| SCRUTINY: HEALTH & SOCIAL CARE REVIEW GROUP (HSCRG) | AGENDA ITEM 12 |
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**DATE OF MEETING:** 6th March 2019

**REPORT OF:** The Chief Operating Officer, Luton CCG

**REPORT AUTHOR:** Mary Bennis, Luton CCG **CONTACT TEL NO.:**

**SUBJECT:** Update of the Implementation of the Dementia Strategy

## PURPOSE

1. The purpose of the report is to update the Scrutiny Health and Social Care Review Group on the progress on the implementation of the dementia strategy and meeting national dementia diagnosis targets.

## RECOMMENDATION

**2. That the Scrutiny Health and Social Care Review Group note the report.**

## REPORT

### Introduction

### National Dementia Strategy

3. Luton Clinical Commissioning Group and Luton Council have been implementing the dementia strategy in Luton and recording progress on the work plan. The strategy was coproduced with people with lived experience, their families and carers along with community providers, community support and voluntary sector organisations, as well as local businesses who are 'dementia friendly'. We researched the priority areas within the national guidance and agreed on seven themes:

   i. Enabling equal, timely access to diagnosis and support
   ii. Promoting health and wellbeing
   iii. Developing a dementia friendly town
   iv. Supporting carers of people with dementia
   v. Ensuring excellent quality of care
   vi. Preventing and responding to crisis
   vii. Evidence based commissioning

4. The strategy will be in place 2016 - 2020 and was launched at a dementia conference attended by 220 local people.The conference raises awareness, encourages people to recognise dementia symptoms earlier, talk about how to manage and live well with dementia, in order to make decisions about their life and personal assets, create advanced care plans while they still have the cognitive ability and mental capacity. There are also opportunities to be part of pharmaceutical research and new approaches such as cognitive behaviour therapies, memory enhancing activities and learning to use daily assistive technology, telehealth and telecare techonology.

**Outcomes of the Strategy**

5. There has been some success in identifying people with dementia earlier, as more people are coming forward when experience symptoms at eighteen months into the degenerative disease, when they notice they are experiencing more than age related deterioration symptoms.Previously people would present at 5 years on the pathway and would have found out whilst attending for other reasons (e.g. that had led to a crisis or urgent admissions into hospital), they were also living with dementia.

6. People and local businesses remain members of the Dementia Action Alliance and want to grow and expand for more people to join the dementia friendly town initiatives. The DAA meet quarterly and are currently developing ideas on how to show the public a recognition sign on stores within the shopping centre, the banks and community resources, so people learn to recognise and want to be part of the movement.

7. The hospital have recognised people with dementia by using a butterfly symbol for people above their bed, to raise awareness for staff.Carers can stay overnight in hospital, there is a carers' waiting area too. This is helping reduce the distress and stigma experienced.

8. Care homes are changing the lay out and environment to be more dementia friendly. Increasing lighting, decor with colours proven to uplift mood. Staff are being skilled up with training by the CCG and primary nursing services to learn to recognise symptoms earlier such as managing hydration, nutritional needs and speech and launguage therapy, continence care, behaviour management, fall reduction, skin care and preservation, reducing all antipsychotic medication.

9. Plans are in place and discussion with family to agree carer plans and contingencies to avoiding hospital admissions when not necessary. There is a plan to introduce dementia friends awareness sessions for all care homes and their visitors.

10. The primary care nursing team are working more closely with the mental health older people's team to create care plans in the community, the multidisciplinary teams are using evidence of caring for people at home as much as possible, such as assistive technology. People are encouraged to have more stimulating

activities, a calm area or place to go in the community, outings to the local amenities and regular socials in the care homes inviting the local community in.

11. We are codesigning with the people with lived experience and carers using their stories to improve the pathway for diagnosis, post diagnostic care and the way they receive advice.Commissioning more carers wellbeing services offering 12 workshops for groups of carers to increase their health, wellbeing and resillience to continue to care for loved ones.

