Wessex Clinical Senate Council

Report on the Dorset Dementia Services Review

1. EXECUTIVE SUMMARY

The Wessex Clinical Senate Council was asked to review Dorset Commissioning Group's plans for dementia services as described in their Outline Strategic Case which serves as a Pre-Consultation Business Case (PCBC), prior to the Stage 2 NHS England (NHSE) Assurance Process. The review has been carried out with the assistance of an External Review Team which reported to the Clinical Senate Council.

The Clinical Senate Council commended the External Review Team for the comprehensiveness and clarity of their review. It noted that Dorset's preferred option is intended to offer a much more holistic and expanded service which is NICE compliant and cost effective by proposing a revised diagnostic model, additional community-based resources including new 'Dementia Co-ordinators' and the formal commissioning of services into the West which have previously only been commissioned in the East of the county.

The Clinical Senate Council noted that there had been less co-production with the local authorities than was both desirable and necessary, although their support was noted. It also suggested that the Clinical Commissioning Group (CCG) illustrate their plans with the use of patient journeys as would be experienced before and after the plans are implemented. It identified risks associated with the plans and made suggestions as to how they could be mitigated where possible, in particular:

- The permanent closure of beds in Weymouth and Blandford could impact disproportionately on rural populations. The CCG should evaluate the extent of the impact on patients and carers and how it will be mitigated.
- Contingencies need to be built into the PCBC up to the present national (CFAS II)

figure for Dorset at 13,102 people with dementia, in order to ensure that there is sufficient capacity if numbers of patients are higher than Dorset expects from its prevalence data. The Clinical Senate noted that the current prevalence data from Dorset had not been accepted by NHSE.

- People with dementia present across multiple health settings and the patient pathways are often complex. In this context, the Dementia Co-ordinator role is innovative and untested. The Clinical Senate Council advised that because of these factors, piloting and phased implementation would be advisable, with careful monitoring of early warning signs.

The Clinical Senate Council did not consider it acceptable to restrict the National Institute for Health and Care Excellence (NICE) recommended provision of Cognitive Stimulation Therapy to patients with a diagnosis of vascular dementia.

Subject to the issues identified in this report being addressed, the opinion of the Clinical Senate Council was that the tests for reconfiguration and bed closures could be met.

2. BACKGROUND TO THIS REPORT

2.1. The Role of the Clinical Senate in Assurance

NHSE has a role to support and assure the development of proposals and the case for change by commissioners. The principles of the assurance are that it should be robust, consistent and supportive. At the heart of the NHSE assurance process for service change are the government's four tests of service change and NHSE's test for proposed bed closures.

The Government's four tests of service change:

1. Strong public and patient engagement.
2. Consistency with current and prospective need for patient choice.
3. Clear, clinical evidence base.
4. Support for proposals from clinical commissioners.

The Bed Closure test requires that:

a. alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
b. specific new treatments or therapies will reduce specific categories of admissions; or
c. where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care.

2.2. The Dorset Clinical Commission Group Dementia Services Review

The Clinical Commissioning Group (CCG) launched the Dementia Services Review in 2014 which, after a short postponement, was re-convened in 2016. The vision of the review is to ensure people living with dementia and their families/carers will achieve similar outcomes, regardless of where they live in Dorset and to be enabled to live well with dementia, no matter what the stage of their illness or where they receive care.

The CCG and partners have produced a new model for dementia care which is presented within the Strategic Outline Case (SOC) which constitutes the Pre-Consultation Business Case (PCBC) required by NHSE. The management case highlights the project process followed and the proposal for implementing the new dementia care pathway.

The Dementia Services Review was enacted following concerns about the existing pathways of care, increasing demand for services, rising costs, an ageing population and national policy. The review project was co-designed with a wide variety of stakeholders and stage two and three were co-produced with a wide range of people including people living with dementia, their family carers, Dorset HealthCare NHS Foundation Trust, the three Local Authorities, Alzheimer's Society, other voluntary sector providers, acute hospital providers, care home sector and local councillors.

