists compared with the less costly beds. Whilst many of the specialist beds are in mental health services, some are managed within community hospitals and others within primary care, where there is limited access to specialist dementia professionals. Two Boards had transferred the care and treatment of patients with dementia to a specialist unit in England because of the lack of a hospital environment that could provide specialist care within Scotland.

### 3.2.3 Environments

Older facilities were in use in many areas which required significant investment for upgrade and maintenance. Specialist dementia units continue to be located on upper floors with no easy access to outdoor areas. These can be old, institutional environments in locations that are difficult for families to visit using public transport.

In many cases the built environment presented challenges for staff in providing person-centred quality care and added to the distress of patients and families. There was a lack of privacy, with bed and toilet areas being shared by up to six people with no personal shower or wash areas.

Purpose-built dementia units had been developed in some areas, with others to be completed by 2019. At the time of the review, four NHS Boards were implementing a bed remodelling plan, driven by low occupancy and units being housed in outdated buildings.

### 3.2.4 Transitions

The length of stay within assessment units was an average of eight to 12 weeks. However, it could be up to two years in some instances and increased significantly when there were legal issues such as lack of specific relevant powers through power of attorney or guardianship. Discharge from these environments was often to a care home or NHS specialist bed either in hospital or in a contracted-out location. Delays in discharge were attributed to lack of funding for a care package and the availability of appropriate care settings within the community.

The length of stay within specialist and transition units ranged from one year to 15 years, with an average of four and a half years. The specialist dementia units exist in isolation and are disconnected from wider health and social care services commissioned by Integration

Joint Boards. Challenges to discharge included social work considering it to be a low priority as the person was in a place of safety. Families were apprehensive about care being provided outwith the specialist hospital environment and there was a lack of knowledge about alternative appropriate accommodation and support. Failed previous discharge to a care home was a common reason why people remained in NHS care.

## 3.3 Good practice examples and changes implemented since the time of review

There was evidence of good practice at the time of the initial review and follow-up visits by the Alzheimer Scotland National Dementia Nurse Consultant. It was evident throughout the review that staff were committed to providing a high standard of care. However, they were often frustrated and hindered by the issues outlined in the previous section.
The Promoting Excellence Framework (2011) had been implemented in every NHS Board visited. Most assessment units held reviews once or twice weekly, with families invited as appropriate.

Good practice in pre-discharge was noted in two Boards. In one, hospital staff and family would visit the care home to offer support to care home staff. The other had consultant-led clinics within care homes which successfully reduced admissions to the ward with outreach working. Two Boards reported a significant reduction in admission where psychiatric liaison teams had been established to support the care homes in their areas.

At the time of the review, there had been a number of recent improvements, including an activity room and areas for family to use or stay overnight. Some units had activity coordinators, with volunteers and community groups providing support for activity and connection. Many of the units visited had activity programmes planned.
Although some units had excellent facilities and activity rooms, staff shortages and lack of time meant the majority were locked, with no therapeutic activity going on within the unit at the time of the visit. When activity was carried out it was provided by nurses, with few units having access to specialist allied health professionals.

## 3.4 Mental Welfare Commission reports

Around 30 Mental Welfare Commission reports on specialist dementia care environments were reviewed. The visits took place throughout 2016 and 2017 across NHS Board areas in Scotland. The issues identified by the Commission were consistent with the extensive review conducted by the Alzheimer Scotland National Dementia Nurse Consultant.
Reports noted recommendations from previous visits – this highlighted that improvements are being made in areas of concern previously raised by the Commission. However, significant issues remained across many of the environments recently visited.

Most frequently occurring was a failure to evidence person-centred care planning and lack of access to multi-disciplinary specialists. A need for meaningful activity and tailored or person centred activity for patients was also recognised in many areas. There were

some instances of a failure to record documentation in relation to the relevant Acts[w] in the patient's file and to consult proxy decision makers and involve family members. Environmental concerns included overly clinical settings, unsuitable buildings and dignity and privacy being compromised.

## 3.5 Moving forward

This section has demonstrated that specialist dementia units are frequently located in environments that do not support person-centred care and can increase the distress of the person with dementia and their family. It has also shown a lack of access to the multi-disciplinary professionals required to support the complex care required in dementia. There is a disconnection between these specialist services and the wider health and social care commissioned by Integration Joint Boards. This creates difficulties with transition and results in a significant proportion of patients in the specialist dementia wards having no clinical need to be in hospital. This makes it difficult to provide appropriate care for the current wide range of differing needs. It also means that resources are not being targeted effectively. Staff within specialist care are committed to providing good quality care, but are hindered by the current obstacles.

The following section provides a model of specialist dementia care for those who have a clinical need to be in hospital. It also outlines an approach to the safe transitioning of the current group of people with dementia in specialist hospital environments who would be more suitably cared for in community settings.

w Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000

# 4. Transforming specialist dementia care

## 4.1 Introduction

Based on the evidence presented in this report, there is an urgent need for widespread redesign of specialist dementia hospital provision across Scotland. This includes the transition of most patients to the community, so they can be cared for in more appropriate settings to enhance their quality of life.

The decommissioning and re-design process can be delivered as a one-time, transformational change. This will require NHS Boards and Integration Joint Boards to review their community provision and capacity; making investments as required to provide the specialist support for those providing care in the community[x]. Moving forward, the Alzheimer Scotland Advanced Dementia Practice Model (2015) provides an approach to ensure that people with dementia are supported within the community.

Our vision is that the modern specialist dementia unit provides a centre of excellence to deliver quality treat and care for the small number of people with dementia who will have a clinical need to be in hospital. This will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions.

## 4.2 Collaborative approach of the review

This vision was made possible by the overwhelming enthusiasm of staff working in this area in welcoming the Alzheimer Scotland National Dementia Nurse Consultant to visit their unit and sharing their practice. It included staff within the specialist dementia units, mental health leads for quality excellence in specialist dementia care, executive directors of nursing and allied health professionals, consultant psychiatrists and psychologists, pharmacology and social work.

This collaborative approach also included people with dementia and their families, the Chief Nursing Officer's Directorate, Commitment 11 Excellence in Specialist Dementia Care Group of the National Dementia Strategy, and the Mental Welfare Commission.

x To provide specialist support to care homes and people with dementia who continue to live at home.

## 4.3 Transformational change: decommissioning and re-investment

The review carried out by the Alzheimer Scotland Dementia Nurse Consultant identified that most patients did not have a clinical need to be in hospital and could be cared for in a community setting. The modest estimation of the proportion of people with dementia who do not have a clinical need to remain in hospital is 60 percent[y].

This estimate is based on extensive consultation by the Alzheimer Scotland National Dementia Nurse Consultant with the multi-disciplinary professional teams and managers across the 63 units included in the review. The Alzheimer Scotland Dementia Nurse Consultant is also aware of work done by some NHS Boards in this area to assess the needs of patients to remain within these units. Whilst this work is not within the public domain, it is the understanding of the Alzheimer Scotland Dementia Nurse Consultant that this work is consistent with the evidence collected throughout the review.

There is also an urgent need for a widespread redesign of specialist dementia hospital provision across Scotland for the estimated 40 percent of people who have a clinical need to be cared for in these environments. This is essential to ensure access to multi-disciplinary professional specialists, provide an environment that supports person-centred care and deliver the required highly skilled therapeutic care and treatment.
It is not possible to provide a precise number of people with dementia in specialist dementia hospital units[z]. The most recent figure available is that of 1,886 NHS Old Age Psychiatry beds for people with dementia in 2014[aa]. This number will have reduced in light of the redesign that has taken place since that time. For the purposes of this report, we estimate a current figure of 1,400 beds.

Based on this figure, 840 people with dementia could be safely transitioned to the community with appropriate support, with 560 specialist dementia hospital beds required across Scotland. The estimated 560 people who need to be cared for in a specialist care unit is less than one percent of the estimated number of people with dementia[bb]. This is consistent with the estimate provided by Brodaty et al (2003)[cc] in the "seven-tiered model of management of behavioural and psychological symptoms of dementia". This would require 45 12-bedded specialist dementia units across Scotland for the estimated 560 people.

The average cost of providing a specialist dementia hospital bed is £2,520 per inpatient week[dd]. This equates to an annual cost of £183 million per year – £110 million of which is on the 60 percent of patients who do not have a clinical need to be in hospital. This £110 million per year could be re-invested in providing highly specialised dementia hospital care and supporting community provision, so that people with dementia are not admitted to hospital unnecessarily.

**y** There was general consensus throughout the review that between 60% to 80% of these beds are not required and that the care of this client group could be met within alternative care environments (Appendix 1).

**z** Outlined in Section 2.3

**aa** Scottish Government audit of NHS Boards for National Dementia Strategy Commitment 11 Working Group

**bb** There is an estimated 90,000 people with dementia in Scotland in 2017 – 560 is 0.6 percent of this total.

**cc** Brodaty et al (2003) "Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery" Medical Journal of Australia https://www.mja.com.au/journal/2003/178/5/behavioural-and-psychological-symptoms-dementia-seven-tiered-model-service

**dd** Based on average cost of inpatient bed per week for geriatric psychiatry ISD (2016) "Speciality group costs: inpatients in long-stay specialities National Statistics release"

The potential savings can be demonstrated by using a current 30-bedded unit as an example. The current average cost for 30 patients is £3.9 million, based on the £2,520 average weekly cost. Implementing a 12-bedded unit with additional multi-disciplinary input will result in the weekly cost per patient rising – we have estimated this would rise to £3,500 per patient for this example, which would cost £2.2 million per year for 12 patients. If £1,000 cost per week followed each person being transitioned to the community, this would be an annual cost of approximately £936,000 per year. This indicative example shows a potential overall saving of £800,000 per year for the decommissioning and transformation of a 30-bedded unit

An average of 60 people with dementia per NHS Board can be safely transitioned to the community with the appropriate level of multi-disciplinary support for those providing day-to-day care. This varies across areas, from an estimated 22 in NHS Borders to 164 in NHS Greater Glasgow and Clyde[ee]. Similarly, the number of specialist hospital beds required across Scotland will vary according to population size and need. Again, this will vary from 15 in NHS Borders to 109 in NHS Greater Glasgow and Clyde[ff].

The review by the Alzheimer Scotland Dementia Nurse Consultant took place between April 2015 and March 2016. We therefore recommend that NHS Boards re-assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings as an initial task in the de-commissioning and transition process.

### 4.3.1 Transition to community and health board planning

An integrated and comprehensive approach is required to support people living with dementia in the community. A coordinated and planned approach is necessary to tackle the acute issues that can arise and enable the delivery of optimum care. Those providing day-to-day care[gg] require specialist support in responding to the complex issues that can arise in dementia. They have a need for advice and guidance on caring to support the reduction of unnecessary hospital admissions.

The decommissioning process will require NHS Boards and Integration Joint Boards to evaluate the level and capacity of community resources to facilitate safe transition. There will be a need to invest where the required multi-disciplinary specialist support is not sufficient to support care homes and people living at home. A proportion of the resources released from reducing the hospital population can be re-invested in building community capacity. The example under section 4.3 shows that there can be savings on current resources, even with £1,000 per week following each person being transitioned to the community.

The review by the Alzheimer Scotland Dementia Nurse Consultant found the financial implications to be part of the reluctance from families in transitioning the person to the community. There should be no financial penalty for families as part of the decommissioning process. The care and treatment of the person with dementia being transitioned as part of the decommissioning process should continue to be met by the NHS Board.

**ee** This is based on the overall estimated number of people with dementia in Scotland and the proportional breakdown across each NHS Board according to population age and size.

**ff** A breakdown by NHS Board is provided in Appendix 2

**gg** This includes family carers, care homes, care at home service and day care

The appropriate legal documentation would be required to transition a person who does not have capacity to consent to the move to a community setting. Welfare power of attorney or guardianship may be held by a family member giving them specific relevant powers.

Where guardianship or power of attorney does not exist, the legal protection required to move a person who lacks capacity should be adhered to, which may delay transition on occasions. Moving forward, the process of seeking guardianship would be commenced when a person is admitted to the specialist dementia unit.

### 4.3.2 Supporting and involving families

The review by the Alzheimer Scotland National Dementia Nurse Consultant identified that the family may be anxious about the person being transitioned to a community setting. The circumstances that led to the person with dementia being admitted to hospital may have been a crisis; once the situation had stabilised, the family may continue to consider hospital to be the most appropriate environment. They may be unaware that there are more appropriate community environments that could provide a better quality of life for the person. It is important to engage closely with the family to work through any apprehension in a supportive manner to reach a resolution.

The family should be fully involved in the transition planning process, with their views listened to and concerns addressed. They should be assured that the ongoing bio-psychosocial needs of the person with dementia will be reviewed and met within the community setting. They should also be certain that there will be no financial penalty as a result of the transition to a community setting.

Where the person is moving to a care home, the family should have the opportunity to visit and meet with staff who will be providing care. There should be a room prepared and opportunity for the family to personalise it. It is likely that most people would be moving to a care home, but there may be occasions when the person is returning home. In these instances, close family members will have had a significant input into this decision.

Moving forward, the family would be part of the ongoing assessment process within the specialist dementia unit. They would be aware that the person's presentation and care needs had evolved over time and there would be an incremental approach to safe transition planning within the multi-disciplinary team. Furthermore, there would have been no expectation that the person would have remained in the unit beyond the intensive clinical need; a well-planned safe transition to the community would be the aim.

## 4.4 Specialist dementia care unit

The specialist dementia unit is designed to provide care and treatment to 12 people with dementia who have a clinical need to be in hospital and who are unable to be supported in a community setting, no matter the level of specialist support provided. The unit will deliver highly skilled care and treatment focused on the therapeutic relationship, delivered by a multi-disciplinary team responding to acute and intensive psychological conditions. The multi-disciplinary team within the unit will have additional support from specialist practitioners, as well as voluntary and community organisations in providing holistic care and treatment in response to the physical, psychological and social needs of each patient.

### 4.4.1 Patient profiles

Guidance on the appropriateness of hospital care in this area is based on a single eligibility question "Can the individual's care needs be met in any setting other than hospital" (Scottish Government 2015)[hh]. The care, treatment and support of most people with dementia can be provided in settings other than a hospital - this includes continuing to live at home or in a care home. Whilst there will be fluctuations in a person's health and the pattern of declining cognitive and physical function is neither fixed nor predictable, care and treatment for most people can be provided in community settings.

There will be a small proportion of people with dementia at any one time who will require specialised hospital care because of acute psychological symptoms resulting from their dementia and the complex interplay of co-morbid mental health conditions, necessitating substantial health care input. This requirement for specialist hospital care is not condition specific. It requires a holistic assessment of the individual, based on the person's overall needs and presentation.

People requiring specialised hospital care are likely to be in the advanced phase of dementia, as determined by the complexity and severity of symptoms. In addition to this, underlying health is a key factor and the influence of co-morbid mental health illness may result in a person with moderate dementia being admitted to the unit.

This group will experience severe behavioural and psychiatric symptoms. This will relate to people with enduring mental health conditions such as chronic schizophrenia, psychosis and severe depression with suicidality. It will also include people who demonstrate extreme behaviours that are harmful to themselves and others, including physical violence. The level of risk involved can require three people to provide care and support at any one time.

The specialised and multi-disciplinary professional approach within the unit will provide the care and treatment required to improve or stabilise the medical condition over a period of time, which may be around 18 months for many patients. The person will then be safely transitioned, once their condition has stabilised for a sufficient period of time and presentation has changed so that it is possible for care to be provided in a community setting.

**hh** Scottish Government (2015) "Hospital based complex clinical care http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf

### 4.4.2 Multi-disciplinary assessment

Many people being admitted to the specialist care unit will have an existing care plan, as they may be transferred from an assessment unit or have been receiving intensive support in a community setting. This may include a detailed formulation plan given the presence of psychological symptoms.

The initial step will be for the multi-disciplinary team to review any existing plan and identify where changes or additions should be made. This may include bringing in additional specialist practitioner/s to review a particular aspect of a patient's presentation.

Each specialist practitioner will conduct their individual assessment of the patient's presentation and needs. They will then take part in the multi-disciplinary review for each patient.

Ongoing regular review will then be required on a weekly basis with the multi-disciplinary team in evaluating care, managing medication and making appropriate changes to the care plan of each patient.

Whilst the person with dementia will be admitted to the specialist care unit as a result of severe psychological symptoms, they will also be experiencing a range of physical health care problems. In addition to this, there will be a need for social stimulation and meaningful occupation. The range of physical, psychological and social issues will require a bio-psychosocial approach to assessment and care planning in understanding and responding to individual experience.

The range of assessment tools utilised by the multi-disciplinary team in their evaluation of the individual's needs should be based on providing a holistic, person-centred approach. This would also include formulation such as the Newcastle Model (James 2011)[ii] in using a bio-psychosocial approach to understand the potential causes of psychological distress. Additional tools would be utilised in the assessment and responses to depression, anxiety and medication review.

Dementia Care Mapping (Bradford University)[jj] provides a structured action cycle approach to assessing and reviewing the ongoing needs of the unit and individual patients. This includes person-centred planning, staff training needs and monitoring and implementing improvements to care.

### 4.4.3 Multi-professional care and treatment

The table below outlines the core group of health and social care specialists who will be located within the unit on a full-time or part-time basis.

ii James (2011) "Understanding behaviour in dementia that challenges" Jessica Kingsley Publisher London

jj University of Bradford "Dementia care mapping" https://www.bradford.ac.uk/health/dementia/dementia-care-mapping/

**Table 1: Specialist dementia care unit multi-disciplinary team**

| Practitioner | Description |
|---|---|
| Registered Mental Health Nurses | Directly involved in all care and treatment of each patient. Direct advanced statements and anticipatory care planning. |
| Registered General Nurses | To respond to and treat physical health care needs. |
| Clinical Support Workers | Deliver person-centred care under the direction of the nurse professionals. |
| Nurse Consultant | Provide expert advice in dementia care and treatment. Provide supervision of nursing within unit. |
| Advanced Nurse Practitioner | Support the mental health nursing and provide medication input |
| Consultant Psychologist | Assessment and prescribing of individualised interventions, formulation plans and neuropsychiatric assessment and treatment. |
| Consultant Psychiatrist | Formal diagnosis of dementia and other mental health illness. Involvement in the management and ongoing review of care and treatment. |
| Specialist Registrar Old Age Psychiatry | Substantive time on the ward and oversee care and treatment in deputising for Consultant Psychiatrist |
| Junior Doctor | Assigned to unit as part of training to develop understanding of specialism – provide support for physical health. |
| Occupational Therapist | Work with the person to develop and maintain a routine of everyday activities that creates a sense of purpose and supports a good quality of life. They can advise on changes to the everyday environment and equipment and adaptions. |
| Physiotherapist | Help restore movement and function through exercise, manual therapy, education and advice. Physiotherapy uses physical approaches to promote, maintain and restore physical, psychological and social well-being. |
| Speech and Language Therapist | Assess, diagnose and manage a range of communication and swallowing needs. The role also encompasses environmental adaptations to support communication, eating and drinking. |
| Dietitian | Assess, diagnose and treat diet and nutrition problems using the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate food choices. |
| Activities Coordinator | Develop person-centred care planning for activities of interest delivered individually and as part of group work. |
| Mental Health Social Worker | Carry out needs assessment, pre-discharge and discharge planning and community care assessment. |
| Pharmacist | Assist in the review and management of medication. |

## Additional specialist health care support

There will also be a need to access a wider range of specialist practitioners in response to the specific requirements and wellbeing of each patient. This will be determined by the assessed bio-psychosocial needs of each individual patient. It will include specialist consultants, such as a geriatrician for complex physical conditions and a cardiologist for heart and vascular health.

Additional allied health professional support will be important, including podiatry to help people stay mobile and independent, and arts therapies delivering highly specialist psychological therapies for difficulty in communication and expressing emotions verbally. Patients may reach end-of-life in the specialist dementia care unit because of a co-morbid condition such as cancer. Access to palliative care specialists will be key to managing pain and other distressing symptoms experienced at end-of-life.

## Social and community connections

It will be important to provide social stimulation and meaningful occupation, so that people remain connected and engaged. This includes supporting continued involvement in the person's existing hobbies, interests and spiritual practices. This will involve utilising connections with external agencies, voluntary organisations and community networks. It will include patients being supported to take part in activities outwith the hospital and community resources coming into the unit to provide social engagement.

The activities coordinator will work with the person and those closest to them to identify opportunities to link with supports within the community. The activities coordinator will also develop person-centred care planning for activities of interest delivered individually and as part of group work.

## 4.4.4 Staff quota

The table below outlines the staffing level within the specialist dementia care unit. This will be the basic level of cover provided by the multi-disciplinary team. This will be under continual review according to the needs of patients and may be increased for particular needs, such as those requiring continuous observation of a patient for their wellbeing and the safety of others.

The multi-disciplinary team is split into the different staff groups and disciplines. Total nursing and clinical care workers equates to 29.8 whole time equivalent staff. An additional 5.4 whole time equivalents will include consultant psychologist, consultant psychiatrist, junior doctor, allied health professionals and additional practitioners including nurse consultant, advanced nurse practitioner, pharmacy and social worker with Mental Health Officer status. The unit should also take students of each profession in order to make this an attractive career choice for the future workforce.