**Dementia Diagnosis Target is set at 66.7%benchmark**

12. Luton has strived to exceed the national dementia target, working with teams and the different community providers to identify people earlier, refer and advise each appropriate service provider of the need for diagnosis and encouraging family and carers to come forward and attend appointments. There has also been support by the CCG to the GP practices to ensure all people diagnosed are confirmed and registered on the quality outcome framework (QOF) held by NHS England to measure progress across England on a monthly basis.

13. The current dementia diagnosis national target is set at 66.77% and Luton has achieved:

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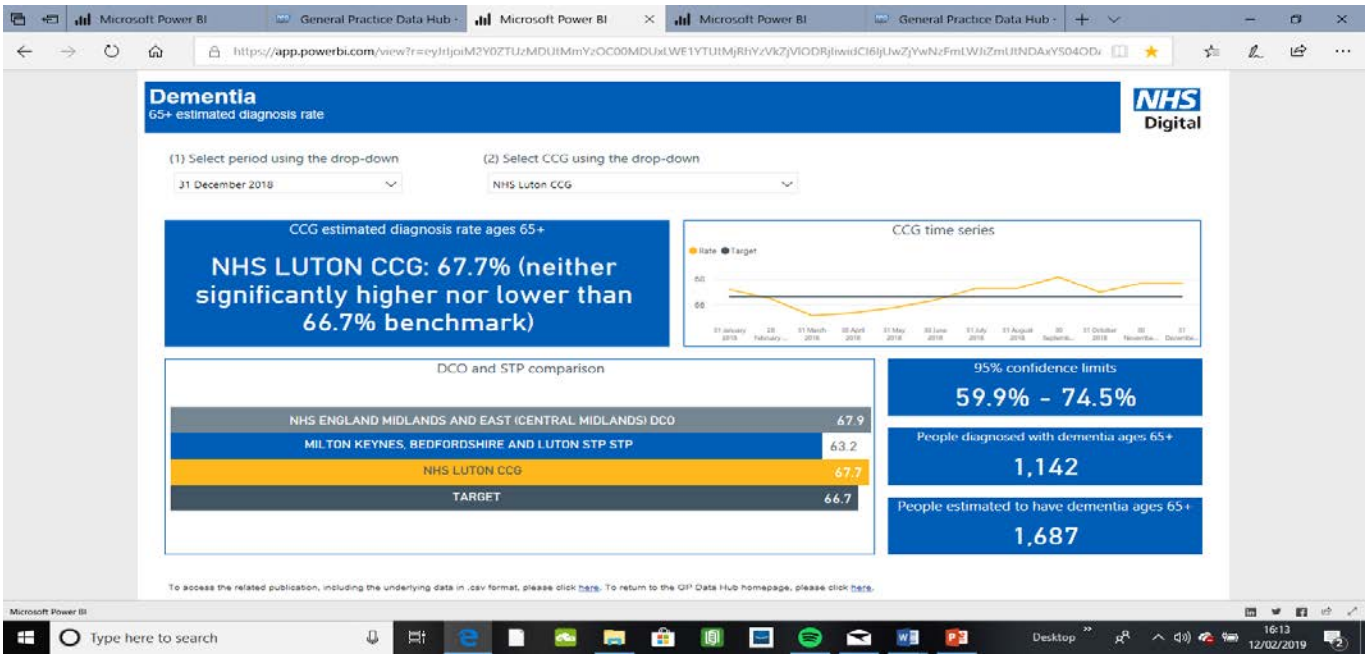
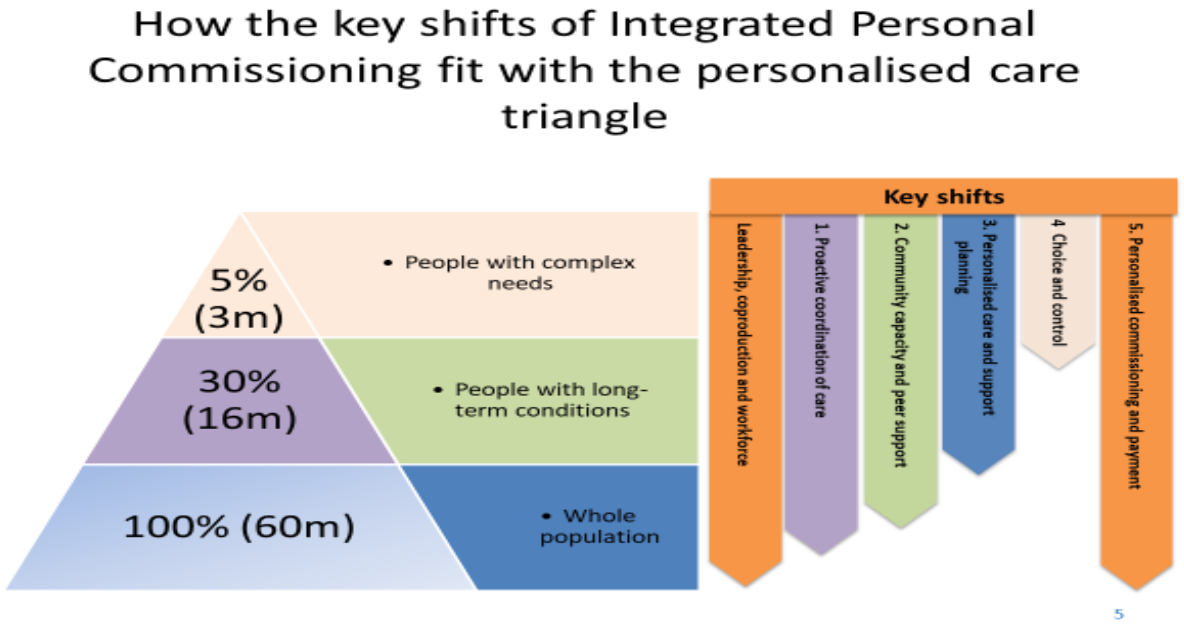
| October 2018 | 67% |
| November 2018 | 67.7% |
| December 2018 | 67.7% |

