Health and Wellbeing Board
Meeting Date 16th January 2020

Responsible Officer: Cathy Davis, Commissioning & Redesign Lead - Mental Health (interim), Shropshire Clinical Commissioning Group (CCG)

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1. Summary

2. Recommendations

REPORT

A report is attached

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

4. Financial Implications

5. Background

6. Additional Information

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

Purpose of the report:

1. To provide the Health and Wellbeing Board with an update on the current commissioning work in dementia.
2. Key work areas for the programme for the coming year
3. Hospital avoidance accreditation update (separate presentation)

Agenda Item:

Introduction

1 Dementia is a growing health problem and of the current 850,000 estimated UK prevalence approximately 550,000 have confirmed diagnosis. Our older population will see the most rapid growth in the next 20 years and as a result a growth an increase in dementia and other conditions affecting the elderly.

2 In Shropshire, Telford and Wrekin there are an estimated 7,410 people living with dementia and 5,390 have a diagnosis.

3 The impact of dementia on Shropshire health services remains significant and is of great cost. Many live with dementia and multiple other long term conditions.

4. Alcohol related brain damage (ARBD), Alcohol related dementia, Alcohol Amnesic syndrome as well as other conditions all occurs as a result of physiological changes to the brain, following long term heavy alcohol use. According to research, Wernicke-Korsakoff syndrome occurs in around 2% of the general UK population and 12.5% of dependent drinkers, extrapolating this to Shropshire equates to 349 people with the condition in the county.

4 People with dementia spend spells in acute hospitals for otherwise home treatable conditions. People with dementia also make disproportionate use of A&E services. Behavioral changes in the person and mental health crisis are the most common concerns for families living with dementia.

Background

5 The NHS England Well Pathway on Dementia (2015) divides the dementia journey into 5 steps.

Preventing Well	Diagnosing Well	Living Well	Supporting Well	Dying Well
Risk of People Developing Dementia is minimized	Timely diagnosis a care plan with a review within 12 months	Access to high quality and safe health and social services for people and for care	People live normally with dementia and access safe and accepting communities	People have the right to die with dignity in a place of their choosing
The Statements: "I was given information about reducing my personal risk of getting Dementia"	"I am able to make decisions and know what to do and who else	"I get treatment and support which are best for my dementia and my life"	"I know those around me and looking after me and supported. I feel included and part of society"	"I am confident my end of life wished will be respected" "I can expect a good death"

	can help me"			

6 Shropshire CCG created its Dementia strategy in 2017 in order to deliver the Well Pathway and respond to findings of an engagement report from Health Watch Shropshire which surveyed people living with dementia. It outlined 4 strategic goals and 7 key objectives to be met by 2020.

Key Objectives of the Shropshire 2017 Dementia Strategy deliverable by 2020

Strategic Goals

1. Diagnose dementia earlier.
2. Increase the provision of support during the earlier stages of the dementia journey through implementing the Shropshire Model for living with dementia.
3. Provide a crisis-resolution team to work collaboratively with community-based physical treatment services, to eventually gate-keep all admissions for people with dementia, ensuring that hospital admission only takes place as a last resort.
4. Provide a greater number of dementia support workers in the inpatient setting.

Key Objectives

1. A greater understanding of what can be done to reduce the risk of dementia in the county, resulting from a successfully implemented prevention strategy.
2. GP based diagnosis, commencement of treatment and specialist advice, resulting from placement of memory and dementia specialist nurses in local practices.
3. Good post diagnostic support to promote social inclusion, functional independence and sustainability of role, whilst ensuring care feels more joined up at the point of delivery. The opportunity for assistance from a Dementia Companion will assist in achieving this.
4. A service that can respond out of hours, to people living with dementia and their carers who are in crisis. This will result from having a properly specified crisis resolution service for people with dementia.
5. Efficient and effective use of inpatient resources. This will result from the provision of sufficient numbers of dementia support workers to enable the needs of people with dementia to be met in a more efficient way, whilst planning for discharge at the point of admission.
6. Robust and effective early discharge arrangements. This will result from dementia support workers working together with Dementia Companions, independent sector providers and home treatment services to ensure that adequate community-based support is provided.
7. Palliative care arrangements that are more responsive to the needs of people with dementia. This will result from closer working with local palliative care specialists, and development and delivery of strategic intentions towards making this happen.