**Table 2: Specialist dementia unit staffing for seven-day week**

| Practitioner | Level of staffing full time equivalent | Grade |
|---|---|---|
| **Nursing and clinical care workers** | | |
| Senior Charge Nurse | 1.0 | Band 7 |
| Charge Nurses | 3.0 | Band 6 |
| Registered Mental Health and General Nurses | 15.4 | Band 5 |
| Clinical Support Workers | 10.4 | Band 3 |
| **Additional nursing staff** | | |
| Nurse Consultant | 0.1 | Band 8B |
| Advanced Nurse Practitioner | 0.4 | Band 7 |
| **Consultants** | | |
| Psychologist | 1.0 | Band 8 |
| Psychiatrist | 0.5 | |
| **Additional doctors** | | |
| Specialist Registrar Old Age Psychiatry | 0.5 | |
| Junior Doctor | 0.5 | |
| **Allied health professionals** | | |
| Occupational Therapist | 0.5 | Band 7 |
| Physiotherapist | 0.3 | Band 6 |
| Speech and Language Therapist | 0.3 | Band 6 |
| Dietitian Additional practitioner | 0.3 | Band 6 |
| Pharmacist | 0.5 | Band 7 |
| Social Worker with Mental Health Officer status | 0.5 | |

### 4.4.5 Knowledge and understanding of dementia

A sound understanding of dementia is essential for all those providing care and treatment within the specialist dementia unit. The Promoting Excellence Framework (2011) provides a structured approach to understanding the level of knowledge and skill required by staff in health and social care services to provide human rights based care and support in accordance with the Charter of Rights (2009)[kk].

**kk** "Charter of Rights for People with Dementia and their Carers in Scotland" (2009) https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf

The level of knowledge and skill required by each practitioner will be determined by their role and level of responsibility within the multi-disciplinary team. The Promoting Excellence Framework provides four levels[ll] of knowledge and skills that staff require to support people with dementia and their family at different phases of the illness[mm]. It also provides "key quality of life indicators" that staff should be supporting people to achieve.

As a minimum, all **ancillary and non-clinical staff** supporting the units should have the knowledge and skills set out in the "Informed" level of Promoting Excellence.
As a minimum, all **clinical staff** should have the knowledge and skills set out in the "Skilled" level of Promoting Excellence, inclusive of clinical support workers and wider team members including roles such as volunteers.

All **professionally registered staff** including medical, clinical psychology, nursing and allied health professionals, will as a minimum have the knowledge and skills set out at the "Enhanced" level of Promoting Excellence.

Specialist dementia units should also receive multi-disciplinary support from practitioners operating at the **"Expertise"** level of Promoting Excellence – noting that this level of practice becomes role and discipline specific. These practitioners should include clinical psychologist, nurse consultant, advanced nurse practitioner, psychiatrist, activity coordinator and a range of allied health professionals.

In addition, there will be a minimum of one practitioner who has completed the NHS Education for Scotland intensive capacity and capability building Dementia Specialist Improvement Leads programme (DSILS). There should be strategic and organisational support and leadership to maximise the role of staff who have completed the training to enable DSILS', to cascade enhanced and expertise education and training to support change and improvement.

### 4.4.6 Working with families

Close family members are partners in care and it is essential that these key relationships are recognised and respected. Staff within the unit should be aware of the powers held by the family member/s, such as power of attorney or guardianship. The family carers have their own rights in addition to those assumed when acting for the person with dementia to "full participation in care needs assessment, planning, deciding and arranging care, support and treatment, including advanced decision making" (Charter of Rights 2009).

The family member/s should be encouraged to be active participants in the care of the person with dementia, including treatment discussions and being invited to multi-disciplinary team reviews. This should be ongoing throughout the person with dementia's stay in the unit and during discharge planning. Whilst attending the multi-disciplinary team review will be appropriate for some, others will be more comfortable in having more informal discussions with those providing care and for their views to be listened to and taken into account in this way. As the family will have been integral to care planning throughout the stay in the unit, the discussion around possible transition will occur gradually and not be presented suddenly.

**ll** Informed, skilled, enhanced and expertise levels.
**mm** Staff are most likely to be working with people at the "Living well with increasing help and support" and "End-of-life and dying well" phase of illness.

Visiting times should be flexible, with the family member/s encouraged to remain as long as they wish. They should be encouraged and supported to continue to make the contribution to care that is important to them and of which they are capable. Family members should be made aware of the possible financial support to enable them to visit the unit, depending on their personal circumstances.

### 4.4.7 Environment and physical space

It is essential that the specialist dementia unit is a purpose built physical environment. It is not appropriate or acceptable for this highly specialised care and treatment to be provided in an adapted building. The specialist built environment provides the opportunity to maximise the therapeutic potential of the space and supports the comfort, safety and activity of patients. It can also act to reduce the occurrence of distress.

Design features that respond to the experience of the illness as well as age-related impairments, can support person-centred care. It provides an enhanced working environment for staff to deliver person-centred care and a welcoming and supportive environment for people visiting the unit, who may spend a large part of their time with their family member, supporting their care. Some important features in dementia design are outlined in Table 3 below.

**Table 3: Some examples of key design features**

| | |
|---|---|
| Built environment | Purpose built environment that maximises therapeutic potential through layout, design and key features. |
| Sound | Absorbance from ceilings, floors, window covering and soft furnishing to support audible communication. Quiet ambience with noise minimised. |
| Corridors | All corridors lead to meaningful places, with endings avoided or made into an interesting feature for engagement and activity. |
| Signage | Clear signage to help wayfinding for everybody, with pictures and graphics in addition to words. |
| Bedrooms | Individual en-suite facilities, room recognisable with easy visibility of bed and personal items on display. |
| Meaningful occupation | Facilities that support engagement in occupation, activity and social stimulation. |
| Outside space | Access to outside space during the day from communal areas. |
| Safety | Environment to minimise risk of self-harm and injury. |

The specialist dementia unit requires an innovative approach to design that delivers maximum therapeutic potential. NHS National Procurement is well positioned to commission the design of a blueprint for the optimal environment to support specialised dementia hospital care. Through this competitive process, an innovative and creative design team can be appointed to create a blueprint that can be used by all NHS Boards to build the specialist dementia unit that provides a living and working environment and supports maximum therapeutic potential and enhances the full potential of each individual patient.

# 5. Conclusion and recommendations

There is an urgent need for extensive improvement of specialist dementia hospital provision in Scotland. This specialist area of practice has been overlooked for too long. There is a lack of the multi-disciplinary specialist care and treatment required and there are environments that are not conducive to person-centred care. Most people in specialist dementia hospital environments can be more appropriately cared for in community settings.

A decommissioning and re-design process would enable the development and roll-out of centres of excellence that would provide the small proportion of people with highly complex psychological needs the care and treatment they need. It would also allow resources to be transferred to the community so that care homes and those providing day-to-day care can receive specialist support and people with dementia are not admitted to hospital, unless it is essential to their clinical care needs. This would provide an efficient re-commissioning of current resources and tackle inappropriate admissions and unnecessarily lengthy stays in hospital.

## Recommendations:

- That specialist NHS dementia care is modernised, providing high quality, human rights-based care, specifically for individuals who cannot be cared for in the community.
- Integration Joint Boards develop a transition plan and a local engagement strategy with their partners, including NHS Boards and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop further community capacity in health and social care services.
- That the Scottish Dementia Working Group and National Dementia Carers Action Network provide the representative groups for this local engagement.
- Integration Joint Boards and NHS Boards assess the proportion of people with dementia that can be safely transitioned to more appropriate community settings.
- The Alzheimer Scotland National Dementia Nurse Consultant provides expert guidance at both a national and local level.
- Integration Joint Boards and NHS Boards build strong and strategic local engagement on:
    - Any necessary de-commissioning and re-directing of resources to the development of specialist dementia hospital units and
    - building further community health and social care services.
- NHS National Procurement to commission the design of a blueprint for a specialist dementia unit that can be implemented by each NHS Board.
- There should be no financial detriment for families as part of the decommissioning process, with the financial cost of the care and treatment of the person with dementia being transitioned to the community continuing to be met by the NHS Board.
- The legal status of patients being transitioned to the community is reviewed and the appropriate legal documentation put in place.

- The creation of modern specialist dementia units that will provide centres of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.

  The estimated 45[nn] specialist dementia units required across Scotland will provide a highly skilled practice area and make it an attractive specialism for ambitious and talented practitioners to deliver highly skilled therapeutic interventions.
  Promoting Excellence Framework the foundation for evidence based care for all practitioners.  Leaders and senior practitioners ensuring that everyone working within the unit are trained at the appropriate level to ensure a high quality therapeutic approach.
  They will be underpinned and supported by the Charter of Rights for People with Dementia and their Carers in Scotland, the Promoting Excellence Framework and the Standards of Care for Dementia in Scotland.
- The timeframe for this process will extend beyond the end-point of Scotland's 2017-2020 National Dementia Strategy

**nn** This is based on an estimated 560 people with dementia who require care and treatment in a specialist dementia unit.

# Appendix 1: Key findings – Review of NHS specialist dementia care (April 2015 to March 2016)

## Introduction

This report outlines the key findings from the review of NHS specialist dementia care environments. This review was conducted by Maureen Taggart, Alzheimer Scotland National Dementia Nurse Consultant, between April 2015 and March 2016. It included 10 NHS Health Boards, over 60 individual dementia specialist care environments and a wide range of stakeholders, including senior managers and executive leads, practitioners and people living with dementia. This unique insight was made possible by the engagement and commitment of NHS colleagues, for which our warmest gratitude is extended.

This report sets out the key issues identified through visits to care environments, discussions with NHS Boards staff and meetings with people with dementia and their families.
A more detailed report will follow outlining recommendations for action and a model of safe transition for people who do not need to remain in these care environments.

## Background

The review of NHS specialist care environments resulted from:

1. Themed visits by the Mental Welfare Commission of dementia continuing care units which outlined 17 key areas for improvement (Mental Welfare Commission (2014) "The Dignity and Respect Report: Dementia Continuing Care Visits"
www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf

2. A roundtable discussion on NHS continuing care hosted by Alzheimer Scotland and University of West of Scotland in September 2014. This event was chaired by Professor Graham Jackson and attended by representatives from the Scottish Government, Royal College of Psychiatrists and NHS Boards.

The purpose of the round table meeting was to develop a better understanding of the issues and challenges within NHS continuing care and specialist dementia care settings and identify what could be done to remedy these.

- The discussion highlighted:
- The static nature of the population within these settings was a significant issue that causes pressure on resources.
- Estimates that around 40%[oo] of this population had no clinical need to be in hospital.
- The difficulty in organising and supporting discharge to appropriate alternative care settings.

oo This estimate was put forward as part of the roundtable discussion – the review by the Alzheimer Scotland National Dementia Nurse Consultant found this to be much higher in practice.

The reasons for the issues outlined above are complex, but were thought to include:

- Financial costs (social versus healthcare), leading to a resistance to move to an alternative setting.
- Continuing healthcare criteria not being applied in many cases (new guidance published in June 2015)[pp].
- Criteria being poorly understood among public and professionals.
- The expectation that NHS continuing healthcare is a "bed for life".
- Lack of alternative accommodation and support.

## Approach to review

**Ten NHS Boards have been included in this review, with over 60 individual specialist care environments visited by the Alzheimer Scotland Dementia Nurse Consultant with the purpose of developing understanding of the issues around transition and discharge.**

Initial contact was made with the Executive and Operational Leads for Commitment 11. Visits were set up with a range of professionals involved in the care and treatment of people with dementia in specialist dementia units[qq] in the following NHS Boards:
Ayrshire and Arran
Dumfries and Galloway
Fife
Forth Valley
Grampian
Greater Glasgow and Clyde
Lanarkshire
Lothian
Scottish Borders
Tayside

Meetings within NHS Boards included: Directors of Nursing, Clinical Leads for Old Age Psychiatry, Consultant Psychiatrist, Associate Directors of Nursing, Senior Nurses, Senior Charge Nurses, Allied Health Professionals (Occupational Therapists, Dietitians and Physiotherapists), Consultant Psychology, Social Work, Nurse and Allied Health Professionals Consultants, Community Psychiatric Liaison Teams, Pharmacy, Service Managers and Professional Leads.

Additional discussion was held with people with dementia within assessment and specialist care units and their families. Staff within these care environments were also included in this review. Visits to NHS contracted bed locations in private sector care homes were conducted. Other key stakeholders were also consulted: Scottish Dementia Working Group, National Dementia Carers Action Network, Healthcare Improvement Scotland, Care Inspectorate, Mental Welfare Commission, Nurse and Allied Health Professional National Group, Alzheimer Scotland Dementia Advisors, Alzheimer Scotland Policy and Engagement Managers, Alzheimer Scotland Carers Reference Groups, Scottish Government Focus on Dementia Team, Advocacy Services, Alzheimer Scotland's Head of Operations and National Education for Scotland.

**pp** Scottish Government (2015) Guidance on NHS complex clinical care http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf
**qq** The term unit is used throughout the findings section to describe the range of environments where assessment, transition and specialist dementia care is delivered.

# Key findings

## 1. Admission Units

The main reasons for admission were 1) increase in distressed behaviour in the person with dementia 2) carer distress 3) failed discharge to a care home 4) risk behaviours that meant care could not be safely managed at home and 5) lack of a care package to support the person with dementia to remain at home.

Length of stay varied greatly across NHS Boards, with an average of 8 to 12 weeks – this was up to two years in some instances. Most discharges from assessment units (estimated 90-95%) were to a care home or NHS specialist beds in a hospital or contracted beds. The application for power of attorney and guardianship increased the length of stay significantly – this was generally by nine months.

Some NHS Boards transferred people to "transition units" as they were not clinically ready for discharge. These transitions could last two to three years, with subsequent move to a care home. There was a higher level of access to multi-professionals within assessment units compared with specialist dementia units. However, this higher level of access was not available in every NHS Board.

Most units held reviews once or twice weekly, with families invited as appropriate. Only two areas had a social worker attached to the ward, with all others having a referral system.

Each area attributed delayed discharges to lack of funding and care packages. A lack of care home places was evident for one NHs Board.

There was good practice in relation to pre-discharge noted in two Boards. In one Board, staff and the family would visit the care home to offer support to care home staff – with community mental health staff or liaison psychiatry attending the pre-discharge meeting.

Another NHS Board had consultant-led clinics within care homes which successfully reduced admissions to the ward. The new "Hospital Based Complex Clinical Care Guidance" (2015) was being used in three Boards. In these areas, the review team met with the family one week after admission to discuss the plan of care, hear their views or concerns and provide a copy of the guidance for patients and their relatives.

## 2. Specialist beds and transitions

Consultant psychiatrists and managers highlighted that they had experienced an increase in complaints in response to attempts to transition patients. Families sought the support of their local MSP, who issued a letter of complaint to the NHS Board.

There were issues around charging policy when provision comes from social care as opposed to health – the financial impact of transition and families viewing specialist dementia units as a "bed for life". In some instances, when the person had been moved from another unit or hospital, families were given a letter to say the person would remain there for the rest of their life.

In cases where discharge to another care setting was proposed, formal appeals from the family were lodged, requiring further review to be carried out by an independent consultant psychiatrist.

In many cases, staff knew the patients well and the family were happy with the care provided – this could result in a lack of motivation for the person to be moved from the unit. Failed discharge to a care home was a common reason why many people remained in NHS care. Length of stay varied from one year to up to 15 years, with an average of 4.5 years. There were diverse needs within the same unit – this ranged from psychological and behavioural issues to end-of-life.

Discharging people with dementia is perceived to be a low priority for social workers, who view the person as being in a place of safety. The local authority insisted on transfer of resources if the person had been in a unit for over a year, as this was classed as long-term care.

When consultants have attempted to discharge people on several occasions without success, it can be seen as a waste of their valuable time to continue to attempt discharge. Many of the NHS contracted out beds have been in place for 20-30 years, with limited reviews of the initial contract. Whilst many of the specialist beds are in community hospitals, some are managed within mental health services and others are primary care, where the GP has limited access to specialist dementia professionals.

**There was a general consensus that between 60% and 80% of these beds are not required – the care of this client group could be met within alternative care environments.**

Most of these specialist units for people with complex clinical care associated with advanced dementia had no access to the multi-professional team of psychology, pharmacy, AHP, advocacy, etc. The main people involved in care were nurses and the consultant – staff recruitment and retention is a significant challenge for many NHS Boards.

One NHS Board had successfully closed many of their specialist beds and reinvested into community services to support people with dementia and their families to remain in their place of choice. At present four NHS Boards are reviewing and implementing a bed remodelling plan – this is driven in part by low occupancy and units being housed in outdated buildings.

There is real concern, and some evidence, that savings will not be re-invested back into specialist dementia care but utilised instead as efficiency savings.

A further two Boards reported a significant reduction in admissions where psychiatric liaison teams had been established to support the care homes in their areas. The three Boards using the new guidance have noticed a change, with families being much more engaged in the planning and discharge of their family member. One Board had also been reducing their beds due to low occupancy.

## 3. Specialist bed costs

There was significant variation in the cost of providing a specialist bed – costs of units ranging from £525 - £1,450 were highlighted. It should be noted that although a bed may cost £1,000 per week, this did not equate to access to a greater number of specialist dementia professionals than the less costly beds.

Low occupancy was noted in three Boards of 67% to 71%, which was consistent with the 2014 bed census.

NHS contracted beds were visited in three independent care home providers. There were various models used in these environments such as private sector beds with NHS management and staff, or private sector beds and staff with no NHS management but who could attend NHS Clinical Governance and Quality Monitoring meetings.

Of the NHS Boards visited, two had transferred the care and treatment of a patient to a dementia specialist unit in England, at a significant cost.

Most of the contracted beds visited are involved with the Commitment 11 local groups and have completed self-assessment and improvement plans. One NHS Board is to bring the specialist dementia care beds back into the acute sector from next year, under mental health management.

## 4. Environments and therapeutic activity

There has been a marked improvement since the Mental Welfare Commission's "Dignity and Respect" report (2014). Many of the units visited by the Commission have been closed, with new dementia friendly units developed and others to be completed by 2019.

However, a significant level of investment is required to upgrade/maintain some of the older facilities. Specialist dementia units continue to be located on upper floors with no easy access to outdoor areas. Features such as long corridors mean these buildings are not fit for purpose, even with adaptations.

It was evident that Commitment 11 improvement plans are making a difference in relation to activities within units. Some NHS Boards have developed an activity room and areas for family to use or stay overnight. One unit evidenced a reduction in falls since the environmental improvements and increased therapeutic activity over the previous year. Some areas had activity coordinators, with volunteers and community groups providing support for activity and connection.

Although some units had some excellent facilities and activity rooms, the majority were locked, with no activity going on in the unit whatsoever at the time of the visit. Staff shortages and lack of time was normally the reason given for this lack of therapeutic stimuli. When activity was carried out, it was provided by nurses, with few units having access to specialist AHPs to offer support.

Some areas highlighted how healthcare associated infection regulations hampered activity due to the concern over cross infection – this was a huge frustration for staff.

Bed and toilet areas could be shared by up to six people, with no showers or personal wash areas.

Some units had lots of personal effects on display for the people with dementia - this included pictures and soft furnishing. There was also some good evidence of life story work and person-centred care. However, other units were very stark, with no personal affects and presented as very clinical areas.

The private sector units visited have upgraded some of their areas to be more dementia friendly, with the majority providing en-suite single room accommodation. There are also improved dining and lounge areas and access to garden and outdoor areas.

Many of the units visited had activity programmes planned. This included Playlist for Life, baking, pet therapy, gardening, art work, exercise and movement, cognitive stimulation therapy, reminiscence, social outings to places of interest and doll therapy. Some of these activities were supported by volunteers, local primary or secondary school children and nurses or occupational therapists. A few of the areas were in the process of evaluating the effectiveness of therapeutic activity in their units.

## 5. Specialist AHP, Pharmacy and Psychology

There was great variation between NHS Boards in relation to access to AHP specialists, pharmacy and psychology. Only 50% of the assessment units had access to AHPs and there was very limited access to pharmacy and psychology. The specialist and complex needs units had virtually no access at all.

Most health care was provided by the consultant psychiatrist and the nursing team. All areas could access an occupational therapist from an acute service; however, there was a waiting time issue. When a falls risk assessment highlighted further intervention and referral to occupational therapy or physiotherapy, this was made to acute or primary care teams for further assessment and management.

There was a process to be followed for access to dietitians, speech and language therapists, geriatrician, Macmillan nurses, dentists and podiatrists to mention a few. Only three Boards had access to psychology via a referral process. However, due to increased referrals from community teams, very few people with dementia in the specialist units were ever supported by the extremely limited psychological services.

Access to pharmacy was minimal and normally only to top-up, as opposed to review, medication. No area had a pharmacist who was present at the multi-disciplinary reviews. However, staff could telephone a pharmacist for advice. Dementia assessment units based within the acute general hospital site did tend to have quicker access to AHPs and geriatricians - units outwith acute had a significant wait for assessment.

The Alzheimer Scotland Dementia Nurse Consultant held a multi-professional meeting in each NHS Boards. During these, there was a general consensus that improving dementia care was a priority. However, it was evident that they still received the lowest budget compared with other mental health services.

NHS Boards have highlighted some improvements in investment since Commitment 11 was implemented in September 2014. There was additional funding in two Boards, with appointments to additional psychology and pharmacy welcomed.

## 6. Skills and knowledge and workforce

The Promoting Excellence Framework had been implemented in every NHS Board visited. The majority had an implementation plan that sat with self-assessment and improvement plans. These were reported to the Chief Nursing Officer Directorate - reporting had taken place in December 2014 and in February 2016.

**Skill mix and staff ratio to patients was lower than all other mental health areas – in most areas there were 40% to 45% registered mental health nurses with 60% to 55% untrained staff. A small number of Boards had a skill mix of 55% to 60% registered mental health nurses with 45% to 40% untrained staff.**

Not all staff within the community hospitals hosting the specialist dementia beds were registered mental health nurses; however, some did have Dementia Champions on site. Whilst there were Dementia Ambassadors in some of the NHS contracted bed units, there were low numbers of registered mental health nurses, with only three covering a 90-bedded area. NHS contracted bed care homes did evidence training in the Promoting Excellence Framework. This was particularly strong at the informed practice level and they were progressing with plans at the skilled practice level.

