Inverclyde council

AGENDA ITEM NO: 11

Report To:	**Health & Social Care Committee**	**Date: 26 August 2010**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: SW/27/10/DG/AM**
Contact Officer:	**Barbara Billings Head of Community Care & Strategy**	**Contact No: 01475 714015**
Subject:	**Scotland's National Dementia Strategy**	

1.0 PURPOSE

1.1 The purpose of this report is to inform the Committee of the content of Scotland's National Dementia strategy, which was published by the Scottish Government in June 2010.

1.2 To inform the Committee of plans to take forward the required actions contained within the strategy.

2.0 SUMMARY

2.1 The aim of the Dementia Strategy is to deliver world class dementia care and treatment in Scotland, ensuring that people with dementia and their families are supported in the best way possible to live with dementia.

2.2 It identifies five key challenges which require to be addressed to meet this aim, and focuses on two key service delivery areas for action: improving support after diagnosis, and improving care within the general hospital.

2.3 Further specific actions are identified which are directed at supporting improvements in care and treatment. These are:-

- The development and implementation of standards of care for dementia, based on the current Charter of Rights produced by the Scottish Parliament's Cross Party Group on Dementia;
- Improving staff skills and knowledge in both health and social care settings;
- Providing integrated support for local change, including the implementation of the dementia care pathway standards and improving information about service impacts and outcomes;
- Continuing to increase the number of people who receive a diagnosis of dementia to enable them to have better access to information and support;
- Ensuring that people in all care settings have access to treatment and support that is appropriate, including specific focus on reducing inappropriate use of psychoactive medication; and
- Continuing to support dementia research in Scotland.

2.4 It is anticipated that these actions, together with a focus on two service delivery areas in the first three years of the Strategy, will result in immediate benefits to people with dementia and their carers, as well as improving efficiency and quality within the care system.

2.5 The Scottish Government is proposing to work with one health and social care partnership to demonstrate how a whole system redesign project can work and deliver improvements. This will be supported by a number of existing national improvement programmes, including the Joint Improvement Team; Mental Health Collaborative; and NHS Quality Improvement Scotland.

2.6 The implementation of the Dementia Strategy will be monitored, and progress and learning from work undertaken will be reviewed and reported on in 2013. A Dementia Strategy Implementation and Monitoring Group will be established by the Scottish Government to undertake this. The detailed arrangements for local reporting into this are yet to be advised.

3.0 RECOMMENDATION

3.1 The Committee is asked to note the objectives of the Strategy, and the priority areas of work; and of the intention to bring a further report to committee outlining an action plan and work being undertaken to implement the Strategy locally; and

3.2 To note that the Inverclyde Partnership have submitted an initial expression of interest to become the National Dementia Redesign Demonstrator Site.

Robert Murphy
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Scotland's first National Dementia Strategy has been developed in the context of the Scottish Government identifying dementia as a national priority. Work has been ongoing over the last year in partnership with Local Authorities, the NHS, organisations within the voluntary and third sector, and with people with dementia and their carers to develop a strategy that aims to transform dementia services. The strategy emphasises the expectation that partnership working at national and local level will continue and develop further to deliver this objective.

4.2 The Strategy identifies five key challenges to be addressed in order to improve the outcomes for people with dementia and their carers. These are:-

1. Fear of dementia that means people delay in coming forward for diagnosis;
2. Information and support after diagnosis for those with dementia and their carers is poor or non existent;
3. General healthcare services do not always understand how to respond well to people with dementia and their carers, leading to poor outcomes;
4. People with dementia and their carers are not always treated with respect and dignity; and
5. Family members and people who support and care for people with dementia do not always receive the help they need to protect their own welfare and to enable them to go on caring safely and effectively.

4.3 The Strategy emphasises the need for change across the whole system of health and social care to address these challenges, and the actions identified to support this are as follows:-

- The development and implementation of standards of care for dementia, based on the current Charter of Rights produced by the Scottish Parliament's Cross Party Group on Dementia;
- Improving staff skills and knowledge in both health and social care settings;
- Providing integrated support for local change, including the implementation of the dementia care pathway standards and improving information about service impacts and outcomes;
- Continuing to increase the number of people who receive a diagnosis of dementia to enable them to have better access to information and support;
- Ensuring that people in all care settings have access to treatment and support that is appropriate, including specific focus on reducing inappropriate use of psychoactive medication; and
- Continuing to support dementia research in Scotland.