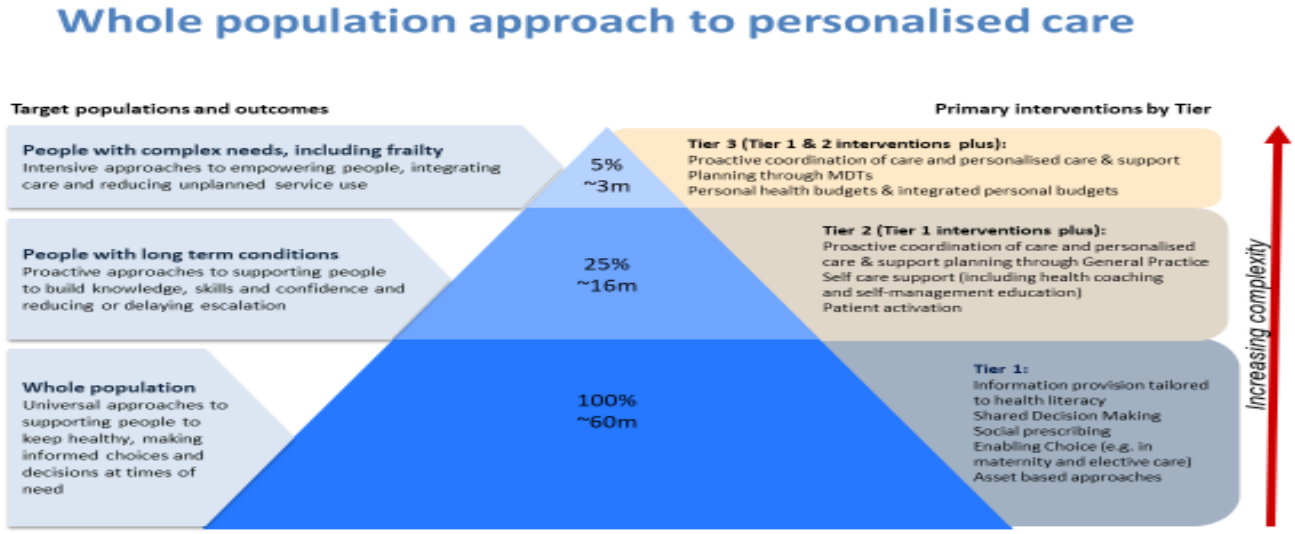



**Personalisation**

14. Following the successful application to be part of the NHS England Integrated Personal Commissioning programme 2015 – 2018 , and Personalised Care Demonstrator programme 2018 – 2019, dementia was given a higher profile. The

