Appendix 6a

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Andrew Williams, Director of Operations for the Fylde Coast Lancashire and South Cumbria NHS Foundation Trust
Date of meeting:	Thursday 16 November 2023

LIVING WITH DEMENTIA – LANCASHIRE & SOUTH CUMBRIA FOUNDATION TRUST

1.0 Purpose of the report

This paper has been written as a brief report for the Adult Social Care and Health Scrutiny Committee given an overview of Dementia Care. The range of services offered to support our population of older adults with cognitive impairment is outlined, along with performance metrics and improvement activity.

2.0 Older Adult Mental Health Services Access, Urgent Care and Community Mental Health Provision

2.1 Initial Response Service (IRS)

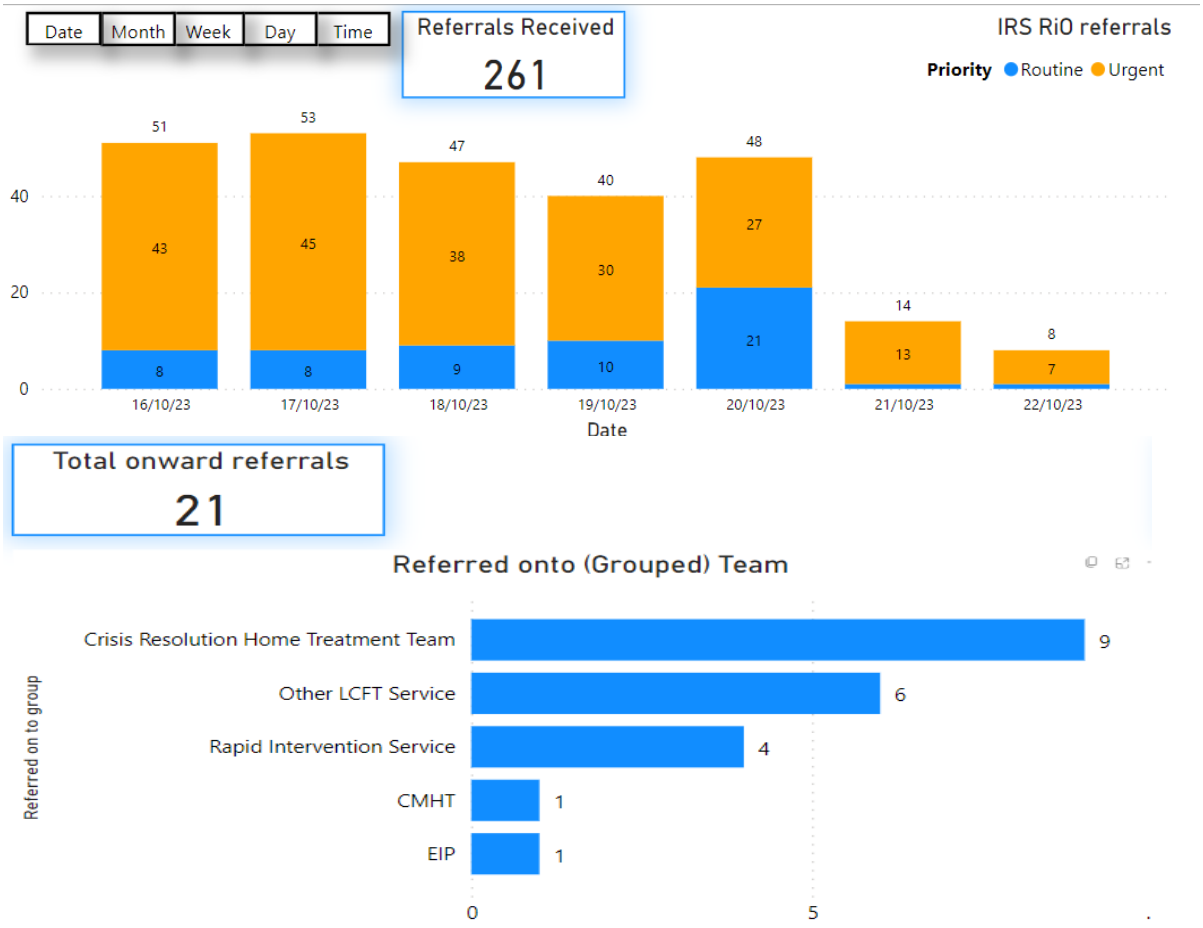
Residents from across Lancashire and South Cumbria who need to access mental health help and support is now able to do so via one number, 24 hours a day. The Fylde Coast Network IRS successfully launched in September 23.

