A 'Better Care Closer to Home' Consultation Fact-sheet: South Derbyshire's Dementia Rapid Response Team

About the consultation

The proposals in the 'Better Care Closer to Home' consultation are about changes to services for two groups of older people who use community hospital services. Those who are recovering from an accident or illness after a spell of inpatient care at a district general hospital and those who have dementia. The proposals would mean the majority of these care needs would in the future be met in, or near to, older people's own homes as long as it safe to do so rather than provided in a community hospital as currently happens.

Why have we produced this fact-sheet?

To provide further information about topics that may be of interest to organisations and individuals wishing to respond to the consultation.

What is this fact-sheet about?

The experience and evidence of a successful Dementia Rapid Response Team (DRRT) provided by Derbyshire Healthcare NHS Foundation Trust (DHCFT) in Derby and South Derbyshire. It is the model for our proposal to establish DRRTs in North Derbyshire.

Dementia Rapid Response Team

Staffing: The Team is multi-disciplinary and includes mental health nurses, psychiatrists, occupational therapists and healthcare assistants, supported by others specialising in physiotherapy, psychology and pharmacy.

Objective: To provide a robust alternative to hospital admission for older people with dementia, whose symptoms are complex and present a high risk, at times of crisis through a same-day response from a flexible, highly responsive team. The team aims to reduce the need for admission into specialist dementia hospital beds and, where it cannot be avoided, to facilitate rapid discharge back home.

How the service works: The service is delivered at the person's home, or the place they call home such as a care home, beginning with a specialist assessment. An individual care plan is developed with the patient and carer. Where home treatment is part of the plan, intensive support is provided. This can be up to four times per day, seven days per week. Typically it is two calls per day for six weeks, determined by need. The service is informed by evidence-based best practice, such as NICE guidance.

It began in March 2015 operating from 9am to 5pm, 5 days per week. In April 2016 it was decided to plan to increase the service to 8am to 8pm, 7 days per week. Out-of-hours support is provided by the older adult on-call psychiatrist who may admit if required.

Evidence: The DRRT evaluated its service from its launch, 1 April 2015, to 8 February 2016. It measured satisfaction with the service using questionnaires. Key facts include:

- 229 episodes of care
- 229 people offered service
- 51% of people live in 24-hour care
- 49% of people seen live in their own home
- 2 x 28-day readmissions, of which the last one was in August 2015

- all areas that are eligible for the service have used it with most use from the City area, which has highest density of population
- average length of stay with DRRT was 26 days.

The evaluation noted the following **impacts**.

- There is an alternative to hospital admission for people with dementia in a crisis situation.
- The pathway for people with dementia has improved.
- The DRRT service has had significant impact across the health community of Derbyshire.

The **outcomes** included:

- a greater than 30% reduction of use of dementia beds and temporary closure of 14-bed ward, enabling temporary redeployment of staff,
- service-users' and carers' feedback was universally positive,
- satisfaction anecdotally of external partners, particularly GPs, is very positive,
- reduced admissions to acute care particularly where delirium/dementia is an issue,
- reduced stay in acute care in wards, Medical Assessment Units and A&E, and
- reduced need for hospital admission from a care home where the underlying need is for a different level of care home as DRRT support staff until an alternate care placement is found.

Admission criteria: Complex and high risk individuals at home who are experiencing a crisis relating to their dementia, or suspected dementia. Other services are unable to support them safely at home and hospital admission would be the only alternative. Inpatients, admitted due to a dementia crisis, who could be safely discharged sooner with a period of intensive support from the team.

Type of support offered:

- A focus on the immediate crisis, identifying it and treating it. For example, behaviour mapping, psychotherapeutic intervention and medication review.
- Identifying and intervening to meet an individual's needs in challenging situations – for example, ensuring daily activities continue.
- Enabling carers to meet a person's needs through modelling (ie: learning through observation and imitation), support and education.
- Collaborating to develop care plans based on advance statements (written statements setting down individual preferences, wishes, beliefs and values regarding their future care).
- Building resilience in caring relationships using techniques such as cognitive reframing (looking at thoughts from a different viewpoint).
- Offering education, advice and support to enable resilience and re-ablement.
- Identify factors which cause stress in the patient and determine ways to prevent and manage relapse.
- Encourage individuals to develop coping strategies and ways to remain at home safely keep safe.
- Enabling individuals and carers to access other support services which may help.

Care pathway: The DRRT are a key part of the pathway and work closely in an integrated way with existing community and acute inpatient services including mental health teams, GPs, adult social care and the voluntary sector. Referrals to the DRRT come via neighbourhood teams and consultants.

Other evidence

Other evidence informing our proposals included key national and clinical evidence. The improvements to date and the future direction of travel are consistent with national guidance and best practice, including:

- 'NHS Five Year Forward View' (NHS England, October 2014)
- 'Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders' (NHS England, February 2014)
- 'Making our health & care systems fit for an aging population' (The Kings Fund, March 2014)
- 'Specialists in out-of-hospital settings' (The Kings Fund, October 2014)
- 'Support. Stay. Save. Care & Support of People with Dementia in their own homes' (Alzheimer's Society, January 2011)
- Studies by Trappes-Lomax et al. (2002) & Lymbery (2002)

Further information

Please refer to the fact-sheet 'Dementia Rapid Response Teams' for information about the proposed model of care for North Derbyshire. Also refer to a PDF document entitled 'Specialist Older Persons Mental Health (OPMH) beds', which is the relevant part of the 'Pre Consultation Business Case Stage 4' (pages 24 to 36). It can be found online at: www.joinedupcare.org.uk

Our proposals are set out in the consultation document. We encourage individuals and organisations to read the consultation document thoroughly before responding.

If you have any further questions about the topic of this fact-sheet please refer to our consultation website for further resources and information about how to contact us: www.joinedupcare.org.uk