4.4 The two key areas for service delivery change within the first three years of the strategy are:-

1. Improved post diagnostic information and support. The strategy identifies the issues that this information and support needs to include.
2. Improving the response to dementia in the general hospital setting, including through alternatives to admission and better planning for discharge.

4.5 The implementation of the Strategy is based on transformational change across the social and health care system, changing practice and doing things differently to improve the quality of care, fit better with the expectations of people with dementia and their carers, and be more cost effective. The strategy stresses the importance of collaborative working on a number of levels.

Effective partnership working between local government, the NHS and voluntary and private sectors.

On an individual level with people with dementia and their carers to ensure their care is fully personalised.

Engagement with people with dementia and their carers to develop policy.

4.6 There are no new direct resources aligned to the strategy, although it is expected that community resources available for dementia will be protected. The Big Lottery Fund has stated its intention to create a fund of £50 million, with the focus of this being to improve individual lives.

4.7 The Strategy follows on from actions that have been taken to improve dementia care and services in Scotland over recent years, and which Inverclyde is actively engaged with currently. These include the establishment of targets for NHS Boards to deliver agreed improvements in early diagnosis and service response to people with dementia by 2011, piloting of post diagnostic support projects, updating information and publications about dementia to assist people to come to terms with the illness, to plan for their future needs, developing the dementia care pathway and improving the quality of care within care homes for people with dementia.

4.8 In Inverclyde work on improving dementia services is already being taken forward. To date this has been through the Modernising Mental Health Programme redesign of Older People's Mental Health Services, with an action plan specifically related to developing the dementia care pathway. Appendix 1

Within the CHP, work has been undertaken with the GP's to improve rates of diagnosis and ensure there is a local register of people diagnosed with dementia, and a local project led by Alzheimer's Scotland and funded by FSF is piloting approaches to early support post diagnosis.

The work on Telecare includes developing the use of Telecare to support people with dementia at home, aimed at enabling people to be safely cared for within their home environments. There is also an existing action plan to improve dementia care within the local care home sector, ["Remember I'm still me" progress report, SW/23/10/BB/AM].

This work is being undertaken on a partnership basis by Inverclyde Social Work Services and the NHS, with input from the third sector and service users and carers.

5.0 PROPOSALS

5.1 It is proposed that a more detailed report on the actions required to implement the National Dementia Strategy is provided to a future Health and Social Care Committee.

5.2 It is proposed that a working group is established to review the existing action plan in light of the strategy, and to develop the plan to address new actions required.

5.3 It is proposed that services continue to pursue current strategies for the modernisation of Mental Health Services within Inverclyde (which includes services for people diagnosed with a dementia) to more effectively meet the needs of the local population by working in partnership. This work will be informed by the updated action plan.

6.0 IMPLICATIONS

6.1 Legal: none

6.2 Finance:

The financial impact of the National Dementia Strategy will be reported to a future Committee.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

6.4 Equalities:

It is anticipated that the National Dementia Strategy will result in improved equity of access to services for people who have Dementia. This will be reported on to a future committee.

7.0 CONSULTATION

7.1 It is anticipated that consultation with people with dementia and their carers will form part of the local implementation and action plan, and will be reported to a future Committee.

8.0 LIST OF BACKGROUND PAPERS

8.1 Scotland's National Dementia Strategy, June 2010.

Appendix 1. Dementia Care Pathway Action Plan

Demand data

National demand estimates:

- The estimated number of people with dementia needing care at least once daily is 44% of the number of people with dementia in an area.

- The estimated number of people with dementia living alone is 13% of people with dementia in an area.

- If it is assumed that all people living alone in the community and 50% of those living with families require services, this will give a working target for service users of 28% of people with dementia in an area.