The new approach to accessing mental health services is managed within a call centre setting and is made up of a team of Call Handlers and Mental Health Practitioners who take calls and manage referrals from patients, service users, families, carers and professionals, aiming to ensure callers are connected to the right professional in a timely manner.

The team may arrange for someone to receive support over the phone or for a mental health practitioner to see somebody at home, at a GP practice or another mutually agreed place to allow further information about current mental health needs. Information about other services that could assist are shared, if appropriate.

This new approach will help improve access to mental health services – particularly during evenings and weekends. Referrals for older adults and those with dementia can go through IRS which is available 24/7, this is in addition to other Health and Social Care professional's referral pathways.

Below shows an example of referral data into Fylde IRS.

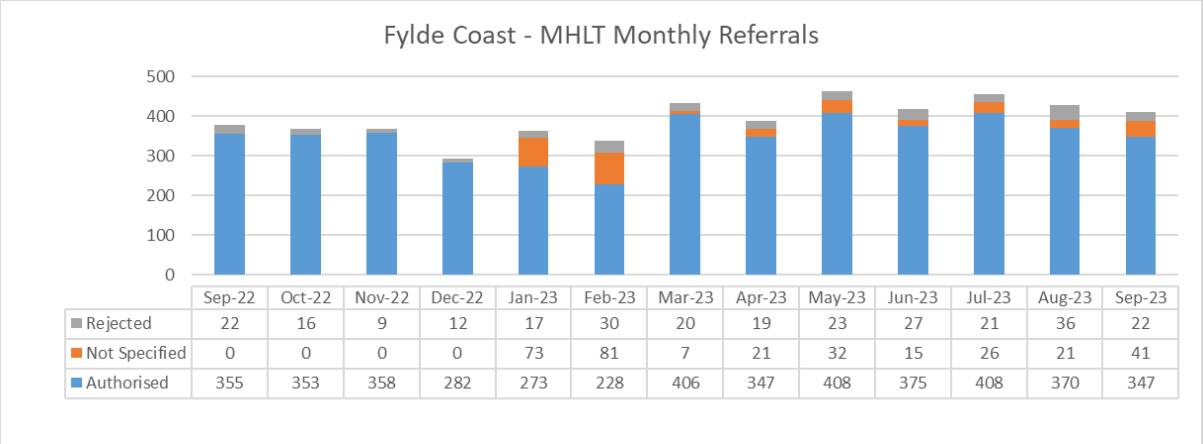


2.2 Mental Health Liaison Team (MHLT)

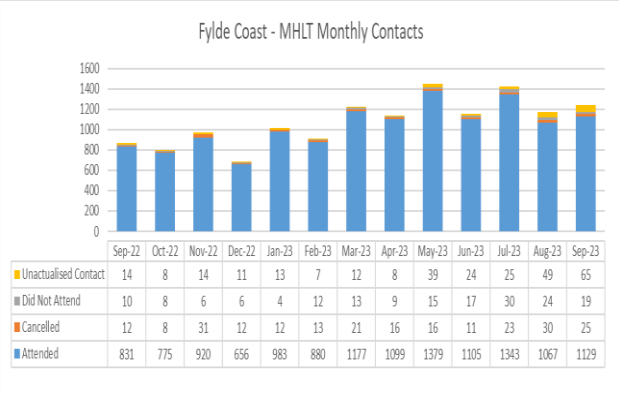
The mental health liaison team service provides a rapid mental health assessment service for individuals aged 16 and over who present to the accident and emergency department and medical assessment unit of the acute trusts. They also provide support to the medical wards at Blackpool Teaching Hospital where required.

There is a multidisciplinary team based at Blackpool Teaching Hospital led by 2 Consultant Old Age Psychiatrists based in the Liaison Team for the Fylde Coast.