All areas visited agreed that staff required their skills and knowledge to be at a higher level –the enhanced and expertise practice levels of the Promoting Excellence Framework were considered to be appropriate. However, this was considered challenging to achieve because of being unable to release staff as staff ratios were too low. Training in responding to stress and distress was highlighted as a priority in all areas. Some areas provided additional resources to assist with the training needs, but many had utilised the "bite size" models from NHS Education for Scotland only and highlighted a lack of support and supervision from psychology as a major issue.

Limited knowledge and skills to support people with advanced dementia and other co-morbidities affecting physical health was a challenge in many areas. Those who had undertaken the "Quality and Excellence in Specialist Dementia Care" programme with NES demonstrated greater knowledge and confidence in caring for complex physical health and delivering end-of-life care.

Some Boards did not have Practice and Improvement Development Support – thus creating an additional obstacle to supporting training. A small number of Boards did train large numbers of staff in "The Journey of Care for Dementia" and had recently trained "Dementia Care Mappers". Some areas had supported staff to train in "The Best Practice for Dementia Care" with Dementia Service Development Centre at the University of Stirling.

## 7. Experience of people with dementia and their families

Meeting with the families of people with dementia who were resident within the specialist assessment units was, in the main, a positive experience. They talked about being included in care and treatment decisions and being encouraged to offer care and support to their family member. They were invited to review meetings with the consultant and nurse, had completed "Getting to know me" or life story work and enjoyed the freedom in most wards to open visiting times.

This was in stark contrast to the comments provided by family members where the person was within a specialist care environment or had been recently discharged from a specialist complex needs unit (transition and what was previously referred to as long term care). They had expressed concern about the attitude of some staff, lack of empathy and compassion, feeling that they were not actively listened to or that their views were not valued. Many of these wards did not have flexible visiting times and families were not supported to engage and support the person with dementia. They did not have access to specialist multi-professional teams and when attending a review or pre-discharge meeting, they stated that "decisions were made before they were invited to speak".

An issue raised by a number of families was the lack of support and services for younger-onset dementia. When assessment was required, younger people with dementia were admitted to acute adult mental health wards where staff had very little skills and knowledge of dementia care. Families did not consider old age psychiatry wards to be appropriate for younger people with dementia. A few areas did have specialist community services that are multi-professional.

# Appendix 2: Transitioning and Specialist Dementia Hospital estimated numbers by NHS Health Board

| Health Board | Estimated number of people who can be transitioned to community | Estimated number of specialist hospital beds required |
|---|---|---|
| Ayrshire and Arran | 67 | 44 |
| Borders | 22 | 15 |
| Dumfries and Galloway | 31 | 21 |
| Fife | 60 | 40 |
| Forth Valley | 46 | 31 |
| Grampian | 86 | 58 |
| Greater Glasgow and Clyde | 164 | 109 |
| Highland | 59 | 40 |
| Lanarkshire | 94 | 63 |
| Lothian | 121 | 81 |
| Orkney | 4 | 3 |
| Shetland | 4 | 2 |
| Tayside | 76 | 50 |
| Western Isles | 6 | 4 |






This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-027-3 (web only)

Published by The Scottish Government, June 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS433766 (06/18)

Scottish Borders

# Integrated Care Fund Project Brief

2015 – 2018

| | | | |
|---|---|---|---|
| **Project Name** | Mental Health - Community Outreach Team (COT) | | |
| **Project Owner** | Irene Thomson | **Application Main Contact** | Irene Thomson |
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**Guidance on Project Brief**

The purpose of this form is to give an outline on the key aspects of the proposal to the Integrated Care Fund 2015-18

Please refer to the accompanying guidance notes for more information on the Integrated Care Fund (ICF) when completing this document.

## 1 Outline project description

*Please summarise the project in no more than 250 words*

Mental health conditions are common among the elderly. NICE(2013)estimastes that around 2 in 5 older people living in care homes have depression, and an estimated 4 out of 5 people in care hoses live with dementia or sever memory problems. Despite the high prevalence of these conditions, NICE advises that these mental health issues are often not recognised, diagnosed or treated. Scottish Borders has the lowest number of care home beds in Scotland but has the highest proportion of people with dementia in care homes (69%)

The Community Outreach Team (COT) would specialise in meeting the needs of older adults with mental illness and dementia, working within care homes and community hospitals across the Scottish Borders

It would aim to provide proactive and responsive support to care homes and community hospitals to help them better meet the needs of their residents and inpatients with mental illness and dementia. Interventions would include carrying out mental health and memory assessments for residents, advising on the best type of treatment for the individual and advising staff on managing the symptoms and behaviours of people with mental illness and memory problems, like dementia, may experience.

The service would also provide training and education for care home and community hospital staff to provide them with the skills and knowledge to provide effective care for residents and inpatients with mental illness and memory problems.

The project would build on the current set up, skills and support offered by the current Liaison nursing staff and would work closely with the existing Community Mental Health Teams, Primary Care and Acute Medical Services

| 2. | **Project's strategic fit** (see guidance notes section 2)<br>*Which local strategic objectives and Scottish Government ICF principles will it meet?* |
|---|---|

**Borders IJB Strategic Plan objectives**

1. Improve the health of the population and reduce the number of hospital admission
2. Improve the flow of patients into, through and out of hospital
3. Improve the capacity for people to better manage their own conditions and support those who care for them

This project would meet all three of the IJB strategic objectives listed above.

**Scottish Government ICF principles**

1. Co-production
2. Sustainability
3. Locality
4. Leverage
5. Involvement
6. Outcomes

| 3 | **Project Aims/ Achievements**<br>*Please give a high level description of what will success look like?* |
|---|---|

How to access the service

- Referrals to the service can be made by GPs, or senior care home/community hospital staff.
- All referrals sent to a COT referral inbox (email or sky gateway)
- Referrals are screened on the same day and the referrer is informed of the outcome. If the referral is appropriate COT will contact the care home or community hospital by phone to arrange an appointment
- If the referral is inappropriate contact will be made and advice given on how to proceed
- The service will also be open to more informal contact and discussion about possible referrals
- The COT will then assess the individual looking at:
    - Advice and treatment regarding specific mental health issues
    - A person-centred care plan that will ideally involve the individual, family, carers and staff in maximising quality of life, physical health and comfort
    - Offer advice and training where necessary to staff to support them in meeting an individual's care needs and maintain them in their current care setting

Aims:

- To provide prompt access to a specialist mental health service for patients in care homes & community hospitals, who have or are suspected of having a mental health need
    - Emergency referrals will be responded to on the same day
    - Urgent referrals will be responded to within 2 working days
    - Routine referrals will be responded to within 7 days

- To promote good practice and develop personalised care plans to maximise an individual's quality of life, in order to maintain them within their current care setting
- To promote the use and consideration of anticipatory care planning for individuals
- To provide a bio-psychosocial model of care in which both non-pharmacological approaches and medication are considered. This may include:
    - Modelling and implementing Stress and Distress techniques – the team will work with an evidence based, psychological model for identifying and treating unmet needs in dementia patients called the Newcastle Clinical Model. This model is used in a number of projects throughout Scotland with the aim of supporting care homes maintain residents within their own environment. It aims to reduce admissions to hospital by supporting staff to develop a better understanding of dementia as well as building a range of skills to enable staff to work with residents in a way that limits stress and distress in those individuals with a diagnosis of dementia
- Signposting to other services or organisations for further support e.g Palliative care
- Assessment and management of risks to an individual, staff or other residents
- To consider the involvement of other professional groups following the assessment of an individual's needs
    - Physiotherapy
    - Occupational Therapy
    - Consultant psychiatrist
    - Psychology
- The service will provide training and education to care home and hospital staff based on best practice and/ or individual needs
- To work with an individual, carers and staff to facilitate a successful transition into a care home environment from hospital and home

Expected outcomes:

- Improved detection, assessment and treatment of common mental health conditions
    - In particular to increase dementia diagnosis rates within the care home population with the aim of finally reaching the Scottish Government's national Local Delivery Plan (LDP) standard for dementia diagnosis in The Borders
- Reduction in antipsychotic prescriptions
- Reducing hospital admissions, facilitating earlier discharge (reduction in delayed discharge days) and the need for care home moves
- Raise awareness of mental health in care homes and community hospitals
- Increased confidence and skills in caring for older people with mental health difficulties and dementia in care home and community hospital staff

| | |
|---|---|
| | **4 What areas of the Borders will the project cover**<br>*Will the project affect the whole of the Borders or a specific locality, if so please state?* |

The project aims to work across the entirety of the Borders but initially it will begin roll out in the South and East (Berwickshire across to Jedburgh, Hawick and Newcastleton) An increase in the areas covered will continue as the staffing has been recruited to and feedback from care homes/ community hospitals in respect of what is or isn't working well has been considered.

It will cover all 92 community hospital beds and provide a service to the 695 care home beds within Scottish Borders. Therefore, it will provide a service to potentially 787 individuals.

The project would anticipate having capacity to assess, plan treatment and intervene (where necessary) for 60-70 individuals per week, with capacity for support workers to work with around 40 individuals and staff teams implementing care plans, etc. In addition a rolling programme of training and implementation of stress and distress techniques will be undertaken with each care home and community hospital throughout the year.

The project will employ QI methodology in order to ensure its practice and service delivery is effective and of good quality

| | |
|---|---|
| **5** | **Which care groups will the project affect?** (see guidance notes section 4) |

Adults of any age within 24 hour care setting who have a dementia diagnosis or adults over the age 70 with a suspected mental illness eg psychosis or depression.

| | |
|---|---|
| **6** | **Estimated duration of project**<br>*Please provide high level milestones and including planning and evaluation time* |

While this funding request is for 2 years the anticipation is that this becomes a permanent project and that costs saved by the reduction of inpatient beds and a reduction in occupied bed days (compared to the current base line) will fund the costs of the service.

| | |
|---|---|
| **7** | **How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs* |

The funding will be spent on the following areas

<u>Staff</u>
0.2 Team Manager time Provided through current MHOAS management time
2 x sessions of medical time per week (£24,394)
1 x WTE clinical psychologist (8a - £58,205)
0.5 x Band 6 Occupational therapist(£19,966)
2 x Band 6 nurses These posts currently exist and will be part of the project (£46,464 per WTE)
4 x Band 5 nurses 2 x Band 5 post currently available to recruit to. (£31,746 per WTE)
4 x Band 3 nurses 2.26 WTE Band 3 Posts currently available to recruit to (£24,423 per WTE)

<u>Travel</u>
Travel costs for all of the above average of approx £200 per month per employee (£24,000 per year)

Training
Training in the Newcastle model for the qualified members of staff in train the trainer. (£2,000) (one off)

Hardware
Laptops and telephones approximate total (£11,000)(one off)

Total recurring costs £444,169
Total existing resources to be put into the project £211,616
Total additional funding required £232,553 (Plus additional one off costs of £13,000)

## 8 What would happen if ICF didn't invest in the project?

The current service will continue. At present there are 2 nurses who cover the whole of the Borders visiting care homes and community hospitals. The current service has no resilience and there is no back up or cover for holidays, sickness absence etc there is little ability to respond to more than one crisis at a time unless in the same or nearby location.

The current service is as responsive as it can be but generally picks up cases at a late stage in the journey by which time staff working with the individual find it difficult to remain positive or see any potential for a positive outcome for them or the resident. It has been difficult to build relationships or build on previous training/educational opportunities e.g. stress and distress because of the now stretched services due to crisis admissions from community hospitals and care homes and continued delayed discharges.

Care provided to people with dementia may not readily meet their needs without advice and guidance from a service with expertise in the care and treatment of older adults with mental health difficulties. As a result care homes may feel unable to meet the needs of individuals, and struggle to provide care at the standard they would wish to do so.

It is anticipated that if there are fewer in-patient beds within Scottish Borders care homes and community hospitals will need to be supported to be able to continue to care for individuals as their illness progresses. Without this type of service if would not be unrealistic to suggest that admission to acute care in times of crisis is more likely. Care home's ability to tolerate challenges may become depleted if they are not supported to manage in times of difficult and responded to in times of crisis. The proposed service will aim to support care homes and community hospitals to avoid admission to acute sites wherever possible.

By working with community based colleagues the proposed project will develop an ethos and culture which enables care providers feel supported and responded to when necessary and ensure there is easy access to expert advice, guidance, support and intervention as required. Alongside this practice individuals will be supported to transition into care home placements, reducing the number of failed admissions and helping care homes to feel more able to meet the needs of individuals expressing stressed and distressed behaviours. The anticipated outcome is this will bring about earlier discharge from older adult mental health wards, community hospitals and community based individuals. The relationship and interaction between the project and the community mental health team will facilitate planned and emergency transitions into care home placements from home, thus avoiding potential hospital admission in crisis.

The result being a reduction in bed days lost due to delayed discharge and reduced avoidable admissions.

While the figures below focus only on older adult mental health inpatient beds it is anticipated that the service will have a positive impact on the whole of the hospital inpatient system, given the demographics of the Scottish Borders and that Dementia is the primary cause of death in females over 70 years of age area and the second highest cause of death (behind heart disease) in males of 70 years locally.

| 9 | **How would the project release resources in order to sustain the project?**<br>*What services would longer be provided or would be provided in different ways* |
|---|---|

The project will release resources by supporting care homes to develop and sustain knowledge and skills to work with people with dementia and other mental illnesses throughout their journey; We anticipate shifting beliefs and culture to enable managers and charge nurses to be confident about providing care to this group of people. The potential impact on hospital admission and early discharge is significant. The project would help to facilitate the recommendations within the "Transforming Specialist Dementia Hospital Care" report to be implemented if carried out in conjunction with commissioning of services, to enable the closure of NHS Borders older adult mental health beds.

Over the past year there has been a rise in the number of bed days lost to care home waits across all inpatient facilities within NHS Borders. In 2017 – 166 individuals were delayed in hospital waiting for care home facilities, occupying 4429 days, the average length of delay per person in 2017 was 26.68 . In 2018, (to November) the number of individual delays dropped to 133 with 4227 bed days lost an average of 31.78 days delayed per person. The numbers for individuals awaiting specialist dementia beds also fell from 22 in 2017 to 20 in 2018 (although this figure does not include December 2018) however, the average length bed days delayed rose from 42.8 days to 54.9 days in 2017 and 2018 respectively.

The bed days lost within the older adult mental health wards is considerably higher. In 2017 there were 13 delays for care homes with 881 bed days lost (average 67.7 days per person) in 2018 while the number of delays remained the same (December figures not included) at 13 the bed days lost rose to 910 an average of 70 bed days lost per person. The team would anticipate having a significant impact on these figures. Clearly any savings made as a result of any reduction in specialist dementia in-patient beds could be transferred to support the project in the longer term. The average cost of older adult inpatient beds within NHS Borders is £473.85 per day, delays costing NHS Borders £417,461.85 and £431,203.50 in 2017 and 2018 respectively, in two wards alone which relates to only 13 patients.

The service would anticipate a positive impact on reducing length of stay across all wards across the acute site, mental health and community hospitals. Investment in the service would ultimately save funds from a whole system perspective but would also result in achieving the aims of the fund. The figures below show the potential savings that could be made by reducing admissions and lost bed days across NHS Borders :

Across all inpatient areas

- In 2017 there were 165 individuals whose discharge was delayed waiting for care home placements totalling - 4425 bed days lost.
- In 2018 (to November) there were 132 individuals whose discharge was delayed waiting for a care – totalling 4215 bed days lost.

The average length of delay rose from 26.82 bed days lost to 31.93 in 2017 and 2018 (to November).

**SAVINGS**

Reducing the bed days lost (across all inpatient beds)

- By 10% would produce a saving of **£201,518.93**,
- By 20% would result in savings of **£399,455.55** *based on Jan to Nov 2018 figures

It is not possible to determine the savings produced by admission avoidance accurately. We are representing this saving by removal of all bed days lost *(as above).

**The project will aim to avoid 10% of admission at a saving of a further £199,716.40.**

When admission avoidance is added to reduction in lost bed days potential savings are:

- **£401,235.33** for a 10% reduction of lost bed days
- **£599,171.95** for a 20% reduction to bed days lost.

| 10 | How would you identify/ recruit staff to support the project? |
|---|---|

Section 7 above identifies the staffing proposal. The following posts are currently vacant or occupied by members of the current team and would transfer to the new service they are

2 WTE Band 6

2 WTE Band 5

2.26 WTE Band 3

We would need to recruit to the remainder of posts on a temporary basis.

| 11 | **Would the project require dedicated project support from the programme team** (see guidance notes section 6) |
|---|---|

**Please return this form to the Programme Team**
**Email: IntegratedCareFund@scotborders.gov.uk**
**Phone:** 01835 82 5080

# ALTERNATIVES TO HOSPITAL DAY OF CARE AUDIT (DoCA+)

**July 2018**

# What was the DoCA+

A snapshot audit of every patient in the Borders General Hospital and Community Hospitals undertaken in July 2018, to assess which patients would be able to receive care in a non hospital setting and what services would be required to achieve this.

## The team

The DOCA+ was carried out by a team of experienced clinicians:

- Consultant Geriatrician – Jenny Inglis
- Consultant in Acute Medicine – Lynn McCallum
- Lead Social Worker – Jane Prior
- AHP – Liz Duffell (Team Leader, RAD)/ Lynn Morgan Hastie – Head of Physiotherapy

Community Nursing – Fiona Houston (Clinical Nurse Manager)/ DN leads Margaret Richardson (Hawick) and Mary Hayes (Peebles)

- GP Superintendent for Community Hospitals (CH visits) (apart from Knoll). Dr Kevin Buchan (Hawick), Dr James Millar (Kelso) and Dr Declan Hegarty (Peebles)

## The Methodology

The existing national DOCA audit tool was used with additional 21 options for non-hospital services identified within reports by John Bolton and Anne Hendry.

DoCA+ was undertaken on:
BGH: Mon. 9th July 2018 (Wards MAU, 6, 16, 7, 9 and BSU) and Wed. 18th July 2018 (Wards 12, 14 and 5)
Community Hospitals: Mon 23rd July 2018 (Hawick, Haylodge) and Thurs. 26th July 2018 (Knoll and Kelso).

# Combined BGH and Community Hospital Results

| Combined Results DoCA+ July 2018 | | | |
|---|---|---|---|
| | **Combined Total** | **BGH** | **Community Hospitals** |
| **Total Number of patients in survey:** | **301** | **218** | **83** |
| Patients identified as going home on day of survey: | 20 | 20 | 0 |
| Patient notes missing at survey time: | 5 | 5 | 0 |
| **Number of patients meeting criteria (appropriately placed in acute hospital):** | **131** | **104** | **27** |
| **Number of patients with an alternative place of care:** | **145** | **89** | **56** |

| **Alternate place of care - by theme** | **Total** |
|---|---|
| Home Care | 79 |
| Nursing Home | 24 |
| Assessment | 15 |
| Discharge to Residential/Extra Care Housing | 9 |
| Discharge Home | 8 |
| Other (process delays) | 6 |
| Awaiting guardianship/other legal issues | 4 |
| | **145** |

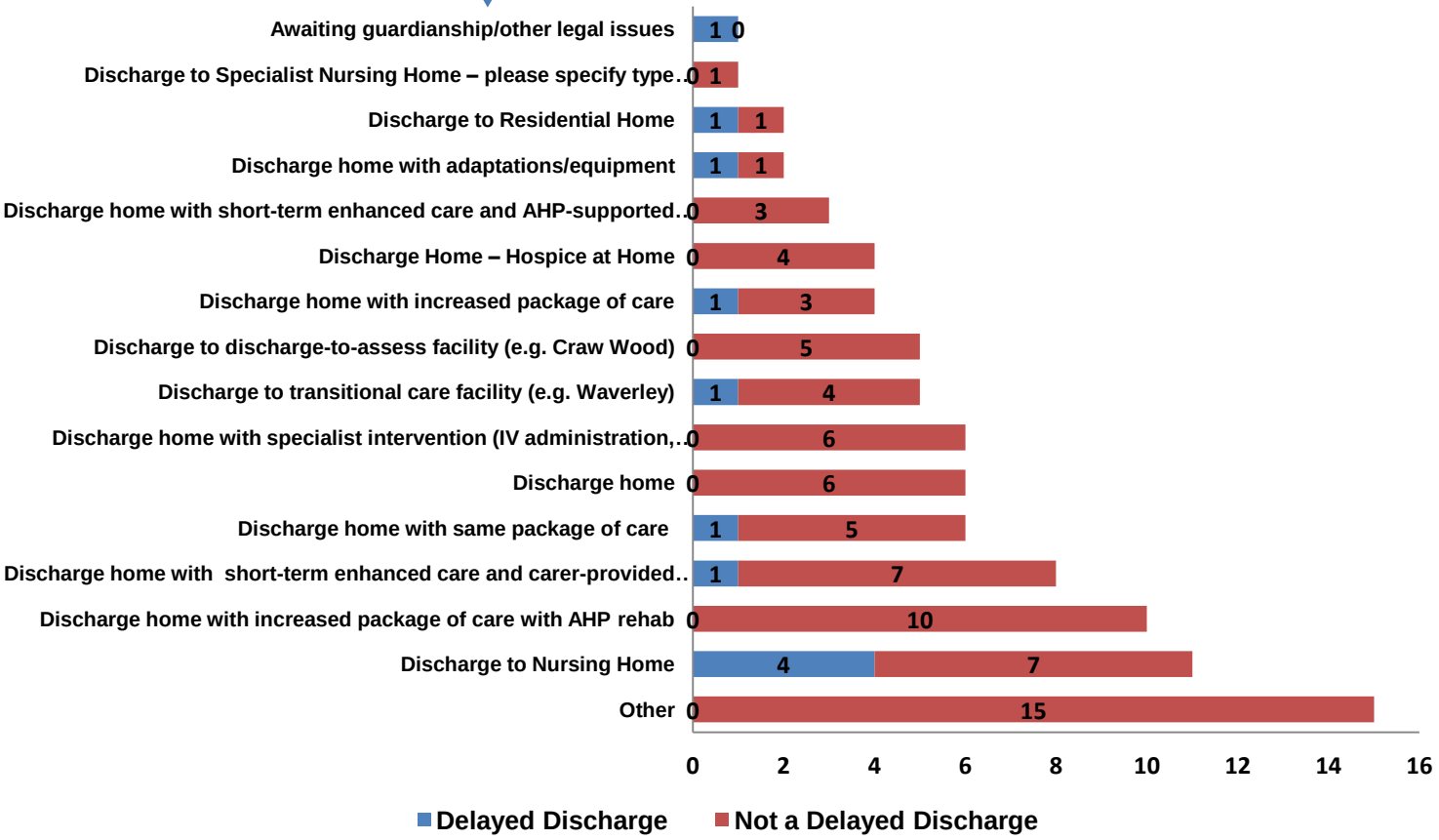
# BGH

- 89 patients (46%) could be managed out of hospital
- 12.4% identified as delayed discharges
- 54 patients could be managed at home with appropriate care
- 15 patients required nursing home care
- 12 patients suitable for step-down residential care in Craw Wood (awaiting assessment/residential care)