- The estimated number of people with dementia who are independent or require help once a week is 17% of the total number of people with dementia in an area.

- This should take into account that some may require theses services for only a short time before they need more intensive care arrangements.

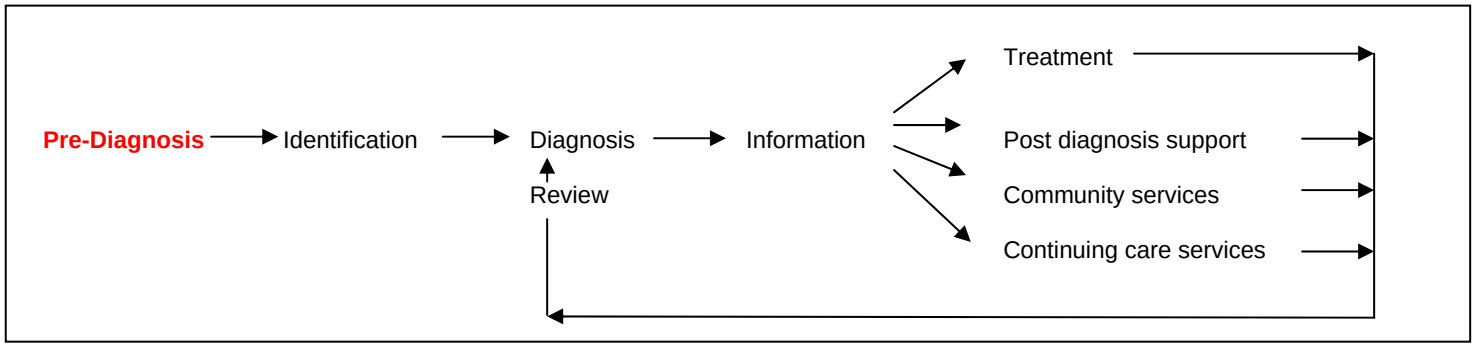
Local context:

- Although the population of Inverclyde is anticipated to fall over the next decade by about 16%, from 85,000 in 1998 to 71,400 in 2013, the number of elderly is anticipated to increase (number of people over 65 to increase by 27% by 2024). This will have disproportionate effect on demands for our services.

  It is estimated that 10% of the population aged 65+ and almost one third (30%) of people aged over 80 years are likely to be affected by dementia. In Inverclyde the older population is expected to increase in real terms and as a proportion of the population overall. This means that there will be a 10% rise in the number older people aged 85-89 and a 36% growth in the numbers of older people who are aged 90 years or more. This level of population change will result in an increase in the incidence of dementia in Inverclyde.

  Please note that the following plan refers to only to **organic** dementia

3.1 Pre-diagnosis services



Action Plan Key

***Italics* = National statement**

Non italics = Local discussion points

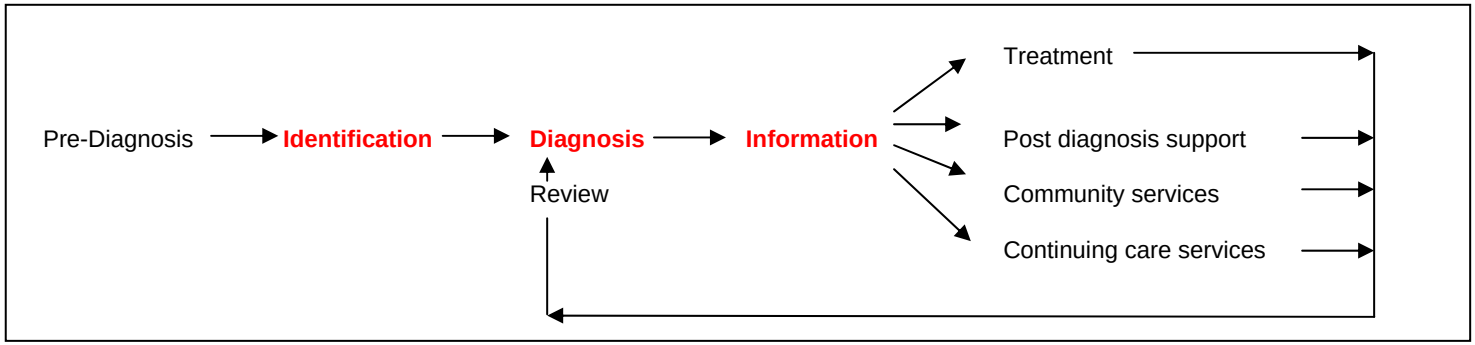
Aims:

- **To understand that dementia is an illness**
- **To recognise the possible significance of symptoms**
- **To recognise that mild cognitive impairment does not necessarily lead to dementia**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Anti stigma and awareness programme	*Local participation in and promotion of national and other initiatives designed to fit local circumstances and need.* *Support, information and advice on memory problems and mild cognitive impairment.* Staff education on what dementia is and how it can be managed from early stage. Staff training for different staff groups – 'Everybody's Business' Promoting and explaining what services are available, including support in Primary Care. Potential diagnosis to be discussed with patient and carers.	Identify levels of training available in Dementia. Identify staff groups to training and to what level. Undertake Training needs analysis across staff group to inform learning action plan. Include training for Carers. Review existing service information, and identify educational information relevant at stages of Dementia.	Learning Action Plan	Subgroup of Project Group: L&D; Bernie McGeown; Deborah G/Margaret A Support from Dementia collaborative Link to CHP communication group/Council information services

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
	Health promotion aspect: for general community; and for people on diagnosis within early interventions Promotion of local services to staff and public. Primary Care role in the first instance. Equality of Access and inclusion. Using mainstream services without having to use speciality services. Access for all age groups.	Engage with Health Promotion Carry out EQIA Engage with Anti stigma partnership to include consideration of Dementia	Appropriate material and agreed approaches established Identification of gaps, inform action plan and identify leads	Deborah G/ Andrina Hunter
Assessment of current and forecast local and regional needs.	*Design of services to align with assessed current and future needs.* Identification of high risk group from practice registers and implements monitoring of this group. Local population demographics (demand methodology)	Develop dementia register Collation of local demographic data	Will meet HEAT target T9 and allow measuring against this target	Alan Hughes/ Jim Ward Deborah G with CHP
Assessment of existing services and identification of gaps in provision.	*Improved local access to services including Memory Clinics and old age psychiatry assessment services.* Care management - signposting Entry to services established.	Process mapping against ICP	Identification of gaps, inform action plan and identify leads	DG/MA /Project Group April 2009

3.2 Diagnosis



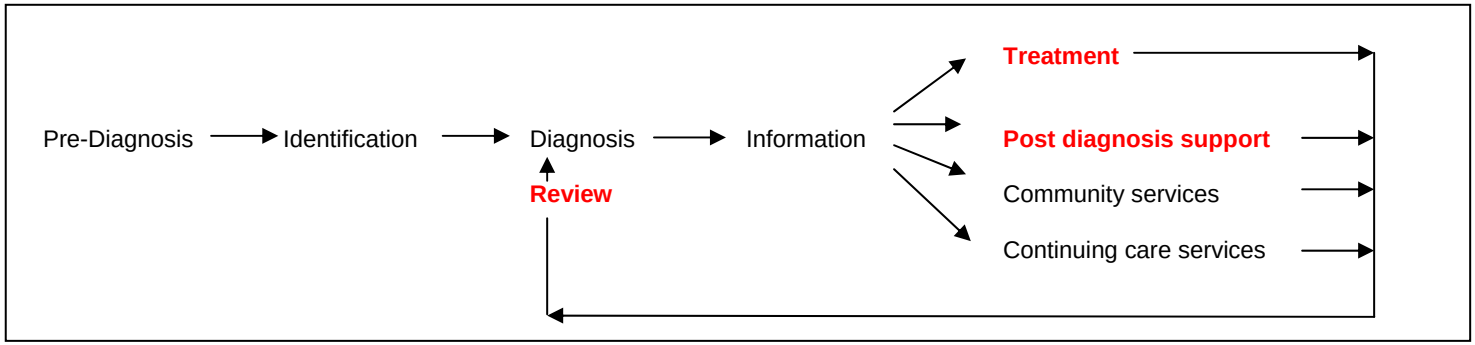
Aims:

- **For the first person with possible dementia to know if symptoms are caused by a form of dementia and to seek appropriate medical response**
- **To identify the type of dementia**
- **Comprehensive advice to service users and carers on dementia and the organisation of local services and support.**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Assessment of local access to diagnosis services *Local multiple entry points, care pathway documents and protocols in place that reflect the needs for those under and those over age 65.*	*GP and wider primary care team services* *Memory clinics* *Neurology services* *Old age psychiatry services* *Appropriate drug treatments* Range of professionals involved need to understand their role in dementia diagnosis	Process map against SIGN 86 and ICP	Meet SIGN Guideline recommendations.	DG/MA Project Group April 09
GP practices to develop specialisation in dementia diagnosis and follow up	GP diagnosis – meeting SIGN guidelines	GPs to review Protocols, Guidelines and Processes.	Meet SIGN Guideline recommendations and feed into overall pathway.	Jim Ward/ Alan Hughes/ Margaret A

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
The potential roles of the primary care team as a whole.	Creating Service Enabling Team from existing teams, may identify individual for register Register – kept at primary care Register populated by first point of contact and register actions by all functions of team.	Process mapping, ICP development; piloting early intervention approaches – will inform future organisation of resources. IT systems and processes to be established.	Appropriate response and access to services based on need and informed by SIGN/ICP.	Alan Hughes/ Jim Ward/ IT services

3.3 Post Diagnosis support



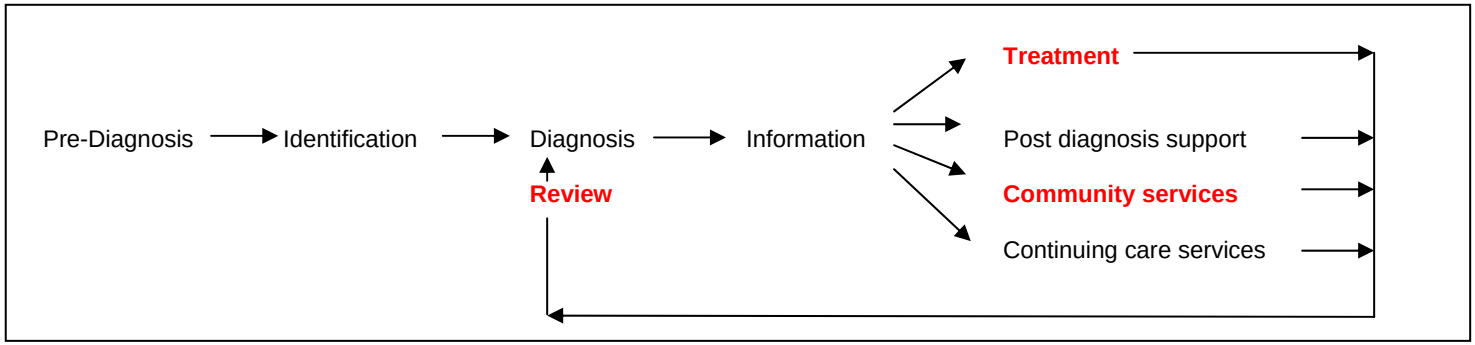
Aims:

- **To plan for the future, including initial advice about the Adults with Incapacity Act (Scotland) 2000**
- **To receive support, advice and information that are required to live with the illness until community services are required**
- **To help maintain independence**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Thorough on going assessment of needs	*Up to date and accessible information and advice.* *Accessible local, on-going counselling and emotional support.* *Access to local independent advocacy.* Inclusion led. *Improved local day opportunities and services.* *Available education and training for carers.* *Information on welfare benefits and financial advice with established links to local Department of Work and Pensions.*	Audit against ICP toolkit. Pilot and evaluate early intervention approaches within identified GP practices [Alzheimer Project work link] Ensure link with Rehab and Enablement work locally.	Identification of gaps and improvements to service that may be required. Model for early interventions developed	Vaughan Jones/ Steering group/ Jim Ward DG