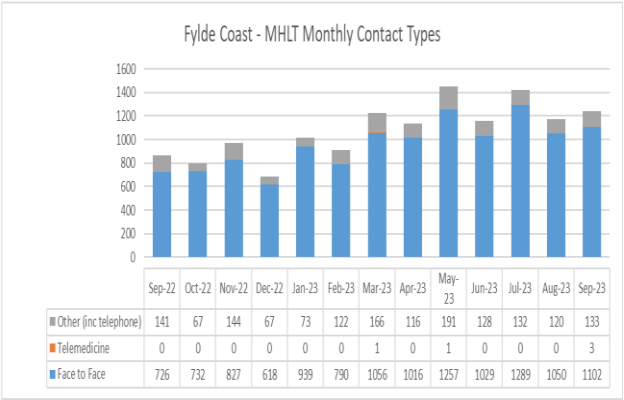
The team has high levels of activity and support patients waiting for admission to mental health wards.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Rejected	22	16	9	12	17	30	20	19	23	27	21	36	22
Not Specified	0	0	0	0	73	81	7	21	32	15	26	21	41
Authorised	355	353	358	282	273	228	406	347	408	375	408	370	347



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Unactualised Contact	14	8	14	11	13	7	12	8	39	24	25	49	65
Did Not Attend	10	8	6	6	4	12	13	9	15	17	30	24	19
Cancelled	12	8	31	12	12	13	21	16	16	11	23	30	25
Attended	831	775	920	656	983	880	1177	1099	1379	1105	1343	1067	1129



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Other (inc telephone)	141	67	144	67	73	122	166	116	191	128	132	120	133
Telemedicine	0	0	0	0	0	0	1	0	1	0	0	0	3
Face to Face	726	732	827	618	939	790	1056	1016	1257	1029	1289	1050	1102

Patients who are appropriate are transferred to the MHUAC (Mental Health Urgent Assessment Centre) where they can be supported while waiting for a bed or discharge to other services or home. Work continues to support improved provision the MHUAC with services that enable community alternatives to be explored for patients where appropriate.

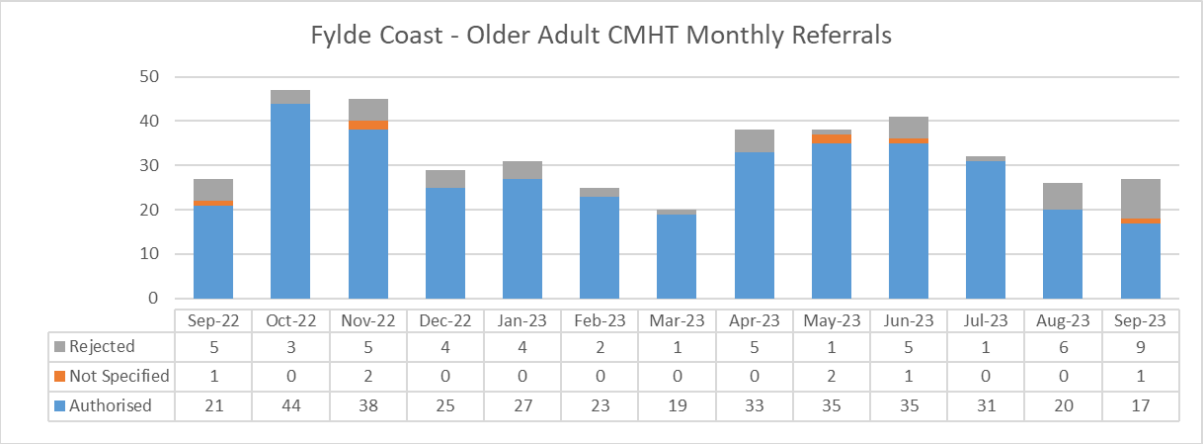
2.3 Community Mental Health Teams (CMHTs) for Older Adults

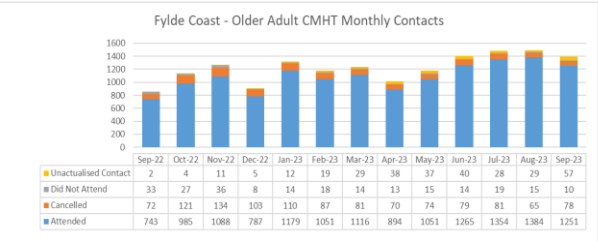
The Older Adult Community Mental Health Teams (OA CMHTs) supports people over the age of 65 with severe and enduring mental health needs, also for those under 65 with an early onset Dementia. They provide assessment, diagnosis, treatment, education and create individualised care planning.