personalised care operating model framework is a pillar within the 10 year NHS Long Term Plan and Five Year Forward View. Luton have embedded the five key shifts of personalised care:




15. We have been expanding the personalised care model into Bedford and Milton Keynes, focussing on:

- **Scale:** personalised care take up between 1% and 2% of the population.
- **Scale:** personal health budgets take up between 1 and 2 in 1,000 of the population.
- **Spread:** elements of personalised care model across relevant STP/ICS geography – with some aspects in place across the whole STP;
- **Extending scope** to incorporate other elements of personalised care as a whole population approach.

16. The GP surgeries and the multi discipliniary At Home First intensive support teams have been part of the development of replicable models, looking at the population health approach and identified all those registered over the age of 65 yrs who are diagnosed with long term conditions including dementia. They are offered a person centered approach of proactive coordination, person centred conversations of 'what matters to them', a person centred care and support plan and access to community and peer support.

17. The team working with the family in partnership to help them get back to optimol health. They experience health coaching, have a thorough health and wellbeing assessment from a multi discipliniary team who will also encouarge people to make hospital avoidance and advanced care plans.

18. The GPs have a regular agenda item for dementia to ensure people are being identifed early, there is close monitoring on the pathway and memory assessment process used. People require a diagnosis, with ongoing support provided by the Alzheimers Society and carers wellbeing support service provided by the Disability Resource Centre and Age Concern. There is the post diagnostic specialist dementia nurse and regular support groups and acitvities arranged.

19. Other progress made in the healthier lifestyle promoted through public health and the community support organisations such as Active Luton, Turning Point total wellbeing service. Working more closely with GPs to help people interact more with their community to reduce the risk of loneliness, whilst making small improvements in their lifestyle such as eating more nutritional meals, taking up hobbies, quiting smoking and reducing alcohol intake. Looking at their assets and positive strengths in their life. People are encouraged to recognise when their memory is changing or their mobility to seek support and be more proactive to stay as independent as they possibly can for longer in their own homes.

20. Activities provided are evidence based. General health and wellbeing improvements are being monitored and the person's experience of services are being sought to constantly improve how we support people using a coproduction and codesign approach.

21. The dementia diagnosis pathway was coproduced and is now due to be refreshed to include the new models of care that have been proven and are business as usual. The pathway now includes community navigation, social prescription, psychological support talking therapies, psychological and behavioural management support within care homes.

22. The frailty and complex care framework has offered an improved service, with everyone over the age of 65 to be given a health check and advice on how reduce any risks and maintain and live their life with any conditions safely. Services are more integrated and offered with the focus on the person at the centre.

23. There is a commitment to be more inclusive, flexible and visable to the local community. To help people understand what it is like to live with dementia, there are virtual dementia tours for the staff and public. There is advice from the specialist dementia nurse, now one in each provider- hospital, memory service and

community nursing services. Advice on how to manage and where to gain support earlier before a crisis or admission. More prevention, avoid and delay approaches are being used to encourage positive change.

24. The mental health provider is offering Quality Improvement projects to encourage more people from the black and ethnic minority community and hard to reach groups to attend memory assessment services, increasing engagement with BAME populations in Luton, gathering information from the public from these communities on what are the potential barriers to engagement, and encouraging people to give their ideas for change.

25. The key providers have increased their workforce to include a specialist dementia nurse in Cambridge Community Services. To support the at home first pathway, enhanced health in care homes, end of life and carers.

26. ELFT have appointed another dementia specialist nurse for the memory service and another consultant psychiatrist to support memory services, offer therapy and medical support advice to care homes. ELFT are offering training on dementia to GPs, care homes and other services.