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
"Dementia as part of everyday life"	*Maintaining autonomy* *Maintaining lifestyles/routines* *Individualising responses* *Sustaining employment for those with dementia and their carers.*	Link to anti stigma and awareness work and realising recovery. Establish link with Recovery Inclusion Group for Dementia to be included		Vaughan J/ John Smith
Future planning Planning for change	Assistance to help those with dementia and their carers to plan for the future, e.g. power of attorney			

3.4 Community Services



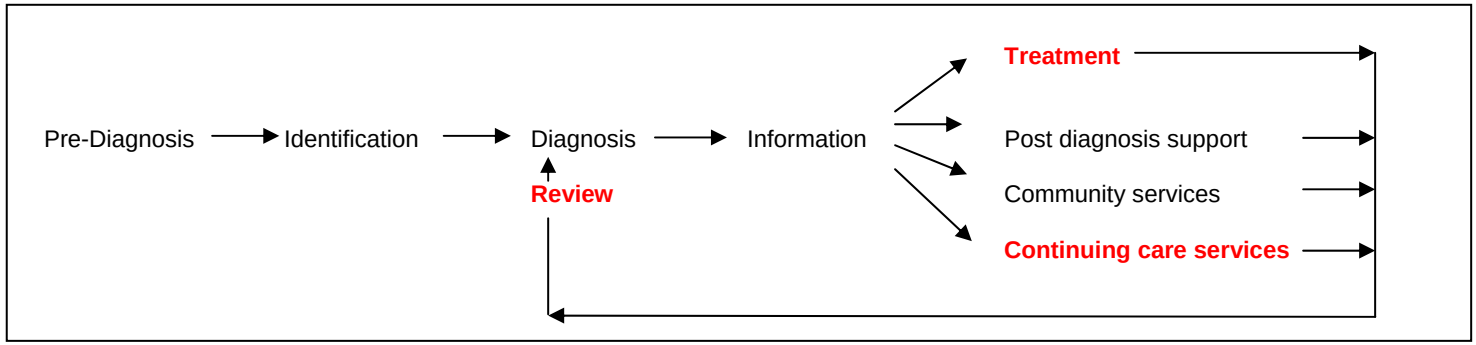
Aims:

- **To enable people with dementia to remain in their own home for as long as they wish and it is possible.**
- **To prevent inappropriate hospital admission and facilitate good discharges.**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Local and regional assessment of numbers and needs	Ensure that services are able to respond appropriately based on level of need. Assessment – more focus on abilities and person's interests/wishes Clarity of care co-ordination and care management roles. Flexible homecare which works with person's strengths and abilities Day Care - Access to range of day facilities. - Community groups/clubs (transport/advertising), link to	Practice Development Review existing approaches to assessment, and complimentary assessment tools e.g. FACE to link with existing SSA Consider current approaches within home care services, including third sector. Link to Home care redesign. Priorities/assessment/criteria to ensure service is utilised and targeted appropriately Wider discussion required with service leads. Proposed initial half day		Local Authority commissioners/ Project Group

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
	anti-stigma and awareness.	workshop to scope day care issues to inform development of capacity and approaches.		
	Respite – Range of flexible respite provision.	Map respite currently available and identify any gaps. Link to existing Respite Strategy group.		Discuss with Yvonne Goldie
	Pharmacy support, ensuring appropriate pharmacy support.	Current business case for clinical pharmacy service.		
People with a diagnosis of dementia will need access to rehab services		Map existing pharmacy services and clarify access.		
The role of assistive technology in managing risk and helping people with dementia maintain their independence.		Develop directory of available services for use by staff and public.		
Availability of intensive packages of support to contribute to changing patterns of long term care and continuing care at home, including palliative care.	Telecare – protocols clear for referrers and uses Community Support Flexible intensive home support Links to development of intermediate care	Clarify existing access, protocols and information, via existing telecare group. Input to Consultation on Telecare Strategy.		Deborah G/Michelle M/ Alison Winters/ Gillian R/ Kate Lowson