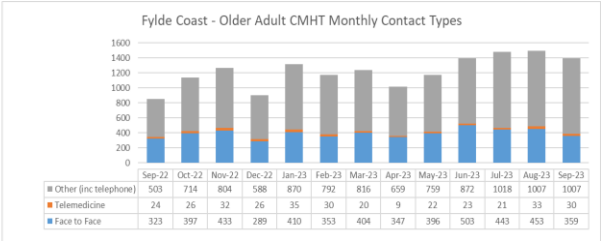
In the Fylde Coast Network, OA CMHTs are based in Shorelands based centrally in Blackpool.

There is good performance in Fylde Coast for the allocation of Care Co-ordinators for adults with some challenges at times due to staffing; no patient has waited more than 3 weeks for a care co-ordinator, whilst awaiting a named Care Co-ordinator they and their family or carers are supported by the Older Adult Duty team.

Ref	Indicator	Target Type	Target	Jul-23	Aug-23	Sep-23	Cumulative month to date *(Reported Every Thursday)*			
							12/10/23	19/10/23	26/10/23	02/11/23
CMHT										
CMH 7	**Number of Cases Waiting for Care Coordinator over 2 weeks in Adult CMHTs**	**Trust**	0	**0**	**0**	**0**	**0**	**0**	**0**	
CMH 47	**Number of Cases Waiting for Care Coordinator over 2 weeks in Older Adult CMHTs**	**Trust**	0	**4**	**2**	**0**	**0**	**3**	**1**	
CMH 8	**Legacy Care Programme Approach (CPA) - 12 Month Reviews (%)**	**Reference Indicator**		**62.0%**	**61.0%**	**60.0%**	**56.5%**	**57.5%**	**58.9%**	







There are high levels of phone contacts to regularly support service users at home and in care homes as well as face to face visits.

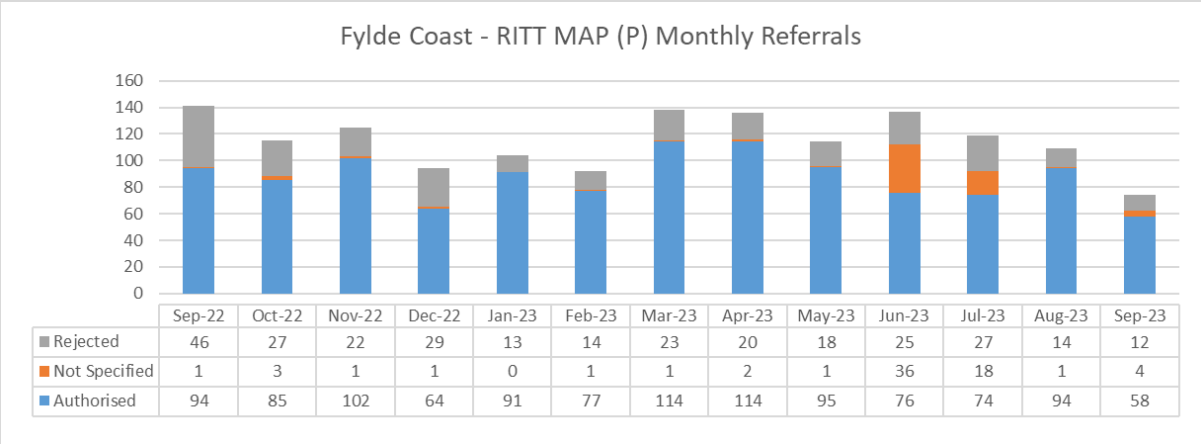
2.4 Rapid Intervention and Treatment Team (RITT)

This service has 2 key functions:

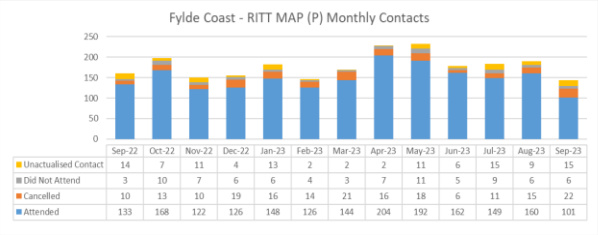
Home Treatment: The aim is to intensively improve a person's mental health within a 6-8 week period, at which point the team refer the patient on to another service for on-going care and support or discharge back to the GP.

The Care Home Liaison Team: This team supports care home staff improve care and support for residents with a diagnosis of dementia. The team aims to support the care home improve quality of life and manage behavioural and psychological symptoms of dementia whilst in the care home.