27. Keech Hospice are carrying out a feasibility for an Admiral nurse to support the my care coordinator, palliative services.

28. The CCG medicines optimisation team have allocated a pharmacist to review medications

29. Plans to have specialist nurse meetings to collaborate and offer peer support to one another as their roles will overlap. Dementia nurse in primary care and Memory clinic to encourage/ support GP surgeries to complete the QOF register once diagnosis has been confirmed.

30. L&D hospital continue to improve patient and carers experiences. Fully implementing John's campaign, identify people on wards with advice to GP in discharge letters to follow up. Dementia training in hospital for all clinical staff training continues. Hospital charter standards to work towards becoming Dementia Friendly. 2019 -2021 working on national incentives alongside other groups

**East of England Self Assessment**

31. Bedford, Luton and Milton Keynes dementia commissioners and providers agreed to complete the East of England network self assessment for dementia post diagnostic support. The STP dementia stakeholders agreed to share their assessments in a workshop held in December 2018 and support each other where there were trends to improve on.The group have agreed to meet once a year to share good practise and develop improvements where possible together.

**Areas identified for further improvement and more collaborative integrated working over the next year**

32. **Care Plans and Advance Care Plans**

The main discussion was on who should be doing the care plans and advanced care plans as people present at different services at different times following the diagnosis. There appears to be several different pathways for people depending on other conditions they may have.

- The voluntary sector in BLMK offer post diagnostic support and there may be an opportunity to explore further about their role in supporting with care plans and advance care plans. It is reported that the Alzheimer's Society already complete 'This is me' with service users and identify their needs and offer advice and signposting to other support services.

- It was discussed that awareness raising is required for the public regarding advance care plans so that people can think and plan for their future whether they have dementia or not it is better to plan in advance while you can make choice and be more in control and share those plans with family in advance also.

- There was discussion regarding the training of GP's in relation to advance care planning as they may be the first and main consistent contact with the service user and will need to have an awareness of when to refer to others for support.

- There was discussion about end of life care and the need for the sharing of records between the different services so that it can be seen as to who is supporting the service user with advance care planning.

- It was identified that an area which could be explored further is about advance care plans being completed in residential and nursing care homes.

- It was discussed that it may need to be reviewed as to when advance care plans need to be completed in the service users pathway and when would be an ideal opportunity to discuss with the service user about this i.e. perhaps following a diagnosis of dementia being given so that the service user can be encouraged to make the plan earlier while they may be more able to make choices or perhaps at a later stage when they have further things to consider. Also, it was discussed about this conversation being part of a wider conversation such as discussing about making a will.

33. It was felt that perhaps an STP wide piece of work may be required to look at who and when advance care plans could be completed and that the East of England's findings from the recent audit may assist with taking this forward. It was suggested that the current advance care plans that are being completed could be shared across Bedfordshire, Luton and Milton Keynes. There was discussion about the opportunity to coproduce the dementia post diagnosis pathway with carers and

people with lived experience. It was felt that a shared digital record is a Bedfordshire, Luton and Milton Keynes STP priority which would assist with reducing possible duplication and improving the sharing of current plans. It was felt that this could also reduce the number of times that service users tell their 'story', which may at times be distressing. It was acknowledged that the STP is focusing on trying to improve interoperability between the different organisations IT systems.

**Annual Reviews**

34. There was discussion about who completes the annual review and that this was an area that needed to be explored further. It was felt that there was an opportunity for advance care planning to be undertaken at this review.

**IAPT and Access to Psychological Therapy and psychological support**

35. There was discussion about the psychological support available from IAPT for people with dementia and that this was an area that could be developed further. It was felt that there was an opportunity for further training of IAPT staff to develop their skills to provide interventions to support people with dementia.

**People residing in care homes**

36. There was discussion about care homes and how dementia friendly they are and about the respite care provision that is available for people with dementia and whether there was adequate provision and whether the provision that is available meets the needs of local residents. There was also discussion about support services that were available in the community to support people with dementia in their own homes to offer respite to family and the person.