Inverclyde council

AGENDA ITEM NO: 3

Report	**Inverclyde Integration Joint Board**	**Date: 4 November 2019**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No: IJB/71/20019/AS**
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Subject:	**DEMENTIA UPDATE**	

1.0 PURPOSE

1.1 The purpose of this report is to provide the Integration Joint Board with an update relating to Dementia work in Inverclyde.

2.0 SUMMARY

2.1 Inverclyde HSCP has been successful in securing the pilot site for developing better dementia care co-ordination arrangements through a two year national test of change in partnership with IHub.

2.2 Inverclyde HSCP has successfully recruited an improvement adviser for two years to drive forward this test of change, funded by IHub to improve care co-ordination across the Dementia pathway.

2.3 A launch event took place on Friday 27th September at the Tontine Hotel in Greenock. Over 100 delegates are due to attend this event to formally launch our work for the next two years. National and local speakers were invited to ensure we start this work with an opportunity to reflect on our success to date and agree our priorities moving forward.

3.0 RECOMMENDATIONS

The Integration Joint Board is asked to:

3.1 Note that Inverclyde HSCP has been identified as a national test site for developing Dementia Care Coordination.

3.2 Note the addition of an Improvement Advisor for 24 months resourced from IHub to drive this work forward in Inverclyde.

3.3 Note that further update reports will be provided on a six monthly basis.

3.4 Agree that future use of the earmarked reserve be linked to the test of change activity associated with the new care co-ordination work.

4.0 BACKGROUND

4.1 Post diagnostic Support data shows that 485 people were diagnosed with Dementia In Inverclyde between April 2016 and March 2019. Of these, 16 were under 65 and almost 60% were females. In June 2016 there were 723 people on GP registers however this figure has fallen significantly due to changes in the new GP contract and is no longer a reliable figure. Prevalence estimates indicate that 1444 people will be living with Dementia in Inverclyde.

4.2 The basis for our approach to supporting people with dementia in Inverclyde has been on building capacity across services and our community to enable people with dementia to live well and remain active participants within their own community, and improving access to appropriate support and intervention at every stage in their illness. Our existing dementia strategy focuses on working towards a dementia friendly Inverclyde. The key objectives within the strategy are to:

- Improve Dementia Awareness and knowledge across services and the community;
- Improve community Inclusion;
- Provide Early diagnosis and support;
- To enable people to live well with dementia.

(Working Toward a Dementia Friendly Inverclyde, Inverclyde Dementia Strategy 2013).

4.3 The action plan supporting achievement of the objectives is based on the outcomes identified within the Inverclyde Strategy:

1. Improved coordination, collaboration, and continuity of care across services;
2. Improved access to services;
3. Improved flexibility of services;
4. Improved capacity of services to be responsive;
5. Increased awareness of dementia within the general public and community;

Increased opportunities for people with dementia, their families and carers to contribute to service planning.

4.4 This work has been led by a multi -agency implementation group and there is an established collaborative approach to improving responses and support for people with dementia. Review of progress with the implementation plan of our dementia strategy identified the need to further focus on streamlining pathways to support and on being able to provide more flexible approaches to meeting people's needs.

4.5 The third National Dementia Strategy was published in June 2017 and signified a shift in the post-diagnostic support commitment whereby it now puts greater emphasis on promoting and supporting flexible post-diagnostic services. People assessed as having a higher level of post-diagnostic support need should fall into the scope of Alzheimer Scotland's 8 Pillars Model or, in some cases, their Advanced Dementia Practice Model, thereby being offered an appropriate intervention. In most or all occasions, this would be coordinated by an appropriately trained health or social services professional as a supported enhancement of their existing professional role, and drawing on a combination of community supports and multi-disciplinary skills and teams as appropriate in each individual case.

Healthcare Improvement Scotland, NHS Education, NHS Information Services Division, Health Scotland, Scottish Government Dementia Policy Team and Alzheimer Scotland developed a proposal to work in collaboration with one Health & Social Care Partnership (HSCP) to design and test approaches to integrated care that will provide co-ordinated and seamless care for people with Dementia from diagnosis to end of life care, informed by the human rights-based approach which underpins the Standards of Care for Dementia in Scotland (2011).