7 The strategy outlines a new model for post diagnosis dementia care in Shropshire. The strategy introduces the role of the dementia companion as the link worker supporting the person to access services and information to have their health and wellbeing needs met:

Support For Carers	Providing Information	Therapeutic interventions on the causes of Dementia
Keeping engaged with the community	Person with Dementia	Making sure mental health needs are met

Planning and Personal Choice	The Dementia Companion	Making sure care is personalised
Making Sure Physical needs are met	Locally Accessible Expert Advice	Creating an enabling environment

8 What has been achieved since 2017?

- ✓ Shropshire CCG funds two companions as part of a pilot - in Oswestry and Ludlow.
- ✓ Achieve diagnosis prevalence rate
- ✓ Assessment and diagnosis increased access- dementia team see people within clinics at MPFT bases in Shrewsbury (Seven Fields Health Village) which is also GP practice (upstairs) Bridgnorth, Market Drayton, Oswestry, Ludlow, for people referred from practices within these localities. Positive feedback from people coming into clinic. People can also be seen at home and within residential and nursing home.
- ✓ Nurse practitioners who are also non-Medical prescribers who undertake the assessments and work closely with old age psychiatrists. Introduced a pre clinic information gathering and information giving (re the assessment process which can be daunting for people) recognising that whilst the memory service is referred to actually people will be given a diagnosis (where appropriate) of dementia. Currently our experienced support workers take on this role with very positive feedback.
- ✓ CCG funding of day services, cafes and peer support.
- ✓ Development of the dementia friendly hospital charter action plan.
- ✓ Development of hospital avoidance programme which was presented to Royal College Psychiatry awarded successful Accreditation.

The Way Forward and next steps

9 National and local developments to note since the publication of 2017 strategy:

- *NHS England target of six weeks for delivering diagnosis from referral.*
- *NHS England monitoring the prescribing of anti-psychotics to people with dementia monthly. Shropshire is currently above the national average rate at 10.6% (376 people)*

10 Public Health England published what to expect after a diagnosis of dementia (2018) which included these standards for personalising dementia care:

- A care plan I am involved with
- A named person who coordinates and monitors my care
- Help with my day to day activities
- Support for the people who care for me

11 The Shropshire Care Closer to Home programme is currently piloting a new personalised and integrated care approach of risk stratification and case management for people aged 65 and over, underpinned by the principles of identifying people and their needs earlier, enabling the provision of proactive preventative care and support from a joined up team of health, mental health and social care professionals.

12 Care is coordinated by a named case manager and the risk stratification tool currently identifies people suitable for referral to the programme based on a range of criteria which is currently based on physical health information. The next phase will be to integrate with mental health and social care information; enabling locally available teams to identify individuals and their needs delivering elements of the standards (personalising dementia care through the provision of proactive integrated holistic and person-centered care planning).

13 Shropshire performs well in terms of diagnosis to prevalence rates currently 71% against the NHS England 66.7% target (currently 65.1%). Whilst the system meets the national target there remains around 31% of people with dementia in the county yet to be diagnosed.

14 Reviews are continued by the dementia team currently although no longer indicated within nice guidelines, aim is to move to a needs led review and utilise capacity for the case management model (care closer to home). Whilst we achieve the national prevalence rate, going forward to support the increase in diagnosis, we aim to develop more clinics in general practice (ensuring referral rates indicated). To consider increasing access to clinics by developing Saturday clinics as aware some relatives find weekdays problematic.

15 Offering wider patient choice on point of accessing assessment and diagnosis should greatly reduce people's non-attendance of an appointment and subsequently increase diagnosis rates. There is potential to also expand delivery of the service at home and in other community hubs/hospitals as well as in-surgery.

16 Historically professionals have viewed alcohol use as a life style choice as a 'free choice' and unless the individual agreed to receive or engage with services then support was often not provided. It is therefore proposed that adult social care have a workforce which understand the impact of alcohol on the individual and that there are systems in place to respond accordingly, this will include developing a plan for people who have dementias as a result of Alcohol Related Brain Damage.

Next Steps

16 Key actions**.**

2017 Strategy Objective/Strategic Goal	Work In Progress	Recommendations	Resource Impact
Preventing Well A greater understanding of what can be done to reduce the risk of dementia in the county, resulting from a successfully implemented prevention strategy.	Joint authority prevention programmes in place as part of wider healthy living initiatives.	Create a Dementia-specific Prevention strategy.	No
Diagnosing Well Earlier diagnosis. GP based assessment and diagnosis, commencement of treatment from specialist nurses based in local practices.	Two surgeries have installed an in-surgery assessment and diagnostic service.	To meet the National guidance in full a further roll