**BGH results and figures –**

Total number of patients assessed 193
Total delayed discharges 12
Patients meeting criteria 54%
Patients not meeting criteria 46%
Number of patients with an alternative place of care 89

| Alternate place of care - by theme | Total |
|---|---|
| Home Care | 49 |
| Nursing Home | 15 |
| Assessment | 10 |
| Discharge Home | 6 |
| Other (process delays) | 6 |
| Discharge to Residential/Extra Care Housing | 2 |
| Awaiting guardianship/other legal issues | 1 |
| | **89** |



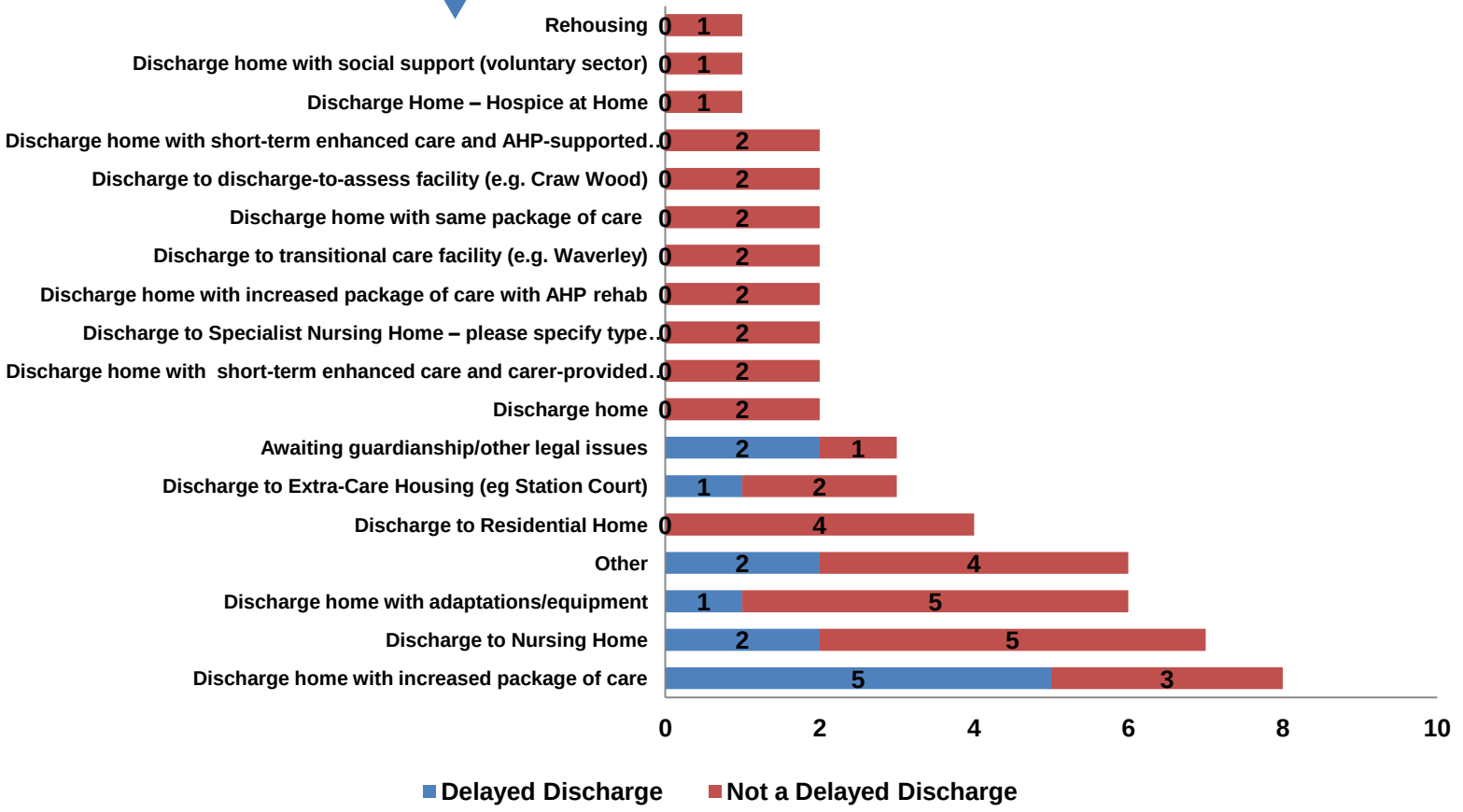
# Community Hospitals

- 56 patients (68%) could be managed out of hospital
- 21.4% identified as delayed discharges
- 32 patients could be managed at home with appropriate care
- 9 patients required nursing home care
- 12 patients suitable for step-down residential care in Craw Wood (awaiting assessment/residential care)

**CH results and figures –**

Total number of patients assessed 83
Total delayed discharges 13
Patients meeting criteria 32%
Patients not meeting criteria 68%
Number of patients with an alternative place of care 56

| Alternate place of care - by theme | Total |
|---|---|
| Home Care | 30 |
| Nursing Home | 9 |
| Discharge to Residential/Extra Care Housing | 7 |
| Assessment | 5 |
| Awaiting guardianship/other legal issues | 3 |
| Discharge Home | 2 |
| | **56** |



# Older Peoples Mental Health DoCA+

A snapshot audit of patients in NHS Borders Older Peoples Inpatient Mental Health facilities (Cauldshiels, Melburn Lodge and Lindean) undertaken 15th November 2018, to assess which patients would be able to receive care in a non hospital setting and what services would be required to achieve this.

**The team**

The DOCA+ was carried out by a team of experienced clinicians:

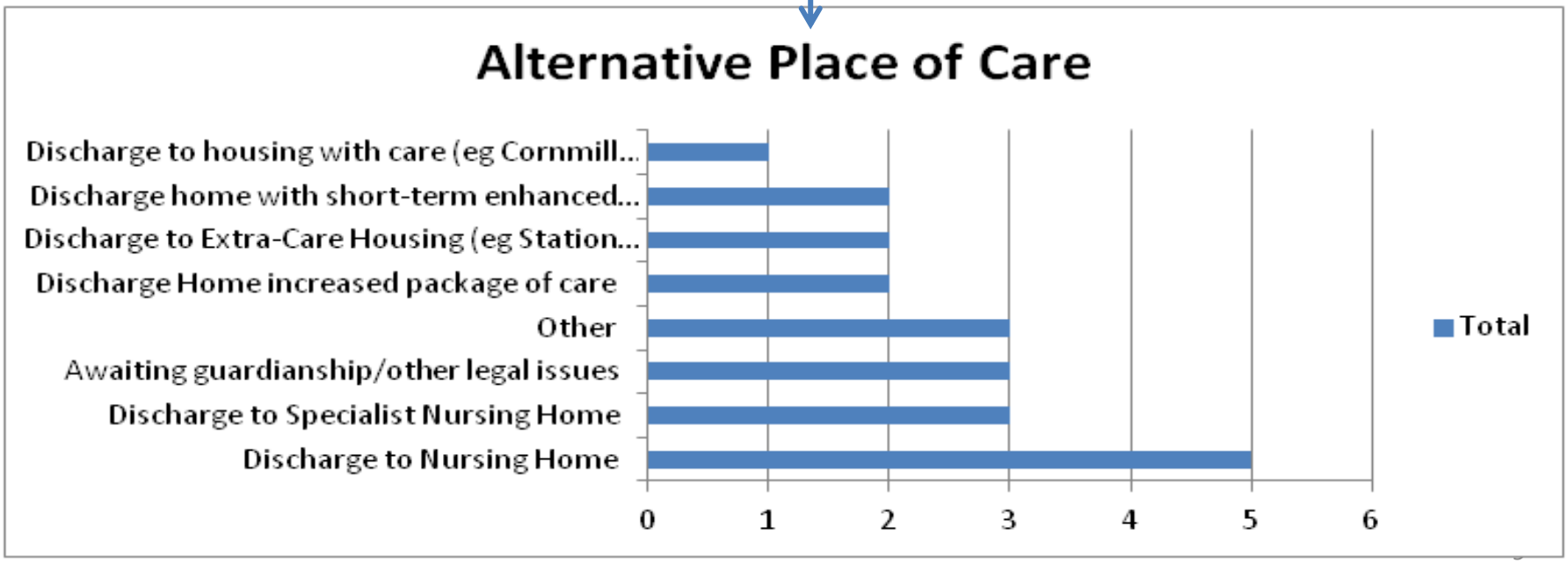
Christine Proudfoot, Alzheimer Scotland Dementia Nurse Consultant, Mental Health
Lisa Clark, Operational Manager, Mental Health
Mrs Rianda du Preez, Professional Lead MH OT, Mental Health
Mrs Stacy Patterson, Social Work
Mrs Diane Keddie, Lead Nurse Excellence in Care
Anne Palmer, Clinical Governance & Quality Facilitator
Gina Allen, Project Support Officer

**The Methodology**

The existing national DOCA audit tool was used with an additional set of criteria for non-hospital services.

# Combined BGH and Community Hospital Results

| Combined Results DoCA+ July 2018 | | | |
|---|---|---|---|
| | Combined Total | BGH | Community Hospitals |
| Total Number of patients in survey: | 28 | 218 | 83 |
| Number of patients meeting criteria (appropriately placed in acute hospital): | 7 | 104 | 27 |
| Number of patients with an alternative place of care: | 21 | 89 | 56 |



# Older Peoples Mental Health

- 21 patients (75%) could be managed out of hospital
- 62% identified as delayed discharges
- 5 patients could be managed at home with appropriate care
- 9 patients required nursing home care
- 4 patients required residential/extra-care housing
- 3 patients were awaiting guardianship and other legal measures


Community Hospital
short term
residential
Hospice at home
AHP
Delayed discharge
criteria
home
GPs
Alternative Place
self care
delays
discharge to assess
Intervention
DOC
enhanced
coding
BGH
Specialist
Waverly
audit
results
appropraiately placed
social care
adaptions
consultant
package of care
Craw Wood
nursing home
information
equipment

# Enhanced Homecare

- DOCA+ - 79 patients

- Identified by
  - Professor John Bolton (Report for Scottish Borders Council and Borders NHS on care pathways and delayed discharges 2017)
  - Professor Anne Hendry (Review of the Clinical Model for Community Hospitals in Scottish Borders, 2018)

- Existing/Tested models
  - Cheviot Healthcare Team
  - Neighbourhood Care Team (Coldstream)
  - Hospital to Home
  - Community-based AHP services
  - Teviot Project (2102-2104)

- Models of care
  - Carers as enablers
  - District Nurses as coordinators of care
  - AHP-led community care model

# Strategic Intent

"undertake a review and development process to provide an agreed and comprehensive model of home-based step up and step down services"

- detail the level of services and the resource required from:
  - Home care staff
  - Community nursing staff
  - AHPs
- Model the impact of the new services over time
- Provide a business case including cost-benefit analysis and potential to release resources

Would provide the H&SCP with a commissioning plan for this tier of services.

**NHS Borders**
Mental Health Service

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Melrose
TD6 6BD
Telephone 01896-827152
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**PRIVATE & CONFIDENTIAL**
Ms Alison Thomson
Executive Lead
The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh EH12 5HE

Date 21st May 2018
Your Ref
Our Ref PG/LMac

Enquiries to Philip Grieve
Direct Line 01896-827157
Email Philip.grieve@borders.scot.nhs.uk

Dear Ms Thomson

Thank you for the feedback and recommendations following the Mental Welfare Commission visit to Cauldshiels Ward, NHS Borders, in February 2018.

The Service notes the recommendations and has initiated improvements to address these as follows:

***Recommendation 1:***
*Managers should consider how risk and nursing assessments can be added to the current system.*

All patients will have a safety care plan in place and will be added to the admission check list to ensure every patient has one in place; this will be reviewed daily and will demonstrate ongoing daily risk assessment. Cauldshiels ward will introduce and reinforce the use of frequency charts, ABC charts, Neuropsychiatric Inventory Assessment to further support subjective observations of overall care.

***Recommendation 2:***
*Managers should raise awareness of nursing and medical staff on the rights of patients who may be detained without authority.*

The Associate Director of Mental Health, Peter Lerpiniere, has a Professional Mental Health Nursing session planned for the 11th June 2018 in which he will discuss "Rights in Mind – a pathway to patients' rights in mental health services" and plans a further 2 sessions specifically for Cauldshiels and Melburn Lodge staff

***Recommendation 3:***
*Managers should review the OT input for patients in Cauldshiels ward.*

Cauldshiels currently consists of an OTTI assessing all new admissions by doing a Pool Activity Level for each patient with suggested activities that can be provided by staff in the ward. The Pool Activity level assesses the level that the patient is functioning at and ensures that activities are presented at this level.

NHS
Borders

A review of OT provision will take place when the new management structure is embedded within mental health.

***Recommendation 4:***
*Managers should ensure a review of the environment taking into account the comments in this report. Given our previous concerns have not been addressed; we will now escalate this recommendation to senior managers.*

A member of the Capital planning team has an identified sum of money that will be allocated to Cauldshiels. A recent walk round took place on 14th May 2018 and a list has been compiled of potential areas that the ward staff see as priority e.g. flooring, lighting, coloured toilet seats/side rails, painting of the walls. This will be reported back to Capital Planning for progression

I trust this response is satisfactory and if you require further information, please do not hesitate to contact me

Yours sincerely

Philip Grieve
Operational Manager for Mental Health

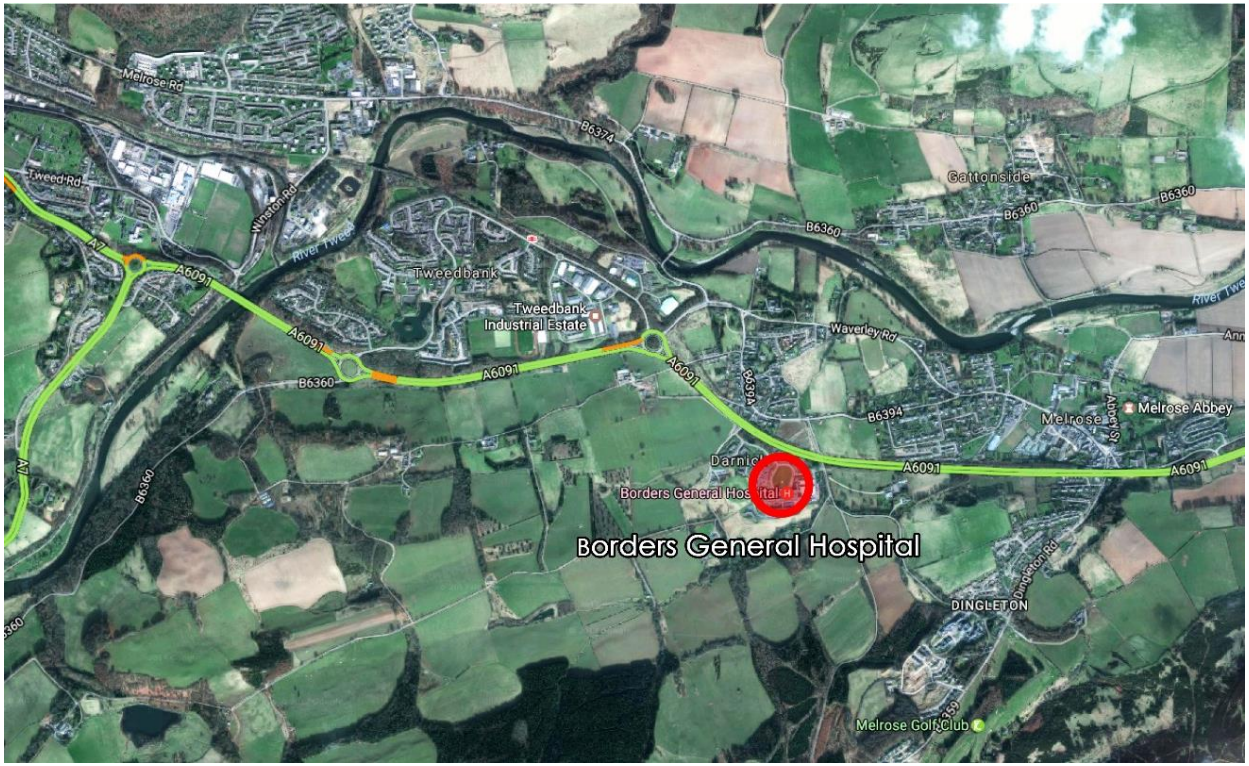

# Feasibility Study
# for NHS Borders

Cauldshiels – Dementia Ward

UNUM PARTNERSHIP
CHARTERED ARCHITECTS

# Contents





# 1.0 Introduction

Unum Partnership Ltd has been commissioned by NHS Borders to produce a feasibility study on the accommodation at Cauldshiels and Lindean Wards within The Borders General Hospital Main Building, currently functioning as a 14 Bed Acute Elderly Adult Dementia Ward and a 6 Bed Functional Elderly Mental Health Ward.

The units have been converted from previous acute hospital clinical uses and extended to provide single bed accommodation to meet the needs of patients with complex and challenging physical and mental health issues. The structural features of the building and its position on the ground floor of an existing 3 storey building has led to significant compromise of layout which is further exacerbated by the provision of single bed accommodation in a floorplate designed for open multi bed wards .

Reductions in staffing levels and the increased complex needs of the patient group who use the ward have significantly hampered the ability of the service to cope with the building environment and facilities.

The requirement for this existing level of bed numbers remains, however significant issues exist for staff where the building does not comply with current guidance on facilities for Dementia Design and improvement is required.

Unum Partnership have been tasked with reviewing the current facilities within the building with the view to incorporating Dementia design best practice and designing out flash points within the building where possible.

# 1.0 Introduction

Through consultation with clinical staff carried out by NHS Borders Estates and Management team and a site visit by the writer, the key issues were identified as follows:

**1/** The nurse call/ staff assistance system has 'blind spots'. This is an immediate and significant risk to staff safety.

**2/** Loose furniture within bedrooms impedes cleaning and compromises Infection Control.

**3/** A significant number of the ensuites are too small leading to significant difficulties in elderly patients being assisted with toilet and washing. The ensuites have WC and washbasin only, with 1 assisted bathroom to be used by 14 patients. The assisted bathroom itself does not comply with space standards for moving and handling. Although Lindean has 1 bathroom for 6 patients, Cauldshiels does not comply with current standards on provision of washing facilities.

**4/** There is very poor opportunity for passive observation throughout the ward due to the complexity of the circulation spaces. The circulation spaces have a significant number of alcoves and dead ends which pose real problems for those with Dementia who are easily disorientated.

**5/** The general environment is not 'Dementia Friendly' and is in a poor condition

- The interior colours and finishes lack visual contrast
- Lighting levels are significantly below standard
- Signage is poor and is not Dementia Friendly
- Unsatisfactory handrail provision has lead to risk to and conflicts between patients

**6/** Lack of Patient day/ activity spaces makes therapeutic activities difficult. There are no designated Quiet rooms or Family visiting spaces and the internal Over night room is rarely used as it has no natural day light.

**7/** Staff Clinical and support spaces including the DSR are too small and there is a general lack of storage/ space for service function. The clinical room is shared between the two wards with Controlled drugs being stored in this one location.

**8/** The staff kitchen is located next to the day room that is currently not being used, at the opposite end from the main hub of the ward and has issues with ventilation and cooling.

**9/** Externally, the location of the ward entrances are poorly sign posted, the entrance to Lindean is in a back service area and there is no footpath to the entrance of Cauldshiels. Additionally the only external patient space for use by both wards is at the entrance to Cauldshiels which is screened by a high fence and is not immediately obvious on arrival.
The cross circulation between patients using the garden space and visitors entering and leaving the ward poses a security risk which is currently managed by restricting access to supervised use only.

**10/** Bedroom doors are currently not self closing fire doors as required by current standards, it is acceptable for this to be retained in existing buildings, however the operation hinders recovery of patients fallen behind doors and the ironmongery is poor for those with Dementia, visual impairments or dexterity issues.

**11/** The staff working at the reception area have identified an issue with patients being able to approach the rear of the desk and interfere with staff or accessing computers at the open desk area. This causes staff to feel threatened and poses a risk to Patient confidentiality.