3.5 Continuing Care



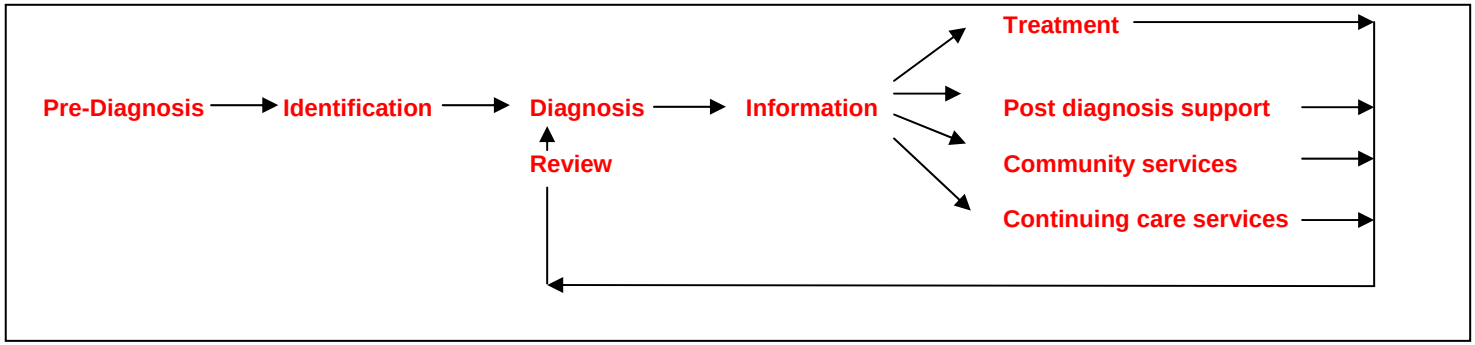
Aims:

- **To care for people who can no longer be cared for in their own home.**
- **To provide for the end stages of dementia or dying of other causes.**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Balance of care between hospital and care home. Revised guidance on NHS continuing care Managing assumptions and expectations of service responses.	Change expectations Coping with challenging behaviour in various places. Prevent inappropriate hospital admission Placement to match patients needs Carer involvement Staff trained appropriately Matching skill to care Outreach to home setting – specialist input	Develop indicators of when situation/needs may be changing Use of dependency tools to assess levels of need across service areas. ? Inclusion of EMI in SCRUGS exercise. Appropriate support and intervention where behaviour becomes more challenging and where this may be an indication of care needs changing. Matched intervention – refer to ICP Increase carers participation in care plans Training needs analysis, as above	Improve shared understanding of progressions of illness, and appropriate responses	MA/ GR/ DG

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
	Community nursing team – extend current Ongoing review of continuing care and appropriateness of environment.	Early support planning for care. Further development of existing protocols around reviews.		
End of life palliative care will be needed. Lack of community based palliative care for dementia.	Advance planning in relation to end of life care, which includes consideration of the preferred place of treatment if the condition worsens. Bereavement support (especially from death in ward – follow up needed)	Scoping exercise to develop understanding of what this means to the service.		Requires link to wider Palliative Care work local and national.
Discharge	Planning prevents readmission Lengthy AWIA procedures			

3.6 Co-ordination



Aims:

- **To ensure that people with dementia have their needs assessed and receive the services they needed seamlessly**
- **To apply the principles and process of Adults with incapacity (Scotland) Act 2000**
- **To ensure that the carers of people with dementia have their needs assessed and receive the assistance they require**
- **To ensure a partnership approach to local and other needs assessment, planning and delivery of dementia care**

Critical factors to be considered	Ways in which service may respond	Local Action	Outcomes	Lead and Timescales
Continued contact at all levels between the statutory and other agencies on the joint planning and delivery of care.	*Care management*			
Consideration of lead agency, where thought appropriate	*Assessment and re-assessment of the person with dementia and their carers* *Appointment of key workers*			
Joint services for the person with dementia and their carer	*Multidisciplinary and joint agency working*			
Agreed local arrangements to share and access information between agencies	*Multiple entry points local care and pathways that are sensitive to the transitions between services and levels of dependency*			