

Session 1e – Transition towards specialist dementia beds

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Creating consistency and equality across Lancashire to support bed reduction

Key Issues

- Development of community infrastructure.
- Communication and whole system working of details of prevention and support provisions in localities.
- Reduce duplication
- Build support around the person – working together.
- Consistent model for Residential / Nursing Home liaison - important priority.
- Communities need to feel confident.
- Understand impact of travelling distances – carer's needs.
- Commissioning of high end Long term care (Continuing Health Care) needs to be as local as possible.
- Intensive care beds (step up / down beds) need to look at use for people with dementia.
- Very robust bed management via Intermediate Support Teams – requires robust and consistent IST / Step up/down.
- Responsive physical assessments, as well as MH assessment
- Fast track through screening
- Links / Collaboration
- Long term conditions teams – joined up and collaborative working.
- Consider how to target any re provision opportunities?
- Acute hospital care liaison
- End of life – implementing gold standard framework.
- Whole system approach – preferred priorities of care – planning early and support for advance statements.
- Training on having difficult conversations early.

Summary

- √ Further development of the community infrastructure to support the specialist beds
- √ Acute general hospital care and liaison with Mental health services
- √ Whole system working to give details of prevention and support provision
- √ Responsive physical and mental health assessment to fast track through services