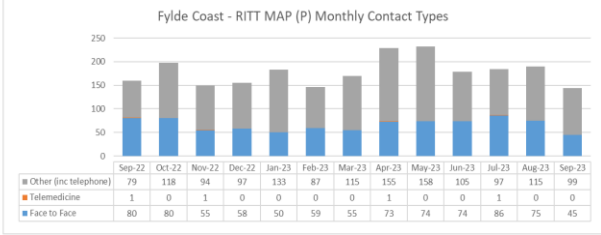
In the Fylde Coast Network, RITT is based at the Lytham Unit.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Rejected	46	27	22	29	13	14	23	20	18	25	27	14	12
Not Specified	1	3	1	1	0	1	1	2	1	36	18	1	4
Authorised	94	85	102	64	91	77	114	114	95	76	74	94	58



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Unactualised Contact	14	7	11	4	13	2	2	2	11	6	15	9	15
Did Not Attend	3	10	7	6	6	4	3	7	11	5	9	6	6
Cancelled	10	13	10	19	16	14	21	16	18	6	11	15	22
Attended	133	168	122	126	148	126	144	204	192	162	149	160	101



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Other (inc telephone)	79	118	94	97	133	87	115	155	158	105	97	115	99
Telemedicine	1	0	1	0	0	0	0	1	0	0	1	0	0
Face to Face	80	80	55	58	50	59	55	73	74	74	86	75	45

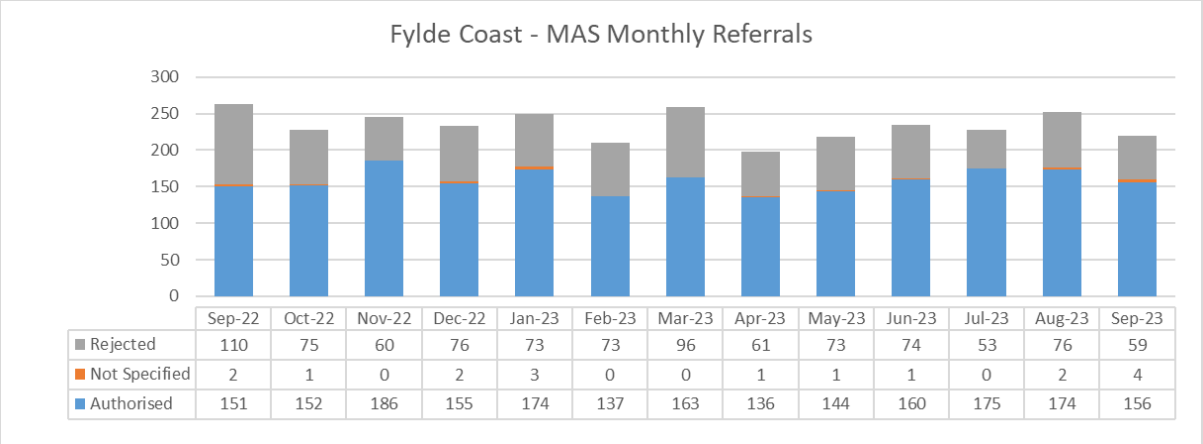
2.5 Memory Assessment Services (MAS)

Memory assessment services are located across Lancashire and aim to comprehensively assess patients who have cognitive impairment, who have been assessed as requiring specialist assessment, diagnosis and treatment.

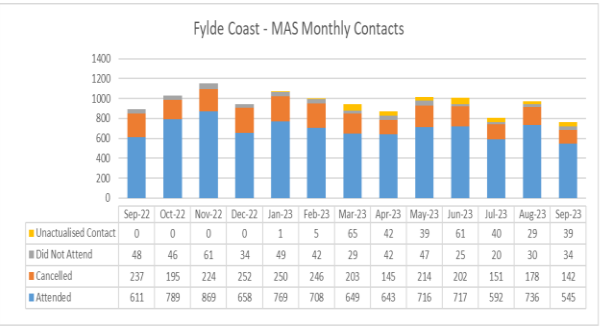
In the Fylde Coast Network, there are Memory Assessment Services (MAS) based in Fleetwood Health and Wellbeing Centre and Lytham Unit.

The teams are made up of nurses, doctors, occupational therapists and psychologists.