**12/** Estates have identified a possible issue with capacity within the Domestic Hot Water flow and return system which may impede the ability to provide additional showering/ bathing facilities. Further investigation will be required if an upgrade to ensuites to include showering provision is included.

The following review of current facilities together with the options appraisal has led to the proposed improvements being separated in to two stages:

**Stage 1**

Essential non structural upgrade works, including nurse call system, lighting, decoration and security provision.

**Stage 2**

Many of the elements and failures of the facility require significant structural alteration to be made compliant or have been found to be unachievable within the current building. A high level review of clinical need and accommodation requirements is included which could feed into an overall appraisal of service provision throughout the Borders General Hospital site and the Borders service area.

# 2.0 Cauldshiels

## 2.1 Entrance

Cauldshiels and Lindean wards are located within the ground floor of the main Borders General Hospital Building with their own separate entrances to the rear of the building away from the car park and past Melburn Lodge. On arrival at the hospital there are signs to direct visitors to the wards however the route appears to be a service road access only which leads to a back of house services area. The location of pedestrian signage on the footpath outside Melburn Lodge appears to direct away from the facilities and pedestrians have to cut across grass or round parts of the service road to approach the entrances. There is no pedestrian or accessible footpath leading to each entrance.

Arrival at both wards is extremely poor. A lack of distinct signage and welcoming or obvious entrance to both of these wards immediately gives a sense that this is a low priority service. On a functional level, the entrance is not observed from the nurses' office other than by CCTV, whilst the visitor must pass directly next to the day room window and then enter through the garden gate to access the door entry system. This access crosses the egress from the day room to the external garden space.

There is little opportunity to change the location of the ward entrances, however additional signage and footpaths could be installed.

# 2.0 Cauldshields

Entrance to Cauldshiels

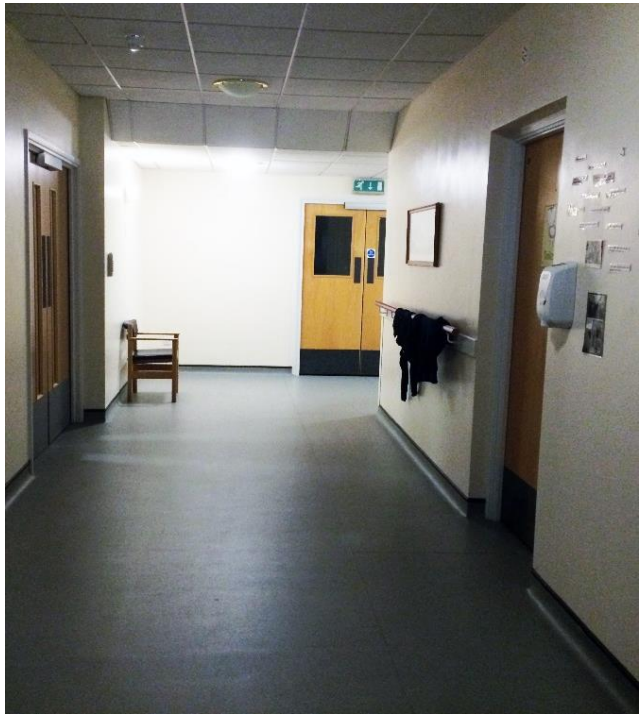
Entrance to Lindean

A pleasant garden space has been created which visually links the two large day spaces, but this is compromised by the entrance to the Cauldshiels ward which does give rise to security issues especially with Dementia patients who tend to wander.

# 2.0 Cauldshiels

## 2.2 General Layout and circulation

From the schematic plan it can be seen that there is little functional order or hierarchy to the location of the rooms within the layout. The footprint was originally designed as open multi-bed wards with a deep plan and a low ratio of perimeter wall to floor area. When originally converted to single rooms, bedrooms were by necessity located on the perimeter to obtain natural light and ventilation. The result was significant areas of circulation that cannot be integrated into functional defined areas.



The corridors do not benefit from any natural light and observation is exacerbated by the deep structural wall fins that create hiding points and alcoves along the lengths of the corridors. This also gives the sense of being in the very bowels of the hospital.

# 2.0 Cauldshiels

# 2.0 Cauldshiels

The main nursing office and reception desk are located at the entrance but due to the spine walls previously noted, this feels quite remote from the two day areas. The reception desk is not designed to prevent patients from having access to the rear of the desk and this can be an issue with patient confidentiality.
From the entrance way, patient bedrooms, day spaces and staff spaces are intermingled. This can lead to widespread dispersion of patients and staff throughout the building during all times of the day, with management policies in place requiring a higher staff/ patient ratio than in other units of this size. This can also lead to feeling of isolation, particularly at the western end of the ward. The location of day rooms at separate ends of the deep U shaped circulation has also caused issues for nursing. The westerly day room is now only used occasionally and is generally locked off. The servery kitchen is also located at this end of the ward which then requires traversing the ward with heated trollies.

Comments from nursing staff also highlight the additional time taken to locate patients within the ward and the high level of conscious interaction required by nursing staff to ensure contact is maintained without the obtrusive measures of close observation.

### 2.3 Bedrooms and Ensuites

The bedrooms and ensuites within Cauldshiels vary greatly in terms of size, orientation and facilities within. This has been known to create tension between patients in other wards over the perceived hierarchy of rooms.

They are predominantly single bedrooms, although there are several that were originally sized to accommodate two beds. Only four of the bedrooms comply with current space standards set out in HBN 04-01 2010 Adult In-patient spaces regarding wheelchair accessibility and moving and handling requirements.

An issue within each of the rooms is the moveable furniture which impedes cleaning. Ideally fitted furniture would be installed. This can respond to the needs of dementia patients and provide easier to clean facilities. This was considered to be a low priority at stage 1 of this study but would be integrated into a new layout.

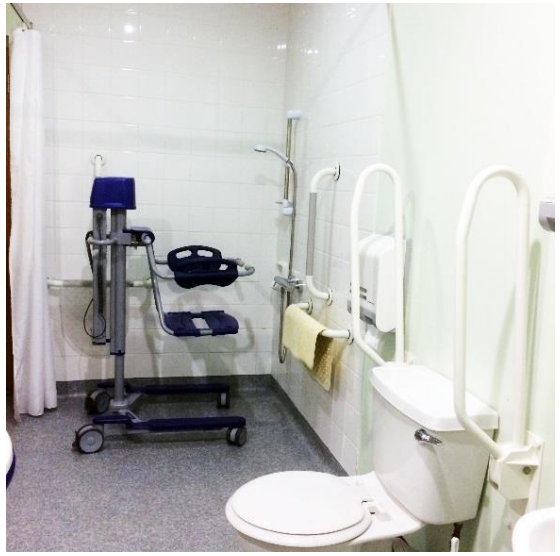
Bedrooms have been fitted out on an ad hoc basis with varying levels of compliant grab rails, colour contrasts and infection resistant surfaces.

Each bedroom has en-suite facilities; however the en-suites vary greatly in size from room to room, the largest being approximately 6 sqm and the smallest less than 3. All contain a WC and wash hand basin, with the larger rooms laid out with a peninsula WC. None of the ensuites contains showering facilities. This leaves all 14 patients having to use the showering facilities within the single assisted bathroom, which is not fully accessible.

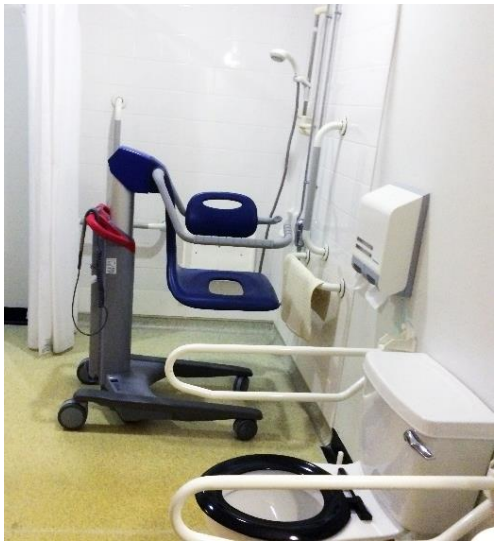
# 2.0 Cauldshiels

**2.4 Assisted Bathrooms**

There is only 1 assisted bathroom in each ward. The layout of each of these rooms impedes the use of hoists as the WC is located too close to the rise and fall bath. These rooms do not comply with the current space standards and a revision to the overall ward layout would be required to provide HBN 00-02 compliant facilities.



Lindean Assisted Bathroom



Cauldshiels Assisted Bathroom

**2.5 Patient Day rooms**

The two patient day rooms are very generous in size for the number of patients within the ward and exceed the provision as set out in SHPN 35. However their dispersed location and lack of proximity to staff areas can make observation difficult. These large spaces also can induce conflict between patients as there are no quiet areas within the ward or private rooms to receive visitors other than patient bedrooms.

There are no Activity or Group rooms within either ward and this has a negative impact on the therapeutic quality of the services that can be provided.

To resolve this issue a reconfiguration of the ward would require to take place.

# 2.0 Cauldshiels

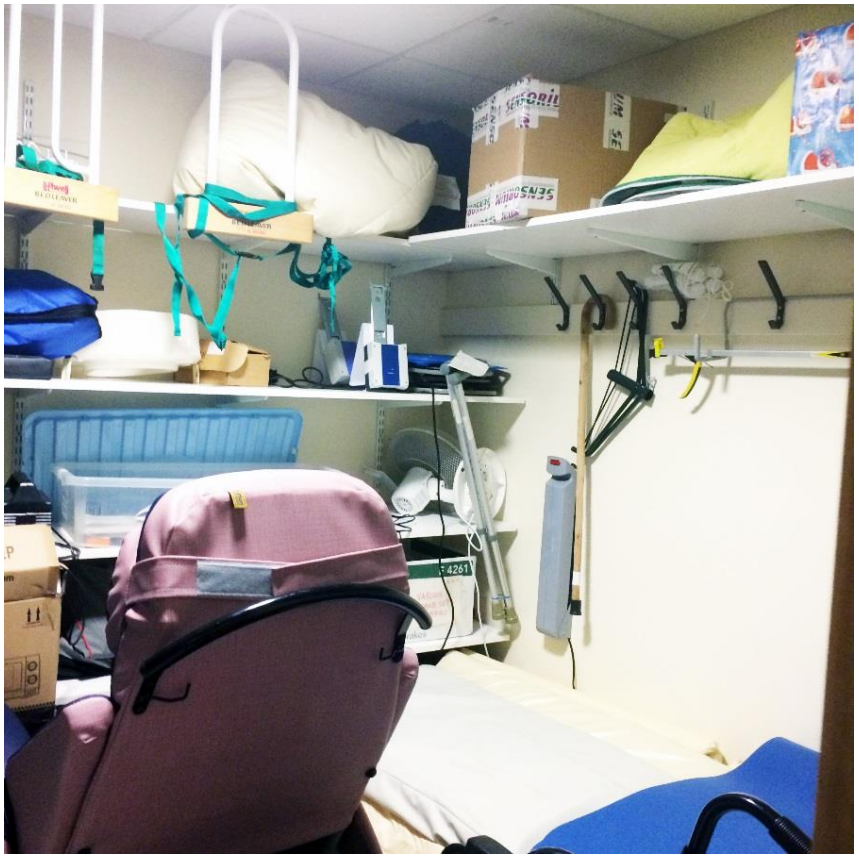
**2.6 Clinical Rooms and Service Provision**

The current clinic room is of insufficient size. There is a lack of storage and no space for an examination couch. A room of 16m2 is the recommended size within HBN00-03 – Clinical and clinical support spaces, to accommodate examination couch and sufficient work surface, Controlled drugs cabinets etc. The situation is further exacerbated as Lindean shares this clinical room and controlled drugs cabinet with Cauldshiels with staff having to leave the ward to retrieve the required medicines and the potential for breaches in patient confidentiality.
A reconfiguration of both wards would include separate compliant clinical space.



### 2.7 Domestic Services and Storage

Domestic Services and storage space is very limited within both wards. There is limited possibility of upgrading this within the current configuration.



Domestic Service Room

# 2.0 Cauldshiels

**2.8 Design for Dementia.**

Many aspects of Dementia design are fundamentally integral to the clarity of the layout and space within a facility and cannot be tacked on as an afterthought. Complex circulation routes and lack of natural day light as well as a lack of visual links to outside make orientation and way finding difficult. The introduction of fresh finishes and specialist signage, pictures and colour contrasts should help improve the current situation and light levels can be significantly improved. It should be noted however that this only goes a small way to bring the facility up to current standards and full Dementia friendly compliance cannot be achieved without a fairly fundamental re-design of the facility.

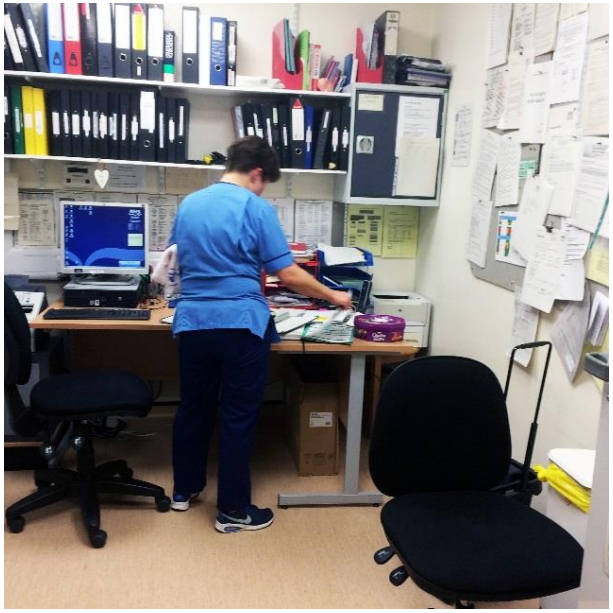
# 3.0 Lindean

### 3.1 General Layout

Lindean ward has recently been refurbished as an Elderly functional mental health ward.
Internally, doors have been upgraded to anti-barricade standards and lighting levels improved.
The decoration is fresh and in good order.

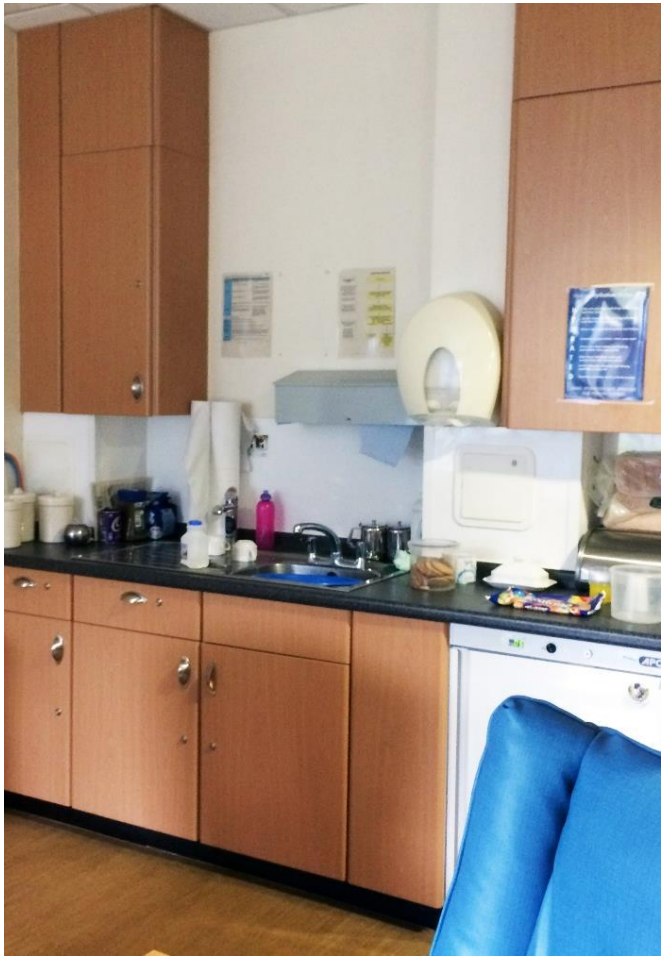
Refer to the comparison of existing area with a notional 6 bed elderly functional ward. It is clear that significant additional floor space would be required for Linden to function as an independent ward.

# 3.0 Lindean



Staff Office

The ward has very much been squeezed into a tight corner with several functions being borrowed from Cauldshiels, such as the clinical room and very little staff and clinical space compromising efficient provision of service. The layout and circulation are also compromised due to the proportions and nature of the existing footprint which hampers observation.



Servery

## 4.1 Stage 1 Essential Non Structural Works

These works are required on the basis of the Service provision continuing on the current situation of a 14 bed ward and a 6 bed ward, maintaining the status quo with regard to bedrooms/ dayrooms/ staff facilities. Actions within this stage are seen as imperative and urgent to improve the current Service provision however will not provide a solution to the physical characteristics and failings in layout and circulation of the building, alter space provision or address patient/ staff facilities.

The works identified in this stage are as follows:

1/ Upgrading of Nurse Call/ Alarm system
2/ Upgrading Door Access / Security System to swipe cards/ fobs
3/ Overhaul and replacement of lighting throughout to current standards.
4/ Full face lift of walls and floor finishes to improve visual contrast and refresh interiors.
5/ Installation of Dementia Friendly signage.

To be considered as part of this refurbishment but not currently essential:

6/ Replacement of Interior doors and ironmongery to comply with fire regulations and anti-barricade requirements.

Due to the nature of this patient group, further discussion and consideration should be given to whether carrying out refurbishment works on a rolling programme could be done without decanting of patients. It may not be possible given the serious disturbance caused and the risks posed by interaction between works and the patient group.

1/ Upgrade of Nurse Call System and personal attack alarms with possible inclusion of Telecare with integrated bed sensors. The existing panic alarms and nurse call system do not work in several areas within the building due to blind spots. Further investigation would be required to coordinate full integration of the stand alone systems and upgrade to a suitable and workable system including bed pressure pad alarms. A budget cost has been allowed in the Feasibility costs.

2/A New Secure access system would be installed to replace the current pin code access control and integrate access to staff controlled areas throughout with panic alarm fobs carried by staff.

# 4.0 Upgrading Works

3/ New Lighting Provision
The Lux levels recommended by the Dementia Design centre are slightly different from the EN 12464 recommendations.
Recommended lighting levels are :-

| | |
|---|---|
| Living rooms | 600lux |
| Bathrooms and toilets | 300lux |
| Bedrooms | 200lux |
| Corridors | 150day/20-50night |

The new lighting layout would involve an increased number of fittings as well as relocation of
several fittings which will necessitate some local remedial works to ceilings. Ceilings throughout the ward are inlay grid suspended ceilings which should alleviate the disruption of this element of the works.

4/ Redecoration to provide visual contrasts and improved wayfinding
An allowance will be made for a full re-decoration of the ward to re-fresh and re-decorate, incorporating colour defining areas and to enhance way-finding. An allowance is included for replacement of all floor finishes.

5/ Signage Review and overhaul.
New Dementia Friendly signage is proposed throughout the ward. At this stage an allowance for new signage is included as further discussion is required on wayfinding signage requirements.

6/ Replacement of internal doors with rationalisation of keys/ security strategy
Replacement of all the doors within the ward is being proposed to bring the fire resistance and separation up to current standards and to incorporate the best practice guidelines of colour contrast and designation of rooms by highlighting patient areas and reducing the visual impact of staff and non-patient areas. All doors will be colour laminate finish and a review of lock suiting to reduce the number of keys required to be carried by staff incorporated. Bedroom doors will be reconfigured to address the issue of accidental barricade from inside patient rooms.

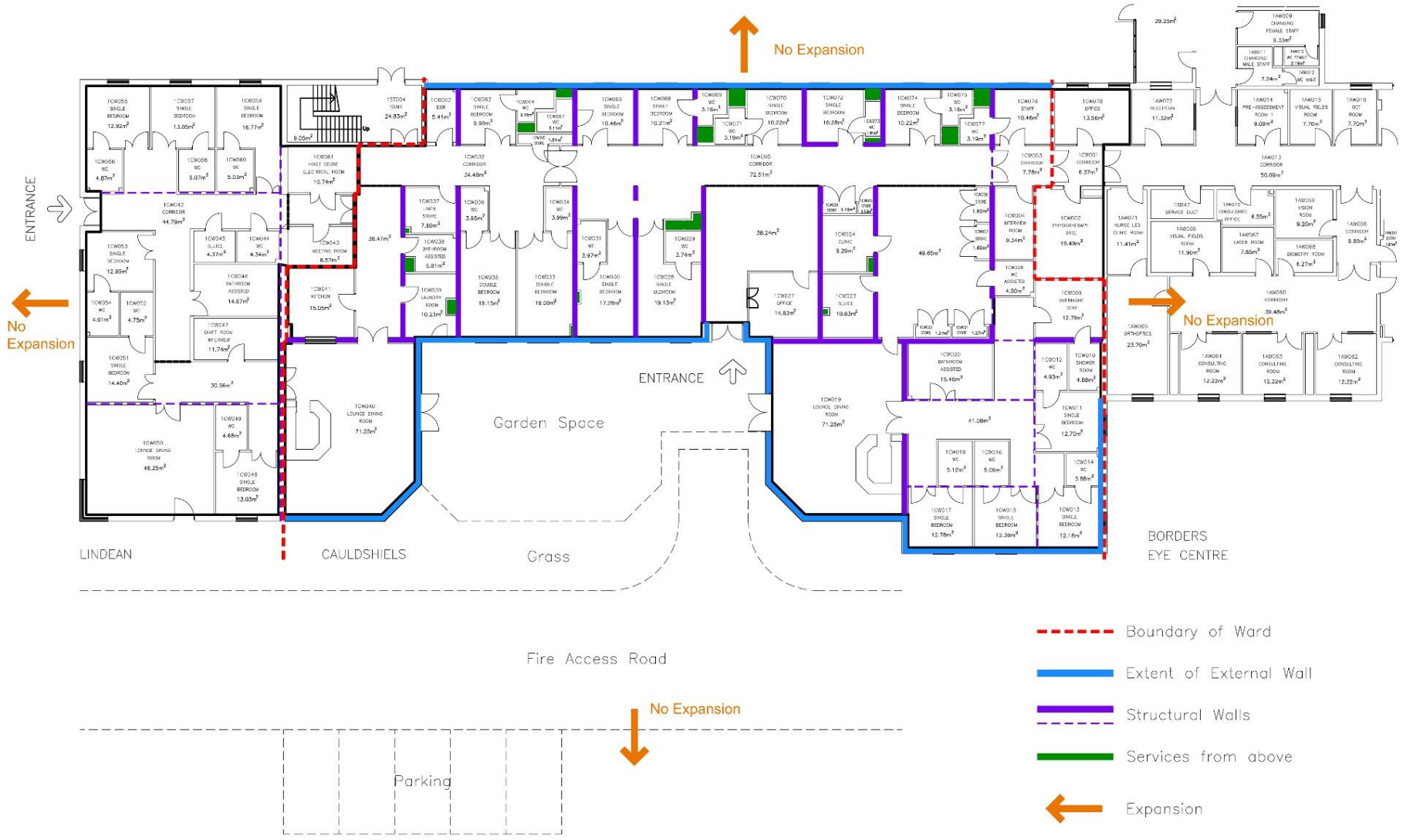
It must be stressed that these upgrades would not address many of the fundamental issues of the service provision within this facility. The purpose of stage 1 has been to identify the steps that are critical to reduce the immediate risks to staff and patients given that a solution to the longer term issues of the two wards may take a significant number of years to be resolved.