4.6 The proposal is to test a whole system approach to delivering an integrated, co-ordinated approach to supporting people from diagnosis of Dementia through to end of life. It is expected that testing of this approach will provide an exemplar of the benefits of health and social care integration and support the implementation of Scotland's third national Dementia Strategy (2017-2020). This work also provides opportunities to support the implementation of Scotland's digital health and care strategy (2018).

4.7 The Chief Officers of East Renfrewshire and Inverclyde HSCP co-lead the workstreams on Older People's Care and Local Care respectively across the NHS Greater Glasgow and Clyde Moving Forward Together programme. They identified the opportunity this programme presents to further develop integrated pathways of care and, based on the work to date in Inverclyde, agreed Inverclyde would submit a bid.

4.8 Inverclyde submitted the bid in May 2019 to iHUB to secure Inverclyde as the test site for the improvement work relating to Dementia. This has been successful.

4.9 IHub will work with the HSCP over the next two years and has released funding to allow Inverclyde HSCP to offer a 24 month post to an Improvement Advisor. This role will help drive forward the work within Inverclyde and co-ordinate feedback to the wider stakeholder group across GG&C NHS including the other 5 HSCPs. The Improvement Advisor is due to take up this post shortly.

4.10 The aim of the project is to:

- improve services and support for people with dementia as part of key actions to strengthen community care and support,
- provide timely interventions to support complex physical and health needs, reduce unscheduled hospital admission days, reduce delayed discharges, and
- improve palliative and end-of-life care.

The project will also explore the use of digital and technological solutions, linking with our existing TEC work to look at innovative ways to best support people with Dementia and their carers, improving experience and outcomes and empowering individuals to self-manage and live independently for longer.

4.11 The project aims to understand how the strategy objectives can be implemented and integrated into practice. We will share learning with the wider Dementia Network in Scotland at regular intervals, in order to support all areas to deliver Dementia Services in line with the Dementia Strategy.

4.12 The project will be initiated with a launch event for stakeholders on 27th September. This will provide an opportunity to provide stakeholders with the background to this work, including some key learning from other Dementia Demonstrator sites work to date. The event will place this project within the local context and review of progress to date from the current Inverclyde Dementia Strategy Implementation Plan, map what is working well and identify and agree key priorities for areas of improvement.

4.13 A Dementia Care Coordination Project group will be established to lead this work. The function of the Project Group will be to design the programme of work focusing on key outputs expected, informed by the stakeholder event, develop an implementation plan and monitor progress and outcomes against the agreed plan. This will also include further engagement with all relevant stakeholders, including people with dementia, their families and carers.

4.14 Inverclyde Council has committed £100,000 in an earmarked reserve to support the continuing implementation of the dementia strategy in Inverclyde. Previous funding of this nature has focused on community work within local communities to improve understanding and awareness of dementia, and supported local organisations and businesses to adapt their environment to better enable access for people with dementia and to feel safe. Going forward, this funding will support initiatives and tests of change

identified within the Dementia Care Co-ordination Project. Use of this will be reflected within the detailed work plan.

5.0 IMPLICATIONS

FINANCE

5.1 **Financial Implications**:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
					Band 7 Improvement advisor employed for 24 months paid by IHUB Scotland

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – An Equality Impact Assessment will be undertaken with service users, carers and other stakeholders as full details of the future redesign emerges.

5.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Through better availability and signposting of the range of primary care support/ professionals, availability of appointments with the

	right profession at the right time should improve.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Specific education and sessions around the range of primary care services is underway.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Through better availability and signposting of the range of primary care support/ professionals, availability of appointments with the right profession at the right time
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	A wider MDT approach with additional/ extended skills to positively supporting individuals.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Improved access to a wider range of professionals and education on services available within the wider primary care/ community setting.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Improved access to a wider range of professionals and education on services available within the wider primary care/ community setting.
Health and social care services contribute to reducing health inequalities.	Improved access and support within the communities with greatest need.

People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	Development of the MDT and additional investment will support practices and GPs to continue deliver primary care consistently and effectively.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with relevant senior officers in the HSCP and

8.0 LIST OF BACKGROUND PAPERS

8.1 None.