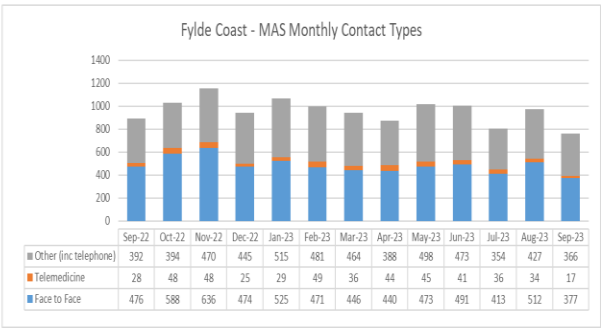
The service sees a high number of patients but consistently meets the Key Performance Target of 99% of patients having an assessment within 6 weeks and at least 20% of patients diagnosed within 6 weeks. The performance data is shown below.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Rejected	110	75	60	76	73	73	96	61	73	74	53	76	59
Not Specified	2	1	0	2	3	0	0	1	1	1	0	2	4
Authorised	151	152	186	155	174	137	163	136	144	160	175	174	156



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Unactualised Contact	0	0	0	0	1	5	65	42	39	61	40	29	39
Did Not Attend	48	46	61	34	49	42	29	42	47	25	20	30	34
Cancelled	237	195	224	252	250	246	203	145	214	202	151	178	142
Attended	611	789	869	658	769	708	649	643	716	717	592	736	545



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Other (inc telephone)	392	394	470	445	515	481	464	388	498	473	354	427	366
Telemedicine	28	48	48	25	29	49	36	44	45	41	36	34	17
Face to Face	476	588	636	474	525	471	446	440	473	491	413	512	377

Ref	Indicator	Target Type	Target	Jul-23	Aug-23	Sep-23	Cumulative month to date (Reported Every Thursday) 12/10/23	19/10/23	26/10/23	02/11/23
Memory Assessment Service (MAS)										
CMH 35	Memory Assessment Service (MAS) % Seen within 6 weeks (OA)	LTP	≥ 70%	98.8%	99.2%	98.7%	93.3%	95.0%	96.9%	
CMH 36	MAS 6 weeks from Referral to Diagnosis % (OA)	Reference Indicator		28.4%	37.4%	35.8%	16.7%	11.6%	10.8%	

2.6 Inpatient Hospital Provision

The Harbour is a 154-bed mental health hospital in Blackpool, which provides care and treatment for adults and older adults who cannot be safely treated at home. The ward team is multidisciplinary and includes a variety of mental health professionals. The hospital has single ensuite bedrooms of varying specialisms over 10 wards, 4 of which are dedicated to older adults:

- Austen: Female advanced care need ward (18 beds)
- Dickens: Male advanced care need ward (18 beds)
- Wordsworth: Male dementia ward (16 beds)
- Bronte: Female dementia ward (16 beds)

Ref	Indicator	Target Type	Target	Jul-23	Aug-23	Sep-23	Cumulative month to date *(Reported Every Thursday)*			
							12/10/23	19/10/23	26/10/23	02/11/23
Inpatient Care										
IP 6	**Median** Discharge LOS *(OA Functional)* *[Unit Locality]*	NHSBN	≤ 75	54	47	83	142	93	93	
	Mean Discharge LOS *(OA Functional)* *[Unit Locality]*		≤ 77	86	127	113	140	106	118	
	Median Discharge LOS *(OA Functional)* *[Patient Locality]*	NHSBN	≤ 75	14	250	83	174	174	215	
	Mean Discharge LOS *(OA Functional)* *[Patient Locality]*		≤ 77	14	245	107	174	174	215	
IP 7	**Median** Discharge LOS *(Dementia)* *[Unit Locality]*	NHSBN	≤ 76	129	206	103	84	84	140	
	Mean Discharge LOS *(Dementia)* *[Unit Locality]*		≤ 76	113	216	150	84	84	140	
	Median Discharge LOS *(Dementia)* *[Patient Locality]*	NHSBN	≤ 76	N/A	225	63	N/A	N/A	N/A	
	Mean Discharge LOS *(Dementia)* *[Patient Locality]*		≤ 76	N/A	225	63	N/A	N/A	N/A	

There are challenges with length of stay on older adult wards as many of the service users require specific placements or bespoke packages of care that can continue to meet their complex needs. However ongoing work continues with our Integrated Discharge Team (IDT) and Local Authority partners and through a weekly Clinically Ready for Discharge Meeting where barriers to discharge can be addressed and plans progressed.