## 4.2 Stage 2 Reconfiguration of Service Provision

An audit of the current space provision against notional desired/ compliant wards was carried out to identify if and where space might be re-allocated to provide a compliant functioning ward. (See Appendix A)

It became apparent from early investigations that Lindean is significantly smaller in area than would be required for a fully self sufficient ward, whilst Cauldshiels appears theoretically to have sufficient floor area. However a review confirmed that the physical characteristics of the two wards and limitations caused by existing structure, services, ratio of internal floor area to external perimeter wall area and site constraints conspire to make the provision of two compliant wards within the current footprint impossible. It also became apparent that the wards are lacking space to the extent that any effort to address each of the space issues noted above resulted in further compromising a different issue or damaging an aspect of the facility that does work, such as the eastern day room or external wall provision to bedrooms. The opportunity for extension of the wards is severely restricted by the fire access road to one side and the Eye clinic and other areas of the BGH to all other boundaries.
Refer to Diagram 01

# 4.0 Upgrading Works



**Conclusion**

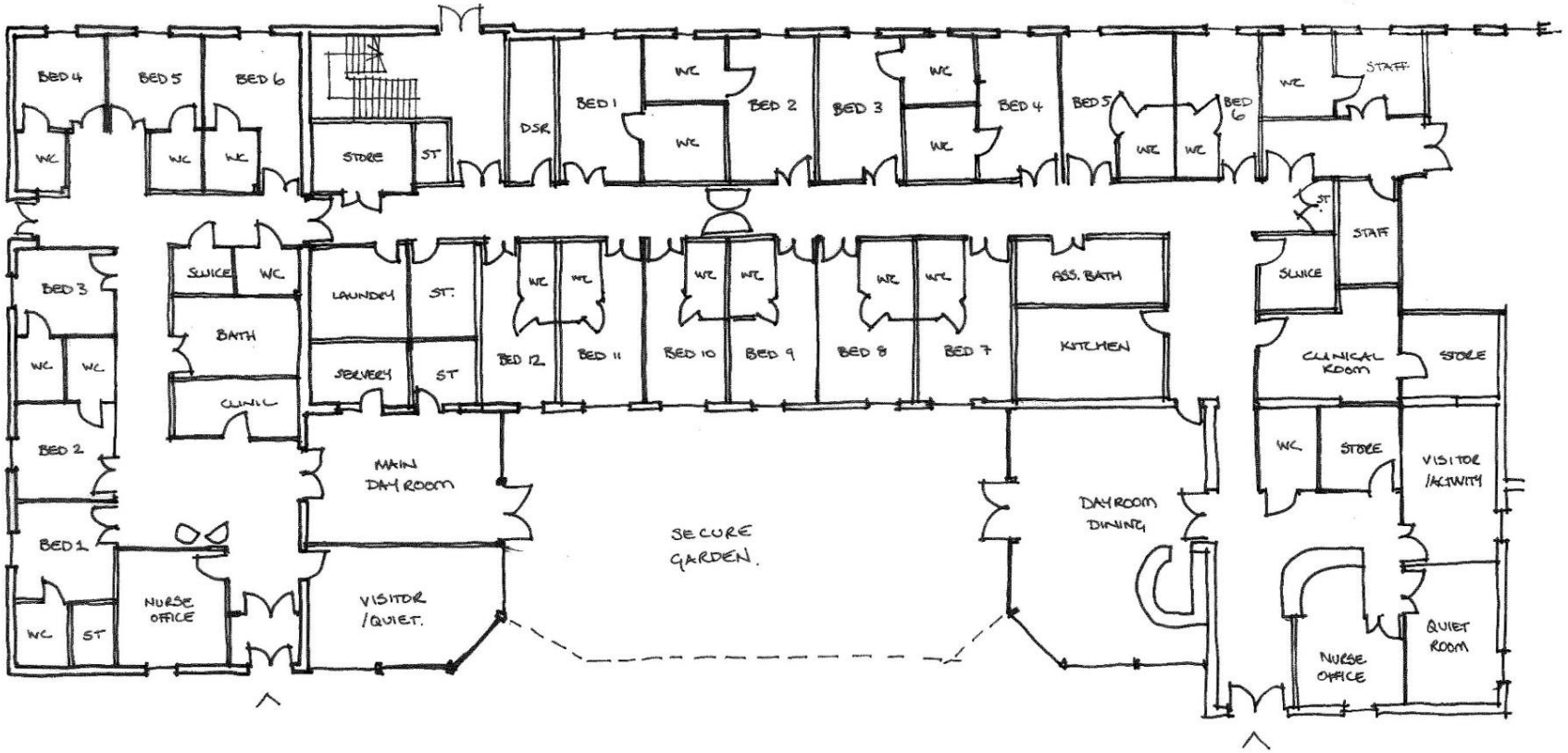
There are various options that could be considered which are listed below. Further discussions with the Finance, Estate and Clinical teams are required to determine if any of the following are worth pursuing and investigated further for their feasibility and to firm up budget costs

A/ A reduction in bedroom numbers for Cauldshiels could be considered.
See sketch option A which has 12 bedrooms. This addresses the functional arrangements of both wards and re-assigns floor area, allowing Lindean to function independently and to arrange the functional spaces in Cauldshiels in a more logical manner. It also addresses the issue of maintaining the integrity of the secure garden by moving the entrance ways. The main issues are whether a 12 bed unit would be sufficient and the major structural reconfiguration that would be required to relocate the main spine corridor. Discussion with the Mental Health Team advised that it was very unlikely a 12 bed ward would meet clinical need so this option has not been pursued further.

B/ Lindean be relocated to another part of the hospital and Cauldshiels expand into the entire space.
This option confirmed that the footprint available here would be significantly in excess of what would be required for a 14 bed ward. An improved entrance and day area can be created and significant improvement can be made to the bedroom wing and corridor. However there is significant space remaining that is surplus to requirements. There is an opportunity to create a 17-18 bed ward or to demolish a part of the existing single storey area to expand the garden space.
This option also requires major structural reconfiguration to re-align the corridor and structural spine walls, and the budget cost includes the cost or provision of Lindean ward elsewhere.

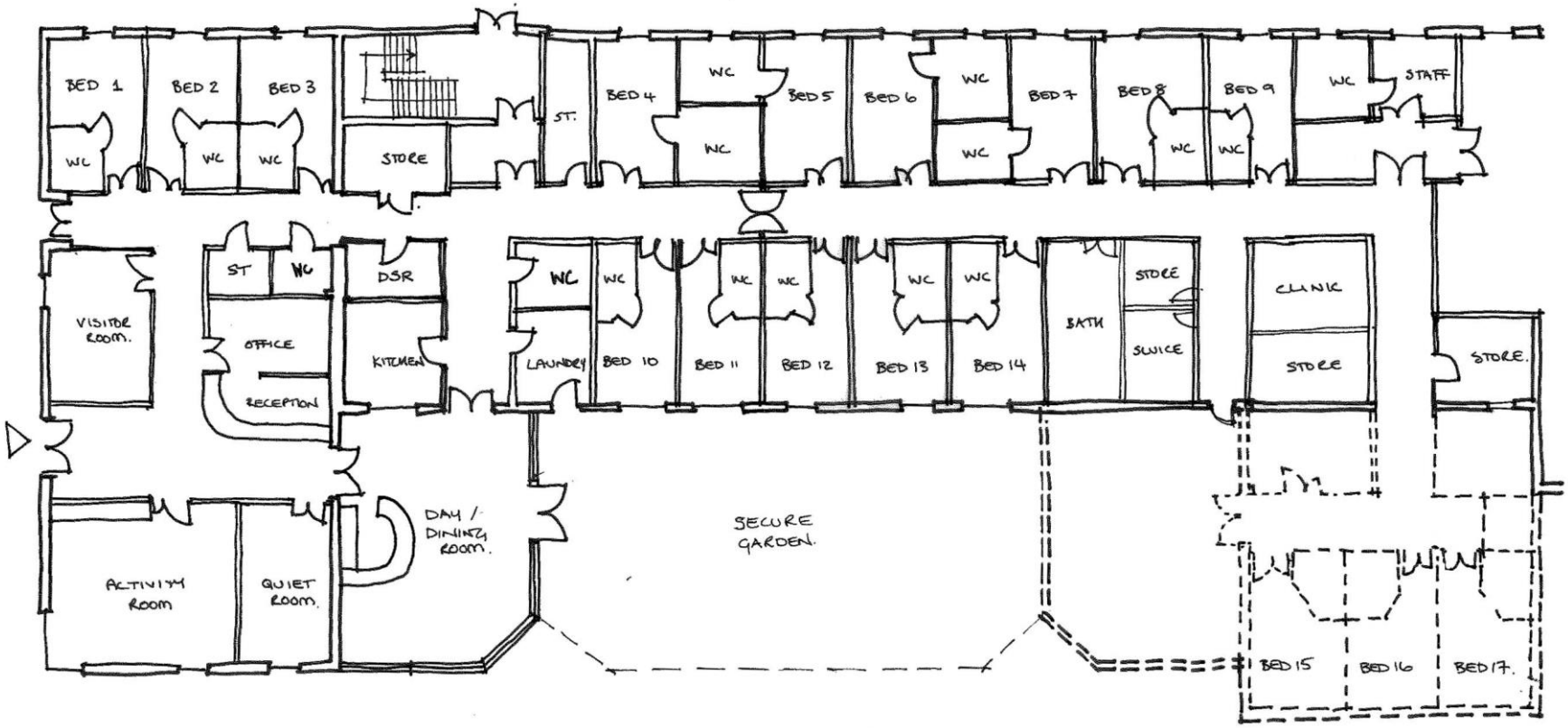
C/ Both wards be relocated elsewhere, preferably new build.

# 4.0 Upgrading Works




Sketch Option A
Cauldshiels 12 Bed / Lindean 6 Bed wards

# 4.0 Upgrading Works




Sketch Option B

Cauldshiels 14 Bed – possibly 17 bed.

## 5.1 Stage 1 Costs

NHS BORDERS
PROPOSED INTERNAL REFURBISHMENT
CAULDSHIELS, BORDERS GENERAL HOSPITAL

30-Jan-17

ELEMENTAL INDICATIVE COST - REFURBISHMENT

GROSS FLOOR AREA 863.00 m2

NRM ELEMENTS

| | GROUP/SUB ELEMENTS | SUB ELEMENT COST | GROUP ELEMENT COST | SUB ELEMENT COST/M2 | GROUP ELEMENT COST/M2 | SUB ELEMENT % | GROUP ELEMENT % |
|---|---|---|---|---|---|---|---|
| 0 | FACILITATING WORKS | | | | | | |
| | | £0.00 | £0.00 | £0.00 | £0.00 | 0.00% | 0.00% |
| 1 | SUBSTRUCTURE | | | | | | |
| | | £0.00 | £0.00 | £0.00 | £0.00 | 0.00% | 0.00% |
| 2 | SUPERSTRUCTURE | | | | | | |
| 2.6 | Windows and External Doors | £12,400.00 | | £14.37 | | 3.10% | |
| 2.8 | Internal Doors | £75,650.00 | | £87.66 | | 18.93% | |
| | | £88,050.00 | £88,050.00 | £102.03 | £102.03 | 22.03% | 22.03% |
| 3 | INTERNAL FINISHES | | | | | | |
| 3.1 | Wall finishes | £19,760.00 | | £22.90 | | 4.94% | |
| 3.2 | Floor Finishes | £44,576.00 | | £51.65 | | 11.15% | |
| | | £64,336.00 | £64,336.00 | £74.55 | £74.55 | 16.10% | 16.10% |
| 4 | FITTINGS, FURNISHINGS AND EQUIPMENT | | | | | | |
| 4.1 | General Fittings, Furnishings and Equipment | £6,000.00 | | £6.95 | | 1.50% | |
| | | £6,000.00 | £6,000.00 | £6.95 | £6.95 | 1.50% | 1.50% |
| 5 | SERVICES | | | | | | |
| 5.8 | Electrical Installations | £105,286.00 | | £122.00 | | 26.34% | |
| 5.12 | Communication, Security and Control Systems | £38,835.00 | | £45.00 | | 9.72% | |
| 5.14 | Builder's Work in Connection with Services | £4,750.00 | | £5.50 | | 1.19% | |
| | | £148,871.00 | £148,871.00 | £172.50 | £172.50 | 37.24% | 37.24% |
| 6 | PREFABRICATED BUILDINGS AND BUILDING UNITS | | | | | | |
| | | £0.00 | £0.00 | £0.00 | £0.00 | 0.00% | 0.00% |
| 7 | WORK TO EXISTING BUILDING | | | | | | |
| 7.1 | Minor Demolition Works and Alteration Works | £23,253.00 | | £26.94 | | 5.82% | |
| | | £23,253.00 | £23,253.00 | £26.94 | £26.94 | 5.82% | 5.82% |
| | | | £330,510.00 | | £382.98 | | 82.69% |
| | Add | | | | | | |
| | Preliminaries | 12.50% | £41,313.75 | | £47.87 | | 10.34% |
| | | | £371,823.75 | | £430.85 | | 93.02% |
| | Add | | | | | | |
| | Contingencies | 7.50% | £27,886.78 | | £32.31 | | 6.98% |
| | TO SUMMARY | | £399,710.53 | | £463.16 | | 100.00% |

## 5.2 Stage 2 Costs

On the basis of recent healthcare projects carried out to completion in house at Armours Consultants, basic rates per meter have been applied to the three options to give very approximate budget costs.

Currently Ward refurbishments are achieving rates of £1200-£1400 per square meter.

New Build Hospital facilities have been costing £3000 - £3500 per square meter, not including site abnormals.

On this basis

Option A – Refurb and Reconfiguration to provide 12 bed and 6 bed units - £1.5 -£2M

Option B – Refurb to provide large 14-17 bed ward with new build 6 Bed ward - £2.8 - £3.5M

Option C – New Build 14 bed and 6 bed ( not including site purchase/ abnormals - £3-£3.6M

# 6.0 Appendices

| Cauldshields Current Schedule of Accommodation | | | |
|---|---|---|---|
| | | | |
| | | Bedroom 1 | 19.13 |
| | | Bedroom 2 | 17.28 |
| | | Bedroom 3 | 19 |
| | | Bedroom 4 | 19.15 |
| | | Bedroom 5 | 9.9 |
| | | Bedroom 6 | 10.46 |
| | | Bedroom 7 | 10.21 |
| | | Bedroom 8 | 10.22 |
| | | Bedroom 9 | 10.28 |
| | | Bedroom 10 | 10.22 |
| | | Bedroom 11 | 12.7 |
| | | Bedroom 12 | 12.18 |
| | | Bedroom 13 | 12.39 |
| | | Bedroom 14 | 12.78 |
| | | Ensuite 1 | 3.74 |
| | | Ensuite 2 | 3.97 |
| | | Ensuite 3 | 3.99 |
| | | Ensuite 4 | 3.95 |
| | | Ensuite 5 | 3.15 |
| | | Ensuite 6 | 3.11 |
| | | Ensuite 7 | 3.16 |
| | | Ensuite 8 | 3.19 |
| | | Ensuite 9 | 1.81 |
| | | Ensuite 10 | 3.16 |
| | | Ensuite 11 | 4.93 |
| | | Ensuite 12 | 3.68 |
| | | Ensuite 13 | 5.09 |
| | | Ensuite 14 | 5.12 |
| | | Lounge/ Dining Room 1 | 71.25 |
| | | Lounge/ Dining Room 2 | 71.25 |
| | | Kitchen Servery | 15.05 |
| | | Assisted Bathroom | 15.46 |
| | | Patient WC | 4.5 |
| | | Patient WC | 5.81 |
| | | Clinical Room | 9.29 |
| | | | |
| | | Office | 14.63 |
| | | Staff Room | 10.46 |
| | | Staff WC | 3.19 |
| | | Interview Room | 9.34 |
| | | Overnight Room | 12.79 |
| | | Ensuite | 4.88 |
| | | Sluice | 10.63 |
| | | Linen Store | 7.6 |
| | | DSR | 5.41 |
| | | Laundry | 10.23 |
| | | Stores | 9.33 |
| **14 beds** | | | **529.05** |
| | | Planning/ | |
| | | Engineering | 49.54 9.4% |
| | | Circulation | 282.21 53.3% |
| | | **Department Total** | **860.8** |

| Notional 14 Bed Organic and Dementia Acute A&T Ward | | | | |
|---|---|---|---|---|
| | | | | |
| 1 | ACTIVITY ROOM | 1 | 19.0 | 19.0 |
| 2 | SINGLE ROOMS | 14 | 12.5 | 175.0 |
| 3 | Ensuite Shower Rooms | 14 | 4.5 | 63.0 |
| 4 | LOUNGE/ DINING ROOM | 1 | 70.0 | 70.0 |
| 5 | QUIET ROOM | 1 | 16.0 | 16.0 |
| 6 | KITCHEN / SERVERY | 1 | 16.0 | 16.0 |
| 7 | ASSISTED BATHROOM | 1 | 16.0 | 16.0 |
| 8 | Patient WC | 2 | 6.0 | 12.0 |
| | | | | |
| 9 | TREATMENT ROOM | 1 | 16.0 | 16.0 |
| 10 | NURSES STATION | 1 | 12.0 | 12.0 |
| 11 | NURSING OFFICE | 1 | 20.0 | 20.0 |
| 12 | STAFF ROOM | 1 | 10.0 | 10.0 |
| 13 | STAFF WC | 2 | 2.5 | 5.0 |
| 14 | INTERVIEW ROOM | 1 | 12.0 | 12.0 |
| 15 | VISITOR/ FAMILY ROOM | 1 | 12.0 | 12.0 |
| 16 | VISITOR WC | 1 | 6.0 | 6.0 |
| 17 | DISPOSAL SLUICE | 1 | 8.0 | 8.0 |
| 18 | LINEN | 1 | 8.0 | 8.0 |
| 19 | DSR | 1 | 8.0 | 8.0 |
| 20 | PATIENT LAUNDRY | 1 | 12.0 | 12.0 |
| 21 | STORES | 1 | 12.0 | 12.0 |
| | **SUB TOTAL** | **14 bed** | | **516.00** |
| | Planning/ | | | 51.6 10.0% |
| | Engineering | | | 15.48 3.0% |
| | Circulation | | | 206.4 40.0% |
| | **Department Total** | | | **789.48** |

Schedule of Accommodation
Cauldshiels Comparison

UNUM PARTNERSHIP
CHARTERED ARCHITECTS

# 6.0 Appendices

| Lindean Current Schedule Of Accommodation | | | |
|---|---|---|---|
| | | | |
| | | Bedroom 1 | 12.92 |
| | | Bedroom 2 | 13.05 |
| | | Bedroom 3 | 16.77 |
| | | Bedroom 4 | 12.95 |
| | | Bedroom 5 | 14.4 |
| | | Bedroom 6 | 13.03 |
| | | En-Suite 1 | 4.87 |
| | | En-Suite 2 | 5.07 |
| | | En-Suite 3 | 5.03 |
| | | En-Suite 4 | 4.61 |
| | | En-Suite 5 | 4.75 |
| | | En-Suite 6 | 4.68 |
| | | | |
| | | Sitting/ Dining Area | 46.25 |
| | | (incl servery) | |
| | | | |
| | | Assisted Bathroom | 14.67 |
| | | WC | 4.34 |
| | | | |
| | | Disposal Sluice | 4.37 |
| | | Office | 11.74 |
| | | Staff room/ Visitor Room | 8.57 |
| | | Store | 10.74 |
| | | | |
| | | | |
| | | | |
| | | | 212.81 |
| | | Planning/ | |
| | | Engineering | 13.54 |
| | | Circulation | 75.35 |
| | | **Department Total** | **301.7** |

| | | | | |
|---|---|---|---|---|
| **Notional 6 Bed Elderly Functional MH Ward** | | | | |
| 6 Bed | | | | |
| 1 | ACTIVITY ROOM | 1 | 15.0 | 15.0 |
| 2 | SINGLE ROOMS | 6 | 12.5 | 75.0 |
| 3 | WCS ( ENSUITE ) | 6 | 4.0 | 24.0 |
| 4 | DAY ROOM/ DINING | 1 | 45.0 | 45.0 |
| 5 | SERVERY | 1 | 12.0 | 12.0 |
| 6 | QUIET ROOM | 1 | 12.0 | 12.0 |
| 7 | ASSISTED BATHROOM | 1 | 16.0 | 16.0 |
| 8 | WC | 1 | 6.0 | 6.0 |
| 9 | TREATMENT ROOM | 1 | 14.0 | 14.0 |
| 10 | VISITOR ROOM | 1 | 12.0 | 12.0 |
| 11 | NURSING OFFICE | 1 | 16.0 | 16.0 |
| 12 | STAFF | 1 | 8.0 | 8.0 |
| 13 | STORE | 1 | 10.0 | 10.0 |
| 14 | DSR | 1 | 8.0 | 8.0 |
| 15 | LINEN ROOM | 1 | 6.0 | 6.0 |
| | DISPOSAL STORE | 1 | 6.0 | 6.0 |
| | **SUB TOTAL** | **6 Bed** | | **285.00** |
| | Planning | | 28.5 | 10.0% |
| | Engineering | | 8.55 | 3.0% |
| | Circulation | | 99.75 | 35.0% |
| | **Department Total** | | **421.8** | |