The PCBC makes the case for change and proposes a revised diagnostic model, additional community-based resources including new ‘Dementia Co-ordinators’ and the formal commissioning of services into the West which have previously only been commissioned in the East of the county. In particular, it is intended to expand the intensive support and treatment service within the community (previously known as Intermediate Care Service for Dementia), offer a crisis helpline and In-Reach Services. A revised model of care is also proposed with the day hospitals integrated with the Intensive Support Service as a means of reducing admissions.

The PCBC outlines the benefits and potential outcomes from this revised model of care. It includes a shortlisted selection of viable options which meet the agreed critical success factors and includes a recommendation for a preferred way forward.

The current provision of services for people with dementia includes community- based services which differ between East and West Dorset and an in-patient unit at Alderney Hospital Poole with a stated 40 beds. In addition, there is an ongoing temporary closure of 12 beds at the Betty Highwood Unit in Blandford Hospital since 2013 and in 2016 the Dorset Healthcare University NHS Foundation Trust closed 16 beds in the Chalbury Unit at Weymouth. Permanent closure of the beds on these two sites was part of the PCBC.

The preferred option is intended to offer a much more holistic and expanded service which is NICE compliant and cost effective. Neuropsychology is included within the diagnostic process and Cognitive Stimulation Therapy would be offered to those patients diagnosed with vascular dementia whom currently have no offer of treatment. Emotional Support Groups for carers are included alongside Dementia Co-ordinators and Early Onset Co-ordinators. Within this option, an In-Reach team would support the care homes, rather than Dementia Co-ordinators providing individual support to all residents. Two Day Hospitals are included in this option and both would be aligned to the Intensive Support service as an extra resource for those in a crisis situation and having complex needs. All of this aims to support efforts to prevent avoidable dementia specialist inpatient admissions, the ethos of providing care closer to home and less disruption and destabilisation for the patient with dementia and their family carers. A crisis helpline, intensive support service, in-reach into care homes and 40 specialist inpatient beds are also included.

2.3. The Review of the Dorset Dementia Services Pre-Consultation Business Case

At the Stage 1 assurance meeting, the Wessex Clinical Senate Council was asked by NHSE to conduct a "light touch", i.e. desk top review, of Dorset CCG's plans for dementia services as outlined in their PCBC, prior to the Stage 2 Assurance Process.

An External Review Team (Appendix A) was appointed in January 2019 drawn from appropriate professionals with knowledge or experience of dementia services to undertake the 'desk top' review, as agreed with NHSE and Dorset CCG. To facilitate the review, the Senate Chair and Manager, who have experience of reviews of service change, asked Dorset CCG some preliminary questions. These questions and the answers to them were sent to the External Review Team, along with a revised version of the PCBC and supplementary evidence.

Although the review was based on documentary evidence only, the review has been carried out in accordance with NHSE's assurance process for service change. This is set out in 'Planning, Assuring and Delivering Service Change for Patients' which was published by NHSE on 28th March 2018. This document provides guidance about the role of Clinical Senates in providing clinical advice to inform NHSE's service change assurance process and is available on the NHSE website: https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

The guidance states that: "where the clinical case for change is complex, commissioners may require an independent clinical review. For CCG led schemes this would most likely be through the clinical senate, although in some cases (for example, very specialist services) it may be appropriate to obtain a review from another independent source such as a royal society or clinical networks".

The External Review Team was appointed by the Clinical Senate Chair and Manager. The team members conducted a desktop review and their comments were summarised in a report which was sent to the CCG for fact-checking on 4th March 2019. Comments were received from the CCG, together with a revised PCBC, together with recalculated prevalence data and benchmarking, on 13th March 2019 and these were sent to Clinical Senate Council members who met on 14th March 2019 to consider their views on the report and the PCBC.

2.4. The Meeting of the Clinical Senate Council

The Clinical Senate Council met on 14th March 2019. The attendance is detailed in Appendix B. Two members of the review team (Aileen Murray-Gane and Christopher Kipps, a Clinical Senate Council member) were in attendance. The Dorset CCG Dementia Services Review Team delivered a presentation on their PCBC, including new data on the prevalence of dementia in Dorset (see below) and answered questions from the members of the Clinical Senate Council. The Senate Chair subsequently presented some key issues arising from the review in order to evoke the views of the Clinical Senate. The Clinical Senate Council then considered the report in a private session and directed the Chair and Senate Manger as to the drafting of its report. The draft was circulated to the members of the Clinical Senate Council for their comments prior to issuing of its advice.

3. THE CLINICAL SENATE COUNCIL VIEWS ON THE REPORT OF THE EXTERNAL REVIEW TEAM

3.1. The Clinical Senate Council’s approach to the report of the review team

NHSE has a role to support and assure the development of proposals and the case for change by commissioners. The principles of the assurance are that it should be robust, consistent and supportive. At the heart of the NHSE assurance process for service change are the government’s four tests of service change and NHSE’s test for proposed bed closures. The Clinical Senate Council reviewed the External Review Team’s report and assessed the advice provided under the headings of the four tests and the bed closure test as set out in ‘Planning, Assuring and Delivering Service Change for Patients’.

3.2. The comprehensiveness and applicability of the review.

The External Review Team members were complimented on the comprehensiveness and applicability of their review. The Clinical Senate Council noted that the review had been conducted in a timely manner within the short period allowed and that the issues highlighted were pertinent to the healthcare of Dorset people with dementia and to their carers.

3.3. The content and clarity of the review and its suitability to the population in question.

The report was clear in its analysis of the proposals and the associated risks. The review included a challenge as to the actual numbers of people living with dementia in Dorset, which may be an underestimate. The Clinical Senate Council also noted that the review demonstrated an awareness of the cultural and logistical issues arising from the rurality of the West Dorset population and the difficulty recruiting carers in rural areas. For these reasons, the Clinical Senate Council regarded the review as clear and appropriate to the population of Dorset.

3.4. The interpretation of the evidence available to support its recommendations.

The External Review Team members were complimented on their interpretation of the evidence, including some of that which was to be found in appendices to the PCBC. The reviewers had demonstrated clinical insight, an awareness of evidence from elsewhere and an understanding of the relevant best practice recommendations, including the recent NICE guidance [NICE guideline 97, Dementia: assessment, management and support for people living with dementia and their carers. Published 20 June 2018 https://www.nice.org.uk/guidance/ng97].

3.5. The likely impact on patient groups affected by the guidance.

The External Review Team had identified issues which may impact on the range of patients who constitute those with dementia, including those with different diagnoses, at different ages and at different stages of disease progression, as well as their carers.

3.6. The likely impact / ability of the health service to implement the recommendations.

The External Review Team identified, as a critical issue, the availability of a suitable workforce and questioned the role and capabilities of the Day and Community Hospitals. The Clinical Senate Council recognised the importance of these issues which are considered further in this report.

4. THE ADVICE OF THE CLINICAL SENATE COUNCIL TO NHSE FOR THE PURPOSES OF STAGE 2 ASSURANCE

4.1. Overview

The Clinical Senate Council welcomed the approach of Dorset CCG to the provision of services to people with dementia and their carers. It strongly supported the ambition to avoid unnecessary hospital admissions and to support people in their homes and communities. The External Review Team had noted that a lot of work had been done, to attempt to formulate a coherent proposal for future development of dementia services and the Clinical Senate Council commended this work. It was disappointing that other issues beyond the control of the CCG had led to less co-production with the local authorities than was both desirable and necessary, although their support was noted. However, the Clinical Senate Council was of the view that the plans outlined in the PCBC included risks to the continuity of the service and to the well-being of patients and their carers that, in its opinion, required that significant steps were taken to ensure appropriate mitigation.

4.2. Strong public and patient engagement

The Clinical Senate Council thought that the CCG had taken adequate steps to ensure strong public and patient engagement, including engagement with people with dementia and their carers. The difficulties in reaching dementia sufferers and their carers were acknowledged. The External Review Team noted that engagement with GPs had not been at scale, the survey being completed by only 14 GPs despite being sent to all GP practices in Dorset. However, in its responses to the draft report, the CCG stated that during 2018, it had employed a GP Fellow with a specific remit of engaging with GPs across the whole of Dorset asking for views around dementia and on different dementia screening tools for primary care.

The Clinical Senate Council suggested that the CCG illustrate their plans with the use of typical patient journeys that would be experienced before and after the plans are implemented. Such scenarios might include:

a. What happens to the person with mild dementia with and without a carer in East Dorset and West?
b. What happens to the patient living in Portland with acute deterioration?
c. What happens to the patient who comes to the day hospital with delirium due to a urinary tract infection (UTI)?
d. What happens if the carer has a sudden acute admission?

4.3. Consistency with current and prospective need for patient choice

The Clinical Senate Council recognised that in the context of dementia, choice was often not expressed by sufferers but by their carers. It is particularly pertinent that 97% of dementia patients admitted to Alderney Hospital are detained under the Mental Health Act. The Clinical Senate Council reminded itself of the geographical location of the two units to be closed, in Weymouth and Blandford respectively and of the public commitment made at the time of the closure of the Chalbury Unit beds in 2016: "….and so we have committed to providing bespoke transport arrangements for relatives and carers".

The situation at present is that there is no in-reach team, similar to that on the East side of Dorset, in the West of the County. The plans aim to address this by investing in an in-reach service in West Dorset. However, the permanent closure of 16 beds in the Chalbury Unit in Weymouth would impact on the population of West Dorset as would the closure of 12 beds in the Betty Highland Unit in Blandford affect the population of North Dorset. These units have been closed temporarily since 2016 and 2013 respectively. The Clinical Senate Council noted that issues arising from difficulties staffing the units with experienced and skilled staff were the reasons given for the temporary closures. The Clinical Senate Council was not informed of any improvement in the workforce situation in the South West.

Whilst it may seem a logical response to centralise inpatient services in one well-maintained, and staffed unit at Alderney Hospital, the Clinical Senate Council was concerned that West Dorset might be disadvantaged in terms of the recruitment of community-based staff, the impact of travel on the amount of time available for clinical care in the community, the clinical capability of the Melcombe Day Hospital (see below) and the travel to the specialist unit in Alderney Hospital.

It was not clear why the decision had been taken to centralise services on the Alderney Hospital site, rather than in another community hospital. The Clinical Senate Council was not provided with data for the travel distances involved in visiting of previous patients in the Alderney Unit, which would have given details of what percentage of carers would have had to travel from West Dorset and how far their journeys would have been. It was not apparent to the Clinical Senate Council what, if any, long-term commitment had been made for ongoing travel assistance following the temporary closure of the Chalbury Unit. The plans needed to include mitigation of hardships that might result from extended journeys to visit in-patients and to meet with their clinical teams.

The Clinical Senate Council was made aware of the difference in the stances taken by NHSE and Dorset CCG on the issue of the prevalence of dementia in Dorset and the impact of these data on diagnosis rates as calculated for the purpose of the National Dementia Diagnosis Rate (DDR). It was noted that the prevalence modelling provided by Dorset to support their prevalence estimates had not been accepted by NHSE, nor had it been formally agreed that Dorset CCG can work to a lower prevalence estimate than other areas in the country. Furthermore, the Clinical Senate Council was informed that cultural and logistic factors caused people in West Dorset to be more reluctant to have an early diagnosis. In view of the documented benefits of an early diagnosis, it was surprising that the need for education about this was not highlighted in the PCBC. The Clinical Senate Council was concerned that a future imperative to increase the rate of diagnosis might divert resources from the proposed plans, with fewer benefits if the patients identified were at a later stage in the disease progression.

The Clinical Senate Council was concerned that it was proposed to restrict the NICE-recommended provision of Cognitive Stimulation Therapy to patients with a diagnosis of vascular dementia. There were a number of reasons why this did not appear to be acceptable:

a. While it is accepted that there is evidence for treatment with acetylcholinesterase inhibitors being restricted to certain sub-types of dementia, this is not the case with cognitive stimulation therapy. There is no evidence to support this restriction.
b. The Clinical Senate Council heard an expert clinical opinion to the effect that many cases of "vascular" dementia have a mixed aetiology and that the diagnosis was too inaccurate to be the basis of such rationing.
c. While it was accepted that this was intended to address the inequity of availability of current treatments for people with vascular dementia, this was a misguided attempt to address real biological differences in the response to drugs.
d. If this approach to inequity were accepted, would consideration be given to patients with mixed disease or patients with Alzheimer's dementia who do not want medication or for whom medication is contra-indicated?
e. The PCBC states that although the rates of coronary heart disease, stroke and transient ischaemic attacks in Dorset are higher than the national average, vascular dementia rates are only 53% of the national average (Appendix D page 24). This apparent contradiction contributes to the concerns about the accuracy of the Dorset prevalence figures and the lack of a sound basis for rationing of access to treatment.

4.4. A clear clinical evidence base

4.4.1. Prevalence

The Clinical Senate Council noted that the PCBC calculations for the service demand were based on prevalence data that differ from the nationally calculated prevalence of dementia (CFAS II); the CFAS II figure for Dorset was 13,102 people, the PCBC figure was 9,025 and, following initial challenge, a recalculated figure of 10,362 people was presented to the meeting of the Clinical Senate Council. While the convergence of the data with the national figure was welcomed, it was concerning to see a 15% increase in the prevalence and associated demand being admitted so late in the planning process. There was an attempt to explain the lower-than-expected numbers as a function of the lower rates of deprivation in

Dorset but the regression figure seemed to indicate that Dorset remained an outlier, even when accounting for this explanation. While financial matters are outwith the remit of the Clinical Senate, the sustainability of a service is a matter that it may properly consider. For these reasons, the Clinical Senate Council was of the view that there was a pressing case for contingencies to be built into the PCBC, particularly in terms of the number of Dementia Care Co-ordinators, in order to ensure that there was sufficient capacity to deal with numbers of patients who were encountered.

Similarly, as mentioned above, the number of patients with vascular dementia is about half of that to be expected. While the Dorset team has suggested that this represents the effects of effective treatments for vascular disease, this is not in keeping with the general associations of stroke and heart disease with vascular dementia. It may also be that the improved vascular health claimed in Dorset may result in people living longer lives which, in turn, means that they will be more likely to develop dementia.

4.4.2. Bed Occupancy

The Clinical Senate Council noted the peak bed occupancy of beds during the month of August (Appendix D page 41) which was related to a lack of social care packages around holiday times, the increased stress on family carers during the hotter months and competing responsibilities during holiday periods. There is also a possibility that this increase could also be related to hydration deficits. The Clinical Senate Council was informed that there is evidence to suggest that a programme of work with care homes, including use of coloured cups, plates etc. makes a real difference to individual’s fluid consumption and reduces the occurrence of UTIs, constipation and other symptoms that otherwise accentuate memory and behaviour difficulties. These in turn trigger avoidable hospital admissions and an accelerating increase in people’s dependence. The Clinical Senate Council regarded it as prudent to plan for such interventions and to take the staff members’ summer vacations into account in such planning.

4.4.3. Dementia Care Co-ordinators

See the Bed Closure Test below.

4.5. NHSE's test for proposed bed closures

The Clinical Senate Council considered the three elements of this test and determined that the first element came into scope:
"*alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it".*

There was potential for the second element to apply: *"specific new treatments or therapies will reduce specific categories of admissions"* but this would be predicated upon detailed planning of dementia-specific interventions in the future. Much of the scope in this regard was related currently to the prevention of physical deterioration or complications, that might prevent acute hospital admissions and did not relate to the reduction in the specialist dementia beds that were under consideration in this review.

The Clinical Senate Council noted that Dorset has pioneered the use of staff working at lower grades in the community as navigators and coaches to address health issues other than dementia. The proposed Dementia Co-ordinator posts at Band 3 as the first point of contact for patients and carers were another example of this initiative. They would replace the Memory Support and Assessment Service which has been subject to some criticism regarding meeting the needs of patients post-diagnosis. They would support circa 200 people with minimal day-to-day supervision. Neither the Clinical Senate Council nor the External Review Team had any knowledge of this model working elsewhere. If there were an opportunity to pilot this initiative in a smaller geographical area as a test prior to wholesale implementation, this could help minimise the risks that might arise from this new way of working. The Clinical Senate Council noted that in the West, travel times would need to be factored in to the workload and that additional training would be required as Dementia Co-ordinators would be 'lone workers'. Recruiting to these posts may also pose a challenge, particularly in the West where there are more retired people and relatively fewer people of working age. The Clinical Senate Council noted the large scope of the Co-ordinators roles, including those specified by the NICE guidance and questioned the capability of a band 3 worker to meet these requirements.

The Clinical Senate Council noted that in the NICE guidance, patients should have access to a named healthcare professional who follows them from diagnosis through-out their clinical course [NICE guideline 97, Dementia: assessment, management and support for people living with dementia and their carers. Published 20 June 2018: https://www.nice.org.uk/guidance/ng97]

4.5.1. Care coordination

The NICE guidance states that services should:

a. provide people living with dementia with a single named health or social care.
b. professional who is responsible for coordinating their care.

And that named professionals should:

c. arrange an initial assessment of the person's needs, which should be face to face if possible.
d. provide information about available services and how to access them.
e. involve the person's family members or carers (as appropriate) in support and decision- making.
f. give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the Mental Capacity Act 2005.
g. ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate.
h. develop a care and support plan, and:
i. agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals.
j. specify in the plan when and how often it will be reviewed.
k. evaluate and record progress towards the objectives at each review ensure it covers the management of any comorbidities.
l. provide a copy of the plan to the person and their family members or carers (as appropriate).

It was unclear as to how there would be communication between Dementia Co-ordinators and the Intensive Support Team, GPs, hospital and care home staff. It would be important to understand how rapidly the Dementia Co-ordinators could escalate concerns about a person with dementia with increasing needs to the Community Mental Health Team.

The Clinical Senate Council discussed whether the provision of 40 beds in the Alderney Hospital would be adequate to ensure that there the service was safe and sustainable in the years ahead. This discussion was conducted without an agreed current prevalence of Dementia in Dorset but in the light of the variation in the estimates of the number of patients. The Clinical Senate Council heard of the new calculations at its meeting on 14th March 2019 which increased the dementia prevalence by 15%. This effectively meant that the figures in the business case which the external team reviewed would need to change and a suggestion was made that confidence intervals were used in the planning. Dorset CCG believed it was taking adequate steps to increase dementia diagnosis rates but were not yet able to say what the diagnosis rates were in different settings, including care and nursing homes. The Clinical Senate Council asked what proportion of Delayed Transfers of Care (DTOC) in each setting were for people with dementia as this information would enable them to tell if there was sufficient capacity in the plans to improve patients' journeys, particularly between care environments. The Clinical Senate Council would have liked to have seen data on how many people in care homes, acute hospitals, in frailty care (using the index) and in general practice were diagnosed with dementia as a baseline, with projected improvements after the new service was in place.

97% of dementia patients who are in the Alderney Unit are detained there under the Mental Health Act. The average length of stay in the unit was relatively long at 106 days and the Clinical Senate Council did not understand why this was and what value this length of stay might add to patient care. It was unclear as to how many of these patients might have improved and be waiting other placements, including nursing home beds. It was uncertain also as to the optimum length of stay for these patients and how this might be achieved.

Neither the External Review Team nor the Clinical Senate Council understood the health-related roles of the Day Hospitals given their minimal clinical staffing levels and there was concern that they could be seriously limited in their ability in providing health benefits beyond social care. The Clinical Senate Council saw an opportunity to integrate physical and mental health services for people with multiple health needs at a Day Hospital and to provide prevention of in-patient admissions but this would require a different level and skill mix of the staff and timely access to specialist medical opinions.

4.5.2. Support for proposals from clinical commissioners.

These proposals were advanced by Dorset CCG. Dorset CCG assured the Clinical Senate Council that local authorities had been closely involved in the development of the dementia services review plans although social care and social care funding remained out of scope.

5. RECOMMENDATIONS OF THE CLINICAL SENATE COUNCIL

5.1. Bed Numbers

The benchmarking data provided have shown that there is considerable variation in the numbers of designated specialist dementia beds. It was stated that the acuity in the current beds is very high but the length of stay is longer than one might expect and occupancy levels seem lower than those seen in a service under significant pressure. Comprehensive proactive management of the needs of people with dementia and their carers in the community, combined with appropriate local authority provision, should mean that specialist inpatient services are sustainable at the level of 40 beds. However, close monitoring and measurement across the components of health and social care for people with dementia, together with timely intervention, is needed for commissioners to be fully assured, as the plans are implemented.

5.2. Risk Mitigation

People with dementia present across multiple health settings and the patient pathways are often complex. In this contest, the Dementia Co-ordinator role is innovative and untested. The Clinical Senate Council advised that because of these factors, piloting and phased implementation would be advisable, with careful monitoring of early warning signs.

The Clinical Senate Council suggests the following early warning system, which does not exclude other measures. There should be continuous real-time monitoring of:

a. Assessment of carer well-being and breakdown.
b. Numbers of patients with a diagnosis of dementia who have Delayed Transfer of Care.
c. Numbers of acute admissions to general hospitals of patients with known diagnoses of dementia.
d. Number of acute admissions of patients with dementia who are diagnosed for the first time during the course of that admission.
e. Numbers of acute admissions to specialist dementia beds of patients with known diagnoses of dementia.
f. The recruitment and retention of the Dementia Care Coordinators
g. The length of time from referral to diagnosis.
h. Waiting times for Cognitive Stimulation Therapy and Neuropsychology.
i. Concerns, complaints and compliments from patients and their carers.

Appendix A – External review team members

Name	Organisation	Title
Christopher Kipps	University of Southampton University Hospital Southampton NHS Foundation Trust	Consultant Neurologist and Honorary Clinical Lecturer/Clinical Director Mental Health Network
Aileen Murray-Gane	Southern Health NHS Foundation Trust	Nurse Consultant for Older Person's Mental Health
Kathy Jackson	Southern Health NHS Foundation Trust	OMPH Operational Manager
Sue Till	Solent NHS Trust	Community Rehabilitation Team Manager/Physiotherapist
Brady McFarlane	Southern Health Foundation Trust	Consultant OPMH Psychiatrist SHFT
Tracey Eddy	Southern Health Foundation Trust	Consultant OPMH Psychiatrist SHFT
Ian Keasey	Public Health England South West	Programme Manager Health and Wellbeing
Hana Burgess	Southampton CCG	GP Partner & Clinical Lead
Erika Lipscomb	Rowans Hospice Portsmouth	Director of Clinical Services
Karen Ashton	Hampshire Social Services	Assistant Director Adults' Health and Care