2.7 Improvement and Innovation

The two Dementia wards at the Harbour, Bronte and Wordsworth, have worked hard in striving to succeed in achieving 'Dementia Charter' status and creating that Dementia friendly environment for our patients. We recognised as part of this journey that it was important for our staff to access training, so the majority of staff have now completed levels 1-3 of the Dementia Core Training Framework which was recommended and we continue this for all new starters. Also our trainee Advanced Clinical Practitioners (ACPs) have delivered a session on Dementia, Delirium and Depression which recognises the symptoms, presentation and challenges and supports staff to overcome those barriers through increased education and awareness.

An aspect of our commitment is working on our physical environments and we have accessed Dementia appropriate equipment that prompts senses and reminiscence for patients, such as REM pods and sensory groups for patients and created sensory rooms for both wards. We have attended community Dementia cafés and hope in the next 12 months to have one set up within our hospital as it is recognised that our patients, carers and families travel at times to access our wards, due to the geography of LSCft. Ensuring our wards look and feel homely, with specific signage, information boards and different rooms for people to engage in activities.

Embedding the 'Triangle of Care' work across the both wards has been a big focus for us over the past 6-12 months. Ensuring that patients and carers have a voice from the beginning by collecting feedback, revising our patient welcome books in line with dementia research and also sending out carers packs and letters on admission have supported us to get communication lines open from the day of admission.

To support our patients, we have worked hard on recruitment and liaising with our volunteer services to obtain 'dining buddies' for both wards to support patients at times that can be challenging when in hospital. In addition, we now have people with lived experience supporting interviews for our wards and within our teams as peer support workers.

Physical health care, especially falls management is a large aspect of our patient safety improvement agenda within our inpatient setting. Research shows that taking someone out of their environment can be a trigger for physical decline and due to the nature of their illness and cognitive decline, falls can be common.

Bronte and Wordsworth have committed to the 'trust wide falls reduction improvement collaborative' over the past 2 years and have developed and trialed some great initiatives as tests of change which has resulted in fewer falls and importantly lower harm. Some of the main initiatives we are proud of are the 'slippers store', 'postural hypertension', 'oxevision' and 'exercise and movement' groups.

Following our working with other professionals, especially physiotherapists, we found footwear typically unsuitable and now offer a service in which if appropriate footwear cannot be accessed, we complete a referral form and a pair of slippers can be provided to a patient until a permanent solution can be sourced. This gives patients stable and suitable footwear to use from admission.

Staff education around what causes postural hypertension and how they can support patients with this diagnosis has helped earlier detection and confidence of staff to carry out this assessment at the earliest opportunity. By creating a support tool that is attached to our physical observation equipment for guide and reference for both patients and staff carrying out the task, this is now used trust wide.

It was recognised that a proportion of our patients can have weakness or problems with muscle strength due to various different reasons, so increasing movement before meal times and at regular intervals in the day, increases their strength.

Oxevision has been installed in our wards since June 2023, after carefully planning, education and a Standard Operating Procedure being created. This system now gives up the knowledge and extra information from our patients to understand what occurs before and after those falls for patients that otherwise would be unwitnessed. With this

information, we are able to better create risk assessments to reduce patient falls and promote things such as sleep hygiene and basic but vital physical observations of patients that otherwise would not engage.

An opportunity for improvement within older adults has been our engagement with the Royal College of Psychiatrists Quality Network for Older Adults Mental Health Services (QNOAMHS). We have attended their annual function, had the opportunity to network with people of different services across the country and build a bigger resource and support network to bring back ideas for our own wards and share good practice. Through this, the Matrons have been asked to join as panel members and to assess and support others services alike.

Following our Care Quality Commission (CQC) self-assessments, QNOAMHS standards and our own ward improvement plans, both wards achieved 'Gold' in our service accreditation assessment and are striving for 'platinum' status.

Does the information submitted include any exempt information? No

3.0 Conclusion

3.1 This paper gives an overview of older adult service including dementia services within the Fylde Coast Network in LSCft and demonstrates the range of person centred services along with new improvements and innovation and current performance data. Areas of strengths are clear through the report in addition to challenges, which we are addressing with system partners.

3.2 Is the recommendation contrary to a plan or strategy approved by the Council? No