Schedule of Accommodation
Lindean Comparison

| Project Reference | |
|---|---|

# FIP Project Mandate NHS BORDERS

## ACCOUNTABILITY

| | |
|---|---|
| **Workstream** | Productivity & Efficiency |
| **Business Group** | Mental Health |
| **Executive Lead** | Nicky Berry |
| **Responsible Officer (Project Lead)** | Simon Burt |
| **Project Support (PMO)** | Holly Hamilton-Glover |
| **Finance Manager** | Viv Buchan |
| **Clinical Lead** | Lucy Calvert |
| **Workforce Lead** | |

| **Business Group** | £000s | WTE | COST CENTRE | SUBJECTIVE | £000s |
|---|---|---|---|---|---|
| Mental Health (Cauldshiels) | **55** | **1.6** | BO1370 | 71D5 | |
| | **70** | **2.71** | BO1370 | 71D5 | |
| | **175** | **6.78** | BO1370 | 71D5 | |
| | **180** | | BO3170 | various | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | £000s |
|---|---|---|
| **Date Updated** | 11/06/2019 | |
| **Updated By** | **HHG** | |
| **BAU** | | |
| **Cost Savings Plan** | | |
| **Turnaround Programme** | | **480** |

| | | Capital £k | Revenue £k |
|---|---|---|---|
| **Proposed Start date (Implementation)** | 01/05/2019 | **Investment Required (if any)** | **623** |
| **Proposed Completion date** | 01/01/2020 | **Steering Group Approval** | |

## SCHEME DETAIL

**Scheme Title**

**Specialist Dementia Hospital redesign**

**Project Narrative**

*Project Details*
*Project Scope*
*Any Connecting Departments*
*What will change?*

**Background**

The Scottish Government report "Transforming Specialist Hospital Dementia Care", June 2018, sets out the recommendations from an independent review of the sector commissioned by The Scottish Government, and makes recommendations on the modernisation of specialist NHS dementia care. The recommendations are wide ranging but essentially include;

1. Creating a modern specialist dementia inpatient unit that will provide a centre of excellence to treat the small number of people with dementia who have a clinical need to be in hospital.
2. Develop a transition plan and a local engagement strategy with partners, including the NHS, Local Authority and people living with dementia, for any necessary de-commissioning process and re-investment in specialist dementia units and to develop any further community capacity in health and social care services.

**Current Demand analysis**

**Cauldshiels:**

The combined beds across Cauldshiels Ward (assessment ward) and Melburn Ward (Treatment Ward) total 26 (14 Cauldshiels and 12 Melburn).

DOCA completed for the 3 Mental Health Older Adult inpatient wards (including the functional illness ward, Lindean - 6 patients) on 15th November 2018. This audit found that overall 62% of patients were identified as Delayed Discharges (21 patients out of a bed total of 32). Of these 3 were identified as requiring "specialist Nursing Home" and 6 to a "Nursing Home". 5 patients were suitable for discharge home and 4 discharges to a suitable residential or extra care housing facility and 3 were awaiting Guardianship/other legal processes to be followed.

**Project Benefits**

*How will the benefits be realised*
*Where will benefits be realised*
*Financial & Non Financial*

The benefits will be realised by reducing the number of inpatient Dementia beds from the current 26 to 12 by January 2020. This will result in Cauldshiels ward closing and the function being transferred to Melburn ward. Melburn ward would become a specialist inpatient ward delivering both assessment and treatment to patients.

The enhanced provision of community resources and expertise will be funded by the disinvestment on Cauldshiels ward and the reinvestment in the community. An estimate reinvestment for the transition of previous inpatients into the community is £1,000 per patient (* Transforming Specialist Dementia Hospital Care report). Based upon the total reduction of 14 beds this would equate to £720,000 of the current £1,100,000 running costs for Cauldshiels ward. The investment will be required for:

CHAT – Providing permanent funding replacing the 2 years temporary funding from the ICF (50%). The remaining 50% funding has been identified from the re allocation of existing resources – Re investment £240,000

5 x additional specialist care home beds – Re investment £ 338,000 (based upon £1,300pw bed price)

1 x additional social worker – Re investment £45,000

**Final Steps to Consolidate Benefits and deliver financial improvements**

Cease new admissions to Cauldshiels
Undertaken implementation plan
Confirm community services operational

**Risk Assessment**

| | | | | | |
|---|---|---|---|---|---|
| **Y** | **Required? Y/N** yes | | **If No provide reason** | | |
| **Y** | **Completed** | | **Fully Authorised** | **Max Risk** | **8** |

**Any other Potential Risks / Impacts**

*Using Risk Assessment Template*

## KEY PROJECT STAGES (shade)

| | A | M | J | J | A | S | O | N | D | J | F | M | A |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Project Initiation & Planning | | | | | | | | | | | | | |
| Project Development | | | | | | | | | | | | | |
| Project Implementation | | | | | | | | | | | | | |
| Project Control | | | | | | | | | | | | | |
| Project Closure | | | | | | | | | | | | | |

## FORECAST BENEFITS

| | | A | M | J | J | A | S | O | N | D | J | F | M | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **000s** | ***2019-20*** | | | 11 | 11 | 11 | *25* | *25* | *25* | *25* | *40* | *40* | *40* | *252* |
| **000s** | ***2020-21*** | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | *479* |
| | | A | M | J | J | A | S | O | N | D | J | F | M | Ave.Total |
| **WTEs** | ***2019-20*** | | | 4.31 | 4.31 | 4.31 | 4.31 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | *6.94* |
| **WTEs** | ***2020-21*** | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | 11.00 | *11.00* |

| **Benefit £K** | % |
|---|---|
| **Pay** | **100** |
| **Non Pay** | |
| **Income** | |

| **Scot Gov Analysis £** | £000s |
|---|---|
| **Service Redesign** | **480** |
| **Workforce** | |
| **Procurement** | |
| **Infrastructure** | |
| **Other** | |
| **Financial Manage/ Corp** | |
| **Drugs & Prescribing** | |

**Mandatory Completion**

| **Scheme Type** | **Recurring £K** | **Non Rec £K** |
|---|---|---|
| **FIP** | 480.00 | |
| **Cost Containment** | | |
| | | |

## PROJECT MANDATE APPROVAL

| | |
|---|---|
| **APPROVED BY FINANCE MANAGER:** | **DATE:** |
| **APPROVED BY EXECUTIVE DIRECTOR:** | **DATE:** |
| **APPROVED BY PMO MANAGER:** | **DATE:** |

**Prepared by:**
Phillip Lunts/Holly Hamilton-Glover/Bill Urquhart

**Sponsored by:**
Phillip Lunts

**Date: July 2019**

# Cauldshiels and Melburn Lodge Bed and Capacity Model
# Summary of findings

## Summary

An Alzheimer Scotland and Scottish Government national report identified that too many people with dementia were being cared for in hospital beds and recommended reduction of inpatient beds and development of alternatives. NHS Borders currently has

- Cauldshiels Dementia Assessment Unit – 14 beds
- Melburn Lodge Dementia continuing care facility – 12 beds

The national report recommended NHS Borders should have 15 beds.

A project to develop alternative models of care has been established and is based on:

1. Establishment of a support team for Community Hospitals and Care Homes (CHAT team)
2. Provision of 5 additional specialist dementia beds

A modelling exercise was commissioned to assess the impact of these changes on numbers of inpatient beds required and the resource requirements for the alternative services.

The outputs of the modelling exercise indicate the following;

- The current admissions and discharges are in balance
- Demand for beds since January 2019 has reduced to a steady requirement of 14-16 beds
- The impact of CHAT team will reduce this requirement by 5.6 beds
- The additional specialist dementia care home beds will reduce this requirement by 5 beds
- Therefore, residual inpatients beds required are 5 beds

## Methodology

The model has been developed based on the following:

1. Review of Cauldshiels and Melburn Lodge activity data for the last 3 years. During this period, the services moved from capturing data on EPEX to TrakCare. Most analysis was carried out on EPEX dataset as it was the largest data run (2 years). A sample analysis of TrakCare data showed similar activity data to the EPEX data, so confirmed this approach was valid. Data on Delayed Discharges was taken from TrakCare as EPEX did not record this data in a robust manner.

2. Development of a predictor model for future bed requirements. The model was based on activity and percentage split of admissions and discharges by source and allows these numbers to be adjusted according to predicted future admission levels and length of stay. Assumptions on the impact of the proposed new service model were provided by Dr Lucy Calvert, Consultant Psychiatrist for Older People and Irene Thomson, Service Manager and reviewed by Peter Lerpiniere, Associate Director of Nursing, Lisa Clark, Clinical Nurse Manager and Christine Proudfoot, Dementia Nurse Consultant.

3. Development of predicted resource requirements for alternative care models. Only limited work on this aspect of model has been undertaken, based on advice from clinicians and managers. Further work can be carried out once the output of the current model has been reviewed.

**Analysis**

Detailed data tables are attached as appendices. The bed model based on current assumptions is also included.

The summary of findings is as follows:

Review of Cauldshiels and Melburn Lodge activity data for the last 3 years.

1. The current system is in balance:
   - Numbers of patients within Cauldshiels and Melburn Lodge have been relatively stable over the past 3 years (up to January 2019), with an average of 11 patients in Cauldshiels and 10 in Melburn Lodge
   - The average occupancy in Cauldshiels is around 80%, indicating that there is not a waiting list of patients for Cauldshiels (otherwise occupancy would be closer to 100%)
   - The average admissions to Cauldshiels are 4 per month. Discharges are also 4 per month
   - There is some flow between Cauldshiels and Lindean (Elderly Functionally Mentally Ill facility) representing overflow when the ward is full. However, the clinical view was that there was similar overflow from Lindean to Cauldshiels and these two cancelled each other out
   - There is a predicted increase in demand, based on demographic data adjusted for age and sex, of 1 additional admission per year each year until 2022.

2. There has been a reduction of around 8 patients across Cauldshiels and Melburn Lodge since January 2019. (Average 23 beds (previous 3 years) falling to approximately 15 beds to date (14 on 19th July)). Professional advice indicates that this is related to the purchase of 7 Specialist Dementia beds opening in Dec 2018/Jan 2019 and some improvements in social care and social work support. Given that the data suggests a steady state, this occupancy is unlikely to change (i.e. increase) unless there are system changes.

3. Admissions to Cauldshiels split into three groups
   - Approximately 40% from home – (27% direct, 12% BGH (BGH admissions are assumed to be 50% home and 50% care home))
   - 40% from care/nursing homes (including above assumptions around source of BGH admissions)
   - Remainder from other sources
   - All Melburn Lodge admissions come from Cauldshiels

4. Current discharge pattern is
   - 50% discharged to care homes
   - 7% discharged home
   - 11% died
   - 16% transferred to Melburn Lodge

5. The split between types of care homes is difficult to calculate but estimated to be;
   - 74% to ‘specialist’ dementia homes (this includes Knowe South, Riverside etc)
   - 24% to care homes

6. 50% of patients in Cauldshiels stayed for less than 60 days and 66% for less than 90 days. Melburn length of stay is not reliably calculable due to the small numbers and very long lengths of stay.

Development of a predictor model for future bed requirements

1. The CHAT team is assumed to achieve the following;
    a. No impact on admissions from home
    b. Reducing admissions from care and nursing homes by 50%
    c. Reducing admissions for physical presentations at BGH (e.g. fractured NOF) by 50% due to improved support and education within care homes
    d. Reducing length of stay for patient discharged to care homes by 20%
    e. Reducing occupied beddays for patients who die by 50% (better support for care homes would reduce admissions of patients in terminal stages by 50%)

There would also be a 50% reduction in length of wait for Melburn Lodge beds because the two units will be combined (assumes 50% of wait was delay to access Melburn bed).

2. Modelling indicates that, based on these assumptions, the CHAT team will reduce demand for hospital beds by 2059 occupied beddays (OBDs) or the equivalent of 5.6 beds (1318 OBDs/ 3.6 beds through admission avoidance and 741 OBDs/2 beds through reduced length of stay)
3. There has been no modelling of the potential impact of the team on the level of care home required. However, professional judgement indicates that more patients could be supported in non-specialist care and nursing homes and even in residential homes.

Development of predicted resource requirements for alternative care models

1. Modelling of demand and capacity required for the new CHAT team has not been undertaken as yet. As the team has not yet commenced, the level of resource required is not fully known. At the moment, the CHAT team establishment is based on professional judgement regarding the level of staffing required to maintain a sustainable locality based model.

2. A separate modelling exercise has been undertaken to determine the demand and turnover within specialist dementia care home beds. Further work is required to firm up assumptions around likely numbers of patients requiring specialist dementia beds.

Bed Modelling summary

The bed model as outlined above indicates the following:

| | | Total expected bed requirements in Melburn Lodge |
|---|---|---|
| *Average occupancy Cauldshiels/Melburn Lodge to Jan 2019* | *21 patients* | *21 beds* |
| *Murray House beds open Jan 2019* | *7 patients* | *14 beds* |
| CHAT team | 5.6 patients | 9 beds |
| Additional specialist dementia beds to be opened | 5 patients | 4 beds |

## Appendices

- Admissions / Discharges
- Length of stay
- OBD 2017-18
- Age/Sex Mix and Population projections
- Pathways

Time period: Admissions between January 2015 to March 2018 (39 months)

### Admissions / Discharges

Cauldshiels

| Source of admission | BGH | BGH A&E | Care Home | Community Hospital | Home | Huntlyburn | Lindean | Melburn Lodge | Nursing Home | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| % of Admissions | 20 | 5 | 16 | 5 | 27 | 3 | 11 | 3 | 10 | 100 |
| Total admissions | 30 | 7 | 24 | 8 | 40 | 4 | 16 | 5 | 15 | 149 |
| Average per month | 0.77 | 0.18 | 0.62 | 0.21 | 1.03 | 0.10 | 0.41 | 0.13 | 0.38 | 3.82 |
| Min-Max | 0-2 | 0-2 | 0-5 | 0-1 | 0-4 | 0-3 | 0-2 | 0-2 | 0-3 | 0-9 |

Melburn Lodge

| Source of admission | Cauldshiels | Lindean | Nursing Home | Grand Total |
|---|---|---|---|---|
| % of Admissions | 93 | 4 | 4 | 100 |
| Total admissions | **25** | **1** | **1** | **27** |
| Average per month | 0.64 | 0.03 | 0.03 | 0.69 |
| Min-Max | 0-4 | 0-1 | 0-1 | 0-5 |

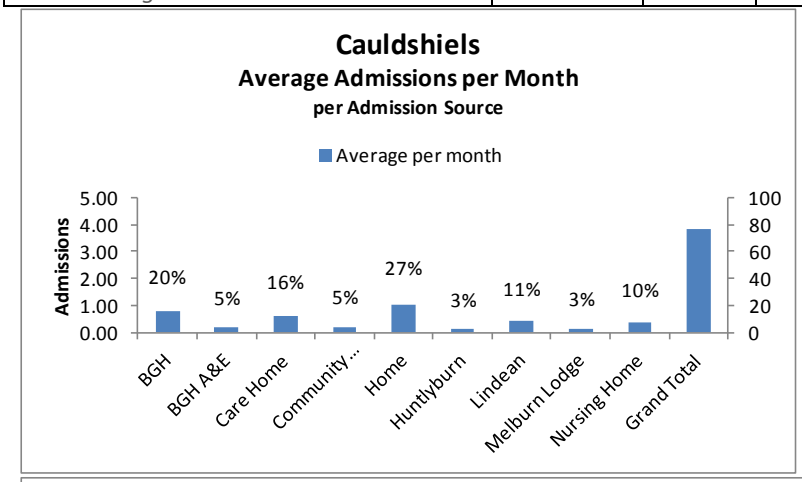
Discharge Destinations

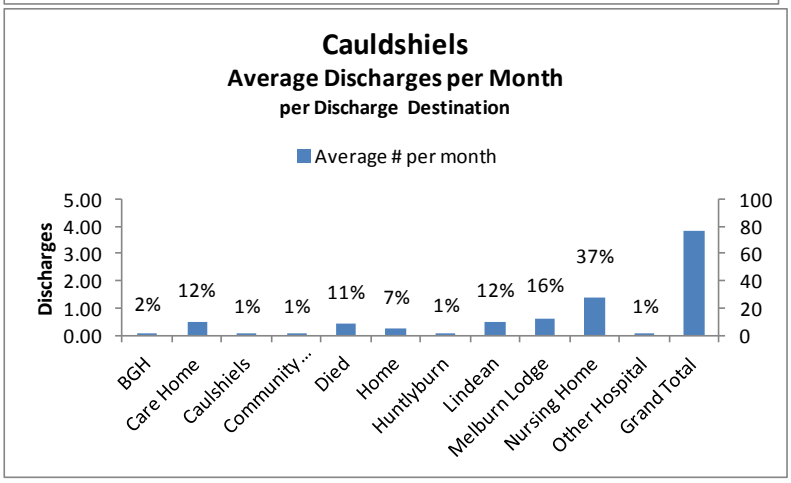
| **Destination** | **Patients** | **%** | **Average per month** |
|---|---|---|---|
| BGH | 3 | 2 | 0.08 |
| Care Home | 18 | 12 | 0.46 |
| Cauldshiels | 1 | 1 | 0.03 |
| Community Hospital | 1 | 1 | 0.03 |
| Died | 16 | 11 | 0.41 |
| Home | 10 | 7 | 0.26 |
| Huntlyburn | 2 | 1 | 0.05 |
| Lindean | 18 | 12 | 0.46 |
| Melburn Lodge | 24 | 16 | 0.62 |
| Nursing Home | 55 | 37 | 1.41 |
| Other Hospital | 1 | 1 | 0.03 |
| **Grand Total** | **149** | | 3.82 |

Melburn Lodge Discharge Destinations

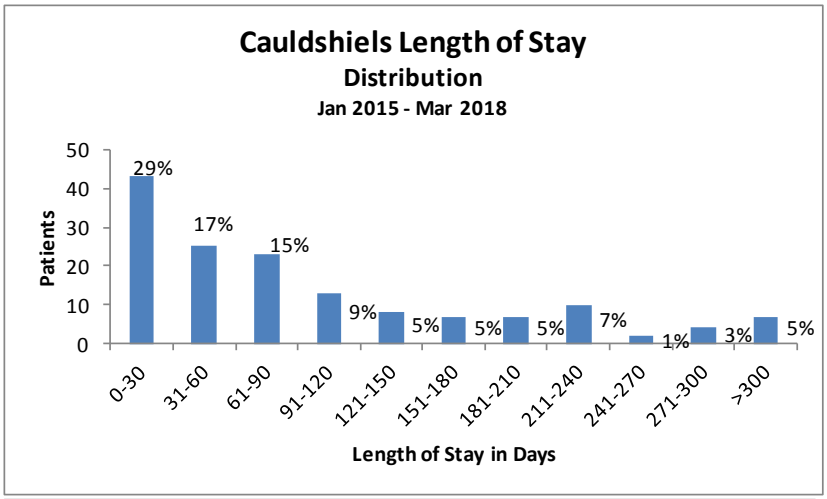
| **Destination** | **Patients** | **%** | **Average per month** |
|---|---|---|---|
| Care Home | 7 | 28 | 0.18 |
| Cauldshiels | 3 | 12 | 0.08 |
| Died | 11 | 44 | 0.28 |
| Home | 1 | 4 | 0.03 |
| Lindean | 2 | 8 | 0.05 |
| Nursing Home | 1 | 4 | 0.03 |

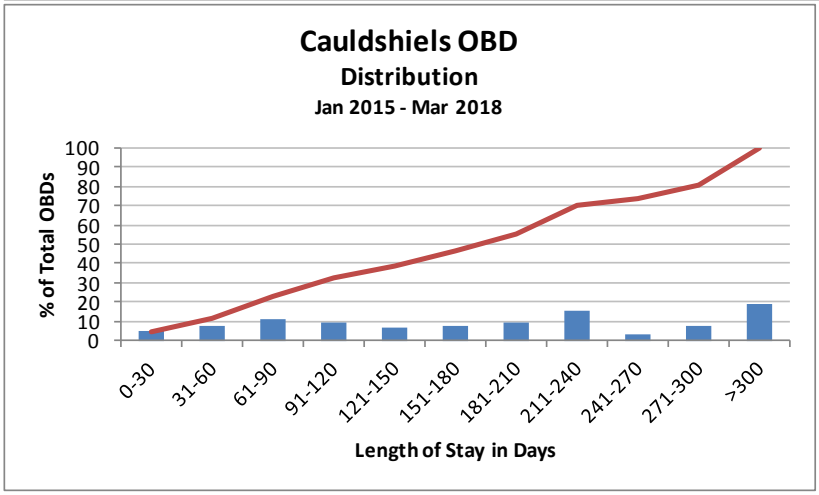
| | | | |
|---|---|---|---|
| **Grand Total** | **25** | | 0.64 |
| *Not discharged Yet* | *2* | | |




