Report to: Coventry HOSC 5 February 2014

Title of paper: Dementia Diagnosis Pathway

1. Purpose of Report

To provide an outline and structure of the proposed Dementia Diagnosis Pathway for older adults across Coventry and Warwickshire.

2. Current

The current services for Older Adults in Secondary Care Mental Health Services across Coventry and Warwickshire have quite different landscapes. There are a range of services which do not offer equal access for service users or carers. Community Services are currently delivered within five traditional CMHT Older Adult Teams across localities.

Historical arrangements with predecessor organisations have seen the delivery in the community of a number of specialist teams. These teams have developed on an ad hoc basis across the Trust in response to specific demands in localities. Due to their small size, these teams can be isolated from the larger Community Mental Health Teams in their localities and there is an inconsistent approach to a more co-ordinated multi-disciplinary way of working.

Currently we have a diagnostic dementia pathway which is predominately delivered by MAC nurses with support from other professionals. However not all cases go through Shared Care, as it is not well established in some areas. Post diagnosis support is sporadic, inconsistent and varies according to who delivers the service and how long this is delivered for. This service is not open access. Memory clinics are provided across the localities with different arrangements, professional skill mix, criteria and a variance in waiting times

Presently, there is no dedicated Crisis Resolution/Home Treatment Teams for Older Adults to provide a 24/7 Crisis Home Treatment to service users or carers with an organic or functional illness. Current services try to support people in Crisis without dedicated resources.

3. Future

Across CWPT it is proposed that services will become Age Independent offering an equitable provision of specialist assessment and treatment for organic and functional service users and carers. The Trust is developing a range of pathways across Coventry and Warwickshire, and this is one specifically for those with a diagnosis of Dementia. It is recognised that as there is an increase in more appropriate community and home treatment services there will be less dependence on in-patient bedded facilities; this will allow the Trust to deliver services closer to peoples' homes whilst having the flexibility to meet the demand of this service user group and their carers.

In the future, there will be one Single Point of Entry (SPE), which will be the initial point of contact for services, ensuring patients and carers receive the right treatment, intervention and service to be delivered by the right person who has the skills and expertise. This is one of the enablers to the success of the Transformation Programme along with the Trusted Assessment for all SCMH. This service will triage the referral and ensure the assessment is booked into the specialist Community Integrated Practice Unit (IPU) 18-21 service for a trusted assessment to take place. This assessment will be jointly agreed with the service user and their carer if appropriate, it will be undertaken in a way that will seek to enable and facilitate engagement, i.e., transport will be arranged/confirmed and any other such enabling services that can be provided to assist.

Community Age Independent Organic Integrated Practice Unit 18-21 (IPU's)

The Organic Community IPU 18-21 will be based in Community Resource Centres (Hubs) across Coventry and Warwickshire and a range of community based venues (spokes). This IPU is configured to deliver explicit outcomes and support the needs of service users and their carers whilst in a non-acute phase of their illness. This service will operate 9am - 5pm Monday to Friday and will be based on service user/carer need and therefore may need to sometimes operate between the hours of 8am-8pm.Outside of these hours' service users and carers will be supported by the Crisis Response and Home Treatment Team.

Within this IPU 18-21 there will be a diagnosis pathway for Dementia as set out below (Diagram 1).This will consist of services which will provide Assessment, timely Diagnosis, Treatment and Post Diagnosis Support and Monitoring of Medication for service users with Dementia and their carer. This will guarantee services are wrapped around the service user meeting their individual needs whilst ensuring a seamless service. The service has been developed in a way that ensures diagnosis, treatment and support will be timely and equitable across Coventry and Warwickshire.

Service users and carers will be signposted and supported via their plan of care for future decision making. Rapid re-entry will be available through Single Point of Entry (SPE) or via the monitoring service. The clinician giving the diagnosis will offer a range of post diagnosis support to both service user and carer, provide information and advice specifically for families and carers, including what to do and who to contact , especially if their condition deteriorates or a crisis happens

The pathway also reflects the needs of those with a diagnosis of Dementia that require specialist advice or treatment within the community (home treatment), also an assessment to meet individual needs via Social Care

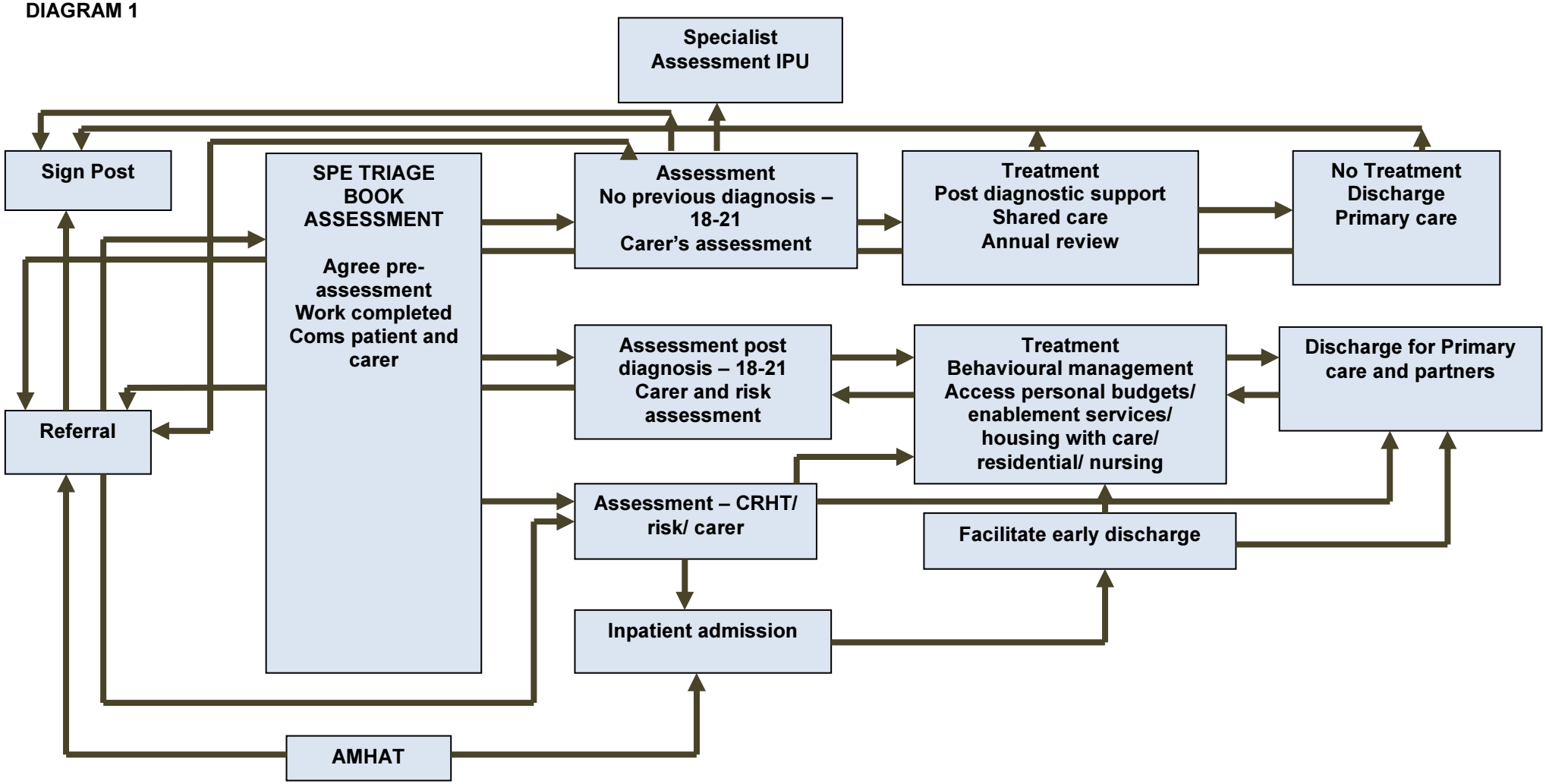
based on FACs (Fair Access to Care) criteria and will act as a conduit to acute services i.e., crisis teams and in-patient facilities.

Post Diagnostic Service

This will be delivered in community settings across Coventry and Warwickshire to support service users and their carers on an individual or group basis. This will be on a rolling programme across the Trust and will consist of a 6-8 week programme for both clients/carers/families. Referrals will be taken from CWPT Dementia IPU 18-21. The service will be tailored to individual needs, which will be offered in collaboration with the Third Sector, either at the time of diagnosis or a point during the six months post diagnosis period.

The aim of the programme will be to offer advice, support from a health perspective to both service user and carer and what they can expect as their condition progresses. They will provide information about other services that are available and how to access them. Those not wishing to take up the offer of post diagnosis support will be discharged with written details of the diagnosis and services available. Approximately three months following diagnosis contact will be made with the service user and carer to offer post diagnostic support if suitable at this time.

DIAGRAM 1


Specialist Assessment IPU
Sign Post
SPE TRIAGE BOOK ASSESSMENT
Agree pre-assessment Work completed Coms patient and carer
Assessment No previous diagnosis – 18-21 Carer's assessment
Treatment Post diagnostic support Shared care Annual review
No Treatment Discharge Primary care
Assessment post diagnosis – 18-21 Carer and risk assessment
Treatment Behavioural management Access personal budgets/ enablement services/ housing with care/ residential/ nursing
Discharge for Primary care and partners
Referral
Assessment – CRHT/ risk/ carer
Facilitate early discharge
Inpatient admission
AMHAT