TORBAY COUNCIL


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| Date: | Friday, 22 March 2024 | Torquay |
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Dear Member

**ADULT SOCIAL CARE AND HEALTH OVERVIEW AND SCRUTINY SUB-BOARD - THURSDAY, 14 MARCH 2024**

I am now able to enclose the response to public questions raised in relation to the Thursday, 14 March 2024 meeting of the Adult Social Care and Health Overview and Scrutiny Sub-Board, which were unavailable when the agenda was printed.

| Agenda No | Item | Page |
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| 11. | **Questions and Answers** | (Pages 41 - 47) |

Yours sincerely

Governance Support
Clerk

**Torbay Council Adult Social Care and Health Overview and Scrutiny Sub-Board – Review of Dementia Support**
**Meeting: 14 March 2024**

**Public Questions and Comments Received and Responses**

| | Question | Theme | Proposed Response | |
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| 1 | It's not easy to put forward a question as a carer for someone with Dementia, as no one actually gives you any information or even tells you where to get any information, after diagnosis; | Access to Information, Advice and Guidance | Living with dementia in Devon: A Carer's Guide (torbayandsouthdevon.nhs.uk)<br><br>The guide focuses on information specifically for carers of people living with a dementia. Where information is relevant to all carers, there is a brief note and signposted readers to other sources.<br>The guide is designed for a carer to dip into at a time of need in their journey to<br>find out what there is out there to help you. | |
| 2 | I understand that care homes supporting dementia patients have one doctor to oversee all the residents in that home. This is not always helpful to the patient as they don't know enough about them at times to make the right decisions. Why is it that the family doctor cannot be called in when there is a problem that may not be attributable to dementia? | Primary Care Support to Care Homes | **NHS Devon response**<br>Enhanced Health in Care Homes<br>National guidance has been published which supports how people are cared for in residential / nursing care homes. The guidance is called "Enhanced Health in Care Homes".<br><br>The guidance states every care home:<br>• is aligned to a Primary Care Network<br>• has a named clinical lead<br>• has a weekly home round supported by the care home multidisciplinary team<br><br>The aim to ensure better coordinated support for people in care homes with a multi-disciplinary team who gets to know the patient and can respond to the patient's holistic needs and reduce unplanned trips and admissions to hospital for patients.<br><br>The introduction of primary care networks and the Enhanced Health in Care Homes framework was designed to support primary care to manage the care of patients in a care home through a multidisciplinary team approach. | |

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| | | | As a general rule if a patient is in a care home, in the area they ordinarily reside and this is within the Primary Care Network footprint, a family GP should be able to attend their patient in a care home.<br><br>There are scenarios where this isn't possible e.g. a person lives in Brixham but is in a care home in Torquay. The patient would be considered a temporary resident and receive care from primary care in the local area. | |
| 3a | What dementia education is available to the hospital and the community and at what level ie Degree and NVQ What priority is it given? | Education | 1. Dementia education is available for any staff group, sessions can be on request including bite size / micro teach sessions to suit the group / area across the ICO which includes acute and community settings.<br><br>2. The following groups have dementia awareness built into their induction programmes:<br>• Healthcare support workers<br>• Preceptorship<br>• International nurses<br>• Allied health professionals<br>3. We also deliver a mealtime companion training session on dementia and eating to volunteers.<br>4. We provide digital training in conjunction with the dementia education framework:<br>• Tier 1 aimed at all staff<br>• Tier 2 – aimed at staff who are in regular contact with people living with dementia<br>• Tier 3 - aimed at managers / leaders in dementia care<br>- staff can access all tiers via the Hive online digital platform<br><br>TSDFT leads part of the dementia degree module in partnership with University of Plymouth & we also MSc module in dementia (usually once a year depending on demand, but due to low numbers has not run for a couple of years).<br>We also provide training to all bank staff | |

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| | | | We deliver safe approaches which includes de escalation techniques and break away techniques<br><br>Future training will include pop up training sessions to care homes via the digital platform<br><br>We no longer provide vocational/NVQs as this is now through South Devon College | |
| 3b | How are behaviours such as aggression and agitation managed across the community and the hospital? | Manging complex dementia | It is on an individual basis depending on the person's need or presentation plus their capacity and diagnosis.<br><br>The Care Home Education and Support (Ches) Team started on 19th April 2017 as a new function within the Community Mental Health Team under Devon Partnership Trust. In January 2019 this became a joint mental health/Social Care Initiative. The purpose of the team is to provide holistic, person centred interventions to people in Torbay Care homes with a diagnosis of dementia who present with behavioural and psychological symptoms of the condition (BPSD). CHES focus on building on existing progress, developing the service and improving the integration, both within the team and the wider health and social care network. CHES works with a holistic and person-centred approach. The objective is to reduce the frequency and severity of challenging behavioural and psychological symptoms exhibited by the person with dementia, and to support the care home to continue with their caring role.<br><br>We undertake this process by:<br>• Exploring physiological factors that can contribute to behavioural and psychological symptoms of dementia, and make recommendations to primary care services. These include areas such as pain, acute infection, malnutrition, dehydration, medication etc.<br>• Gathering information about the person's life history in order to complete non-pharmacological | |

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| | | | recommendations for the care home to implement and include in care plans.<br>• Exploring pharmacological interventions where necessary (including de-prescribing medications) and medications that can have an adverse impact on the clinical course of dementia. | |
| 3c | What is in place to avoid admission to hospital from residential and nursing homes? (NB – this question was received from Cllr Douglas-Dunbar via the public question route). | Admission avoidance | **Care Home Education Service** will also support in answering this question.<br><br>**NHS Devon response**<br>Enhanced Health in Care Homes<br>The Enhance Health in Care Homes initiative is designed to provide better co-ordinated support for patients in residential care.<br><br>Multi-disciplinary teams including primary care, community healthcare, social care and where appropriate, VCSE and secondary care (acute hospital) specialist clinicians work together with patients to respond to individual needs and develop care and support plans.<br><br>This supports avoiding admission to hospital by having a multidisciplinary team which responds to a patients holistic needs and responds to changes in health as they happen.<br><br>Immedicare<br>A pilot is being undertaken with Care Homes in South Devon and Torbay where there is a high level of people from residential care being taken to hospitals.<br><br>Immedicare is a nurse-led telemedicine (telephone) service which provides 24/7 support 365 days of the year.<br><br>Care homes have unlimited access via webcam / video call for support advice and non-medical prescribing e.g. antibiotics to manage UTI's, chest infection, eye drops etc. | |

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| | | | Immedicare works as part of the local community teams and where needed will escalate support to other teams if patient needs are more complex.<br><br>Urgent Community Response (UCR)<br>Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes:<br>• Access to physiotherapy and occupational therapy<br>• Medication prescribing and reviews<br>• Help with staying well-fed and hydrated<br>Confusion / delirium, including an increase or new confusion or acute worsening of dementia and delirium, are included within the service.<br><br>UCR teams receive appropriate training so that they can understand and support the diverse needs of their local populations. This includes:<br>• comprehensive frailty training<br>• training on symptom assessment<br>• training on dementia, mental health and mental health first aid<br>• education around the needs of, and reasonable adjustments for, people with a learning disability and/or who are autistic.<br><br>Virtual Wards<br>Torbay and South Devon has in place a number of Virtual Wards which provides patients with hospital levels of care in their own home. VW's include Frailty, Cardiology and Respiratory.<br><br>Frailty Virtual Ward currently runs as admission avoidance. There are plans to expand this over the coming months as recruitment is undertaken for | |

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| | | | additional medical cover. Patients with dementia have been admitted to the Frailty Virtual Ward.<br><br>Care Co-ordination Hubs and SDEC (same day emergency care) arrangements are in place in Torbay and South Devon via the hospital. These are designed to identify people accessing ambulances or at the front door of ED to coordinate care, support and alternative treatment to ED and avoid patients being admitted to hospital if there is a more appropriate service for their need.<br><br>Support for Carers (post discharge and avoids readmission)<br>In particular there are two schemes which help carers to maintain their caring role and avoid a return to hospital for the patient:<br><br>1. Funding or up to 3-month loan of equipment to support the caring role post discharge.<br><br>This can be equipment to support the caring role (eg washing machine for issue with continence), give a carer peace of mind (eg Lifeline alarm), or to enable them to have a break during post-discharge period (eg closed circuit TV)<br><br>2. Work with voluntary sector partners – Age UK and Torbay Communities (plus domiciliary care including Personal Assistants and enabling services) to develop a comprehensive post-discharge 6-week free support package for unpaid carers. This will include:<br>• On-ward identification of families/ Carers involved in someone' support to ensure robust conversations pre-discharge, including need for training / ongoing support<br>• Particular attention to carers who require significant reassurance which may delay discharge | |

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| | | | • Minimum of weekly follow-up calls to ensure carer is supported and identify any unmet needs<br>• Minimum 2 hrs weekly sitting / enabling service so that the carer can have a break.<br>• Linking carer into ongoing community-based Carer and VCSE support | |
| 4 | Dementia/ carehomes / covid …. The mistakes … never ever should we have left people isolated in bedrooms for weeks and months. Please discuss. | Covid response | Following government guidance of the time. | |
| 5 | Purple Angel Dementia held at Barton Church is a fantastic place to visit on three Saturdays a month with various free activities held for all the visitors. This is a well deserving project to get all the support you can give them. | Voluntary sector support | | |
| 6 | Singing/Dancing group for Dementia sufferers at The Edge Bolton Street, Brixham every 2nd and 4th Wednesday of the month 2pm til.4pm | Voluntary sector support | | |