Length of Stay



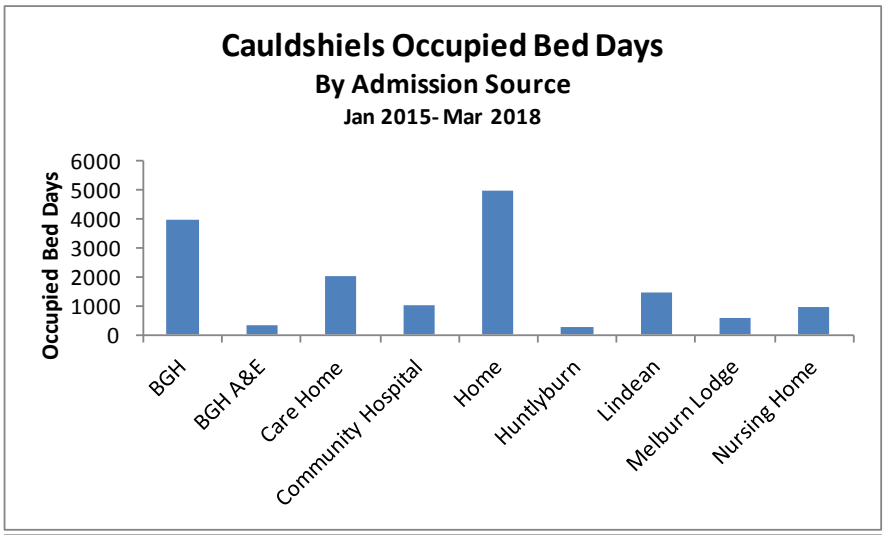



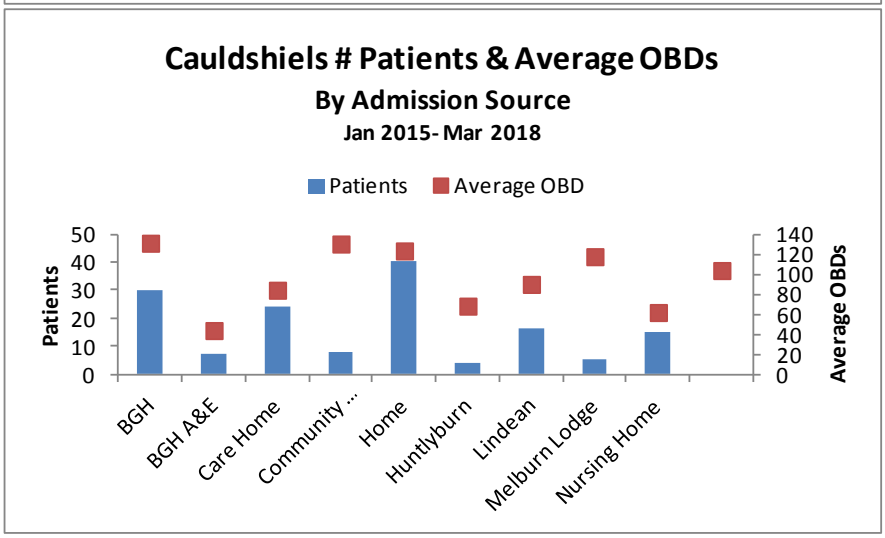

Cauldshiels Total Length of Stay by Admission Source (All 2015-2018 admissions)

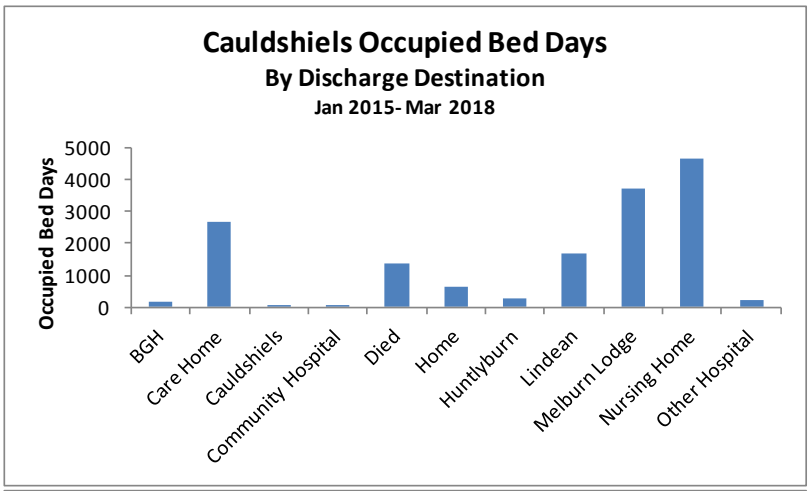
| LoS by Admission Group | Patients | OBDs | Average LoS |
|---|---|---|---|
| BGH | 30 | 3931 | 131 |
| BGH A&E | 7 | 307 | 44 |
| Care Home | 24 | 2019 | 84 |
| Community Hospital | 8 | 1042 | 130 |
| Home | 40 | 4934 | 123 |
| Huntlyburn | 4 | 273 | 68 |
| Lindean | 16 | 1439 | 90 |
| Melburn Lodge | 5 | 588 | 118 |
| Nursing Home | 15 | 928 | 62 |
| Grand Total | 149 | 15461 | 104 |

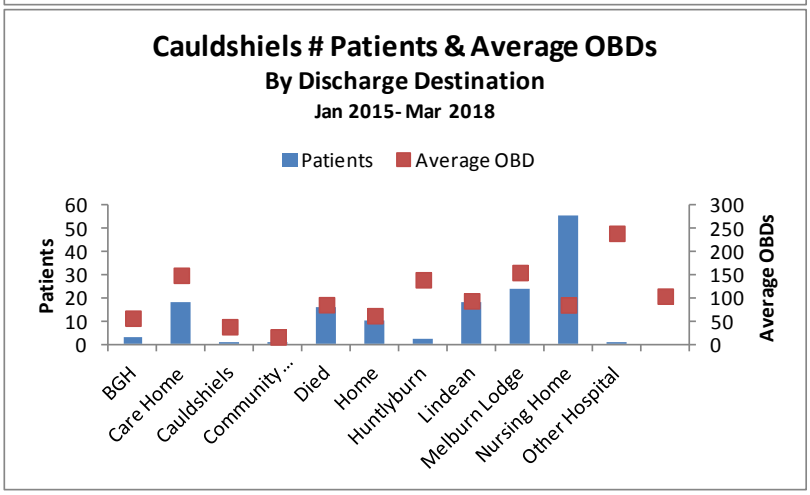
Cauldshiels Total Length of Stay by Discharge Destination (All 2015-2018 admissions)

| LoS by Discharge Group | Patients | OBDs | Average LoS |
|---|---|---|---|
| BGH | 3 | 169 | 56 |
| Care Home | 18 | 2676 | 149 |
| Cauldshiels | 1 | 38 | 38 |
| Community Hospital | 1 | 16 | 16 |
| Died | 16 | 1366 | 85 |
| Home | 10 | 617 | 62 |
| Huntlyburn | 2 | 278 | 139 |
| Lindean | 18 | 1686 | 94 |
| Melburn Lodge | 24 | 3710 | 155 |
| Nursing Home | 55 | 4666 | 85 |
| Other Hospital | 1 | 239 | 239 |
| Grand Total | 149 | 15461 | 104 |

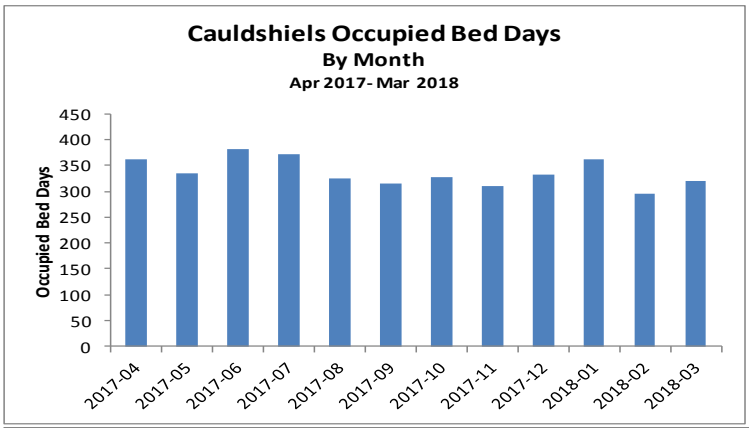


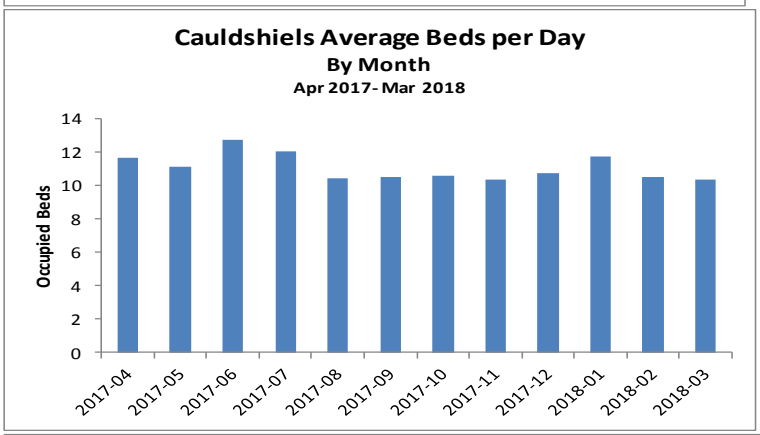



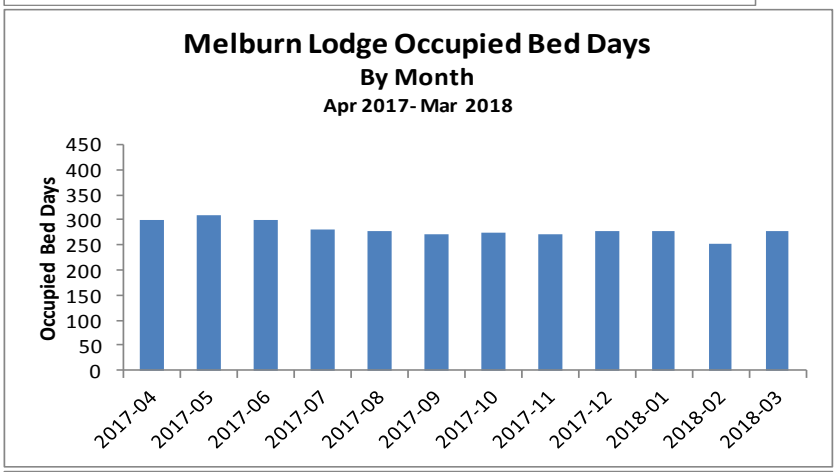


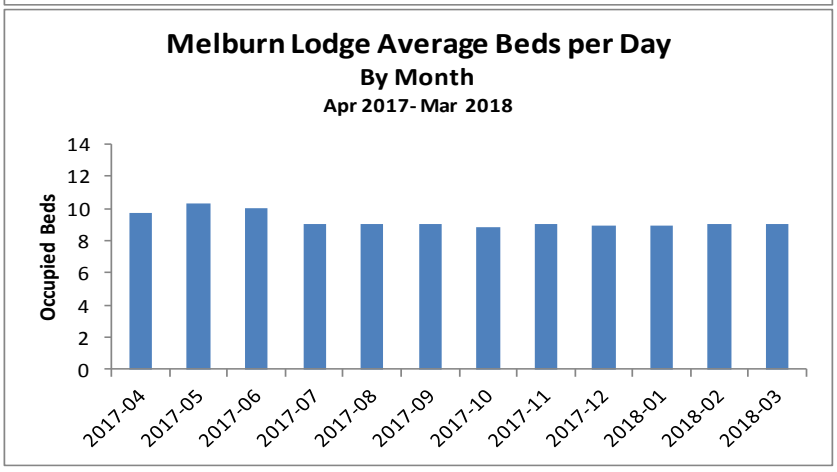




OBD 2017-18
Actual beds Occupied during each month




Age/Sex Mix and Population projections

Cauldshiels Age Group / LoS

| LoS<br>Age Group | 0-30 | 31-60 | 61-90 | 91-120 | 121-150 | 151-180 | 181-210 | 211-240 | 241-270 | 271-300 | >300 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Under 65** | 3 | 2 | | | 1 | | 1 | 1 | | | 1 | 9 |
| **65-74** | 5 | 2 | 3 | 3 | 2 | 1 | | 2 | | 1 | 4 | 23 |
| **75-84** | 25 | 14 | 12 | 8 | 1 | 4 | 5 | 3 | 1 | 2 | 2 | 77 |
| **85+** | 10 | 7 | 8 | 2 | 4 | 2 | 1 | 4 | 1 | 1 | | 40 |
| **Grand Total** | **43** | **25** | **23** | **13** | **8** | **7** | **7** | **10** | **2** | **4** | **7** | **149** |

Cauldshiels Age Group / LoS

| LoS<br>Age Group | 0-30 | 31-60 | 61-90 | 91-120 | 121-150 | 151-180 | 181-210 | 211-240 | 241-270 | 271-300 | >300 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | 25 | 14 | 11 | 4 | 4 | 5 | 4 | 3 | 0 | 0 | 1 | 71 |
| Female Under 65 | 3 | 1 | | | | | 1 | 1 | | | 1 | 7 |
| Female 65-74 | 3 | 1 | | | 1 | | | | | | | 5 |
| Female 75-84 | 12 | 9 | 7 | 3 | 1 | 3 | 2 | 1 | | | | 38 |
| Female 85+ | 7 | 3 | 4 | 1 | 2 | 2 | 1 | 1 | | | | 21 |
| Male | 18 | 11 | 12 | 9 | 4 | 2 | 3 | 7 | 2 | 4 | 6 | 78 |
| Male Under 65 | | 1 | | | 1 | | | | | | | 2 |
| Male 65-74 | 2 | 1 | 3 | 3 | 1 | 1 | | 2 | | 1 | 4 | 18 |
| Male 75-84 | 13 | 5 | 5 | 5 | | 1 | 3 | 2 | 1 | 2 | 2 | 39 |
| Male 85+ | 3 | 4 | 4 | 1 | 2 | | | 3 | 1 | 1 | | 19 |
| **Grand Total** | 43 | 25 | 23 | 13 | 8 | 7 | 7 | 10 | 2 | 4 | 7 | 149 |

Population Projections (based on Age / Gender Mix)

Patients Admitted

| | Population 2017 | Population 2018 | Population 2019 | Population 2020 | Population 2021 | Population 2030 | Population 2040 |
|---|---|---|---|---|---|---|---|
| **All Patients Admitted 2015-18** | 149 | 152 | 155 | 158 | 162 | 202 | 243 |
| **%increase on 2017** | 0 | 2 | 4 | 6 | 8 | 35 | 63 |
| **Average per year** | 46 | 47 | 48 | 49 | 50 | 62 | 75 |

Projected Average Beds per day

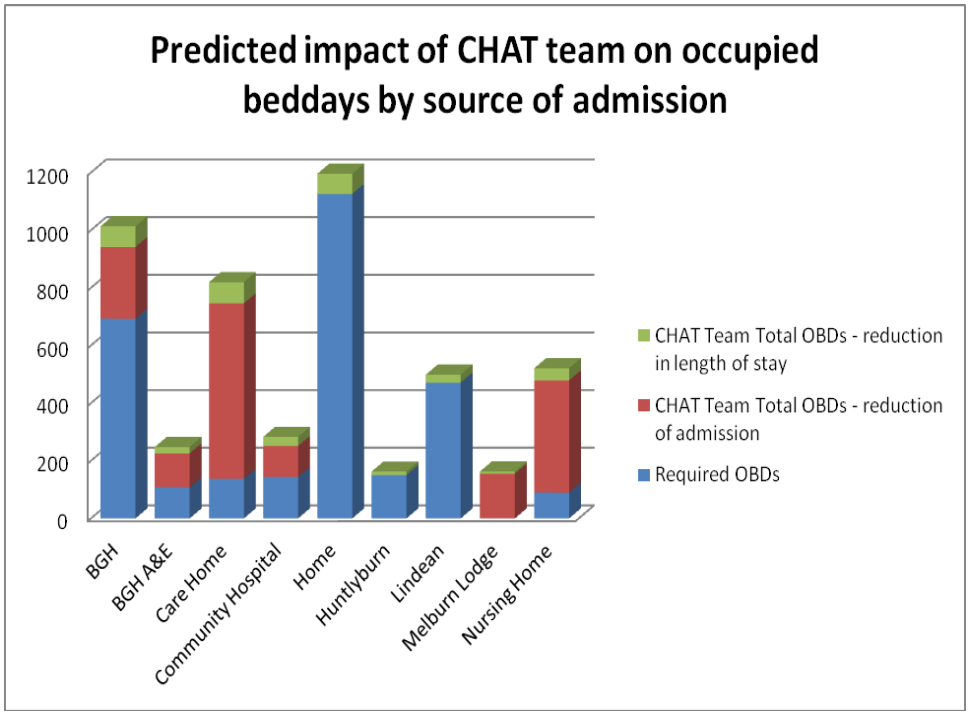
| | Population 2017 | Population 2018 | Population 2019 | Population 2020 | Population 2021 | Population 2030 | Population 2040 |
|---|---|---|---|---|---|---|---|
| **2017/18 OBD** | 4039 | 4115 | 4202 | 4273 | 4365 | 5403 | 6413 |
| **%increase on 2017** | 0 | 2 | 4 | 6 | 8 | 34 | 59 |
| **Beds per day** | 11 | 11 | 12 | 12 | 12 | 15 | 18 |

Pathways

Cauldshiels Top 13 Pathways by %

| Source | Destination | % |
|---|---|---|
| Home | Nursing Home | 11 |
| Care Home | Nursing Home | 7 |
| BGH | Care Home | 5 |
| BGH | Died | 5 |
| BGH | Nursing Home | 5 |
| Home | Lindean | 5 |
| Nursing Home | Nursing Home | 5 |
| BGH | Melburn Lodge | 3 |
| Care Home | Melburn Lodge | 3 |
| Home | Home | 3 |
| Home | Melburn Lodge | 3 |
| Lindean | Lindean | 3 |
| Lindean | Nursing Home | 3 |
| | | 61% |

Impact of Community Hospital and Care Home Team on occupied beddays (predicted)



9th August 2019 EMT Paper Dementia Services Redesign, Supporting Information

Breakdown of Investments and Savings

A net saving of £474,202 will be realised, in summary;

| | |
|---|---|
| Total Budget for Cauldshiels ward | £1,102,455 |
| Investment already in place (existing staff to be redeployed) | £210,426 |
| **Total Funding** | **£1,312,881** |
| Total estimated costs for New Care Home and Community Assessment Team (inclusive of 1 FTE Social Work post) | £500,679 |
| **Total Costs of New Provision** | **£500,679** |
| **Contingency** (previously identified for 5 specialist beds) | **£338,000** |
| **Total saving** | **£474,202** |

This can be broken down further;

| **Cauldshields Savings** | | **Recurring** | **Recurring (Excl MHOAT)** |
|---|---|---|---|
| Total Budget for Cauldshields Ward | | 1,102,455 | 1,102,455 |
| Total Budget for MHOAT staff | | 210,426 | |
| Total Funding | | 1,312,881 | 1,102,455 |
| Total estimated investment | | | |
| Staffing | 476,679 | | 266,253 |
| Travel | 24,000 | | 24,000 |
| | | 500,679 | 0 |
| Total Cost of new provision | | 500,679 | 290,253 |
| Contingency | 338,000 | 338,000 | 338,000 |
| **Total Saving** | | **474,202** | **474,202** |

The posts that will be transferring from the existing MHOAT are as follows;

0.2 WTE Team Manager – provided through current MHOAS management time (£11,510)
2 WTE B6 Nurses – these currently exist and within MHOAS costs (£92,928)
2 WTE B5 Nurses – vacant posts held within MHOAS (£63,492)
2.26 WTE B3 Nurses – vacant posts held within MHOAS (£42,496)

This accounts for the £210,426.

The additional staffing can be broken down as follows;

| | | Existing | New | Additional |
|---|---|---|---|---|
| The posts that MH were going to meet for the COT project are: | | | | |
| 0.20 WTE Team Manager - which will be provided through the current MHOAS management time | | 11,510 | 11,510 | 0 |
| 2.00 WTE Band 6 Nurses – these currently exist and I believe they are within the MHOAS cost centre | | 92,928 | 92,928 | 0 |
| 2.00 WTE Band 5 Nurses – these are the vacant B5 posts that had been getting held within MHOAS | | 63,492 | 126,984 | 63,492 |
| 2.26 WTE Band 3 Nurses – these are the vacant B3 posts that had been getting held within MHOAS | | 42,496 | 97,692 | 55,196 |
| | | 210,426 | 329,114 | 118,688 |
| | | | | |
| Social Worker | 1.00 | | | 45,000 |
| | | | | |
| **Indirect staffing** | | | | |
| Medical | 0.20 | | | 24,394 |
| Psychology | 1.00 | | | 58,205 |
| AHP | 0.50 | | | 19,966 |
| | | | | 102,565 |
| | | | | |
| TOTAL ADDITIONAL ESTIMATED COSTS | | | | 266,253 |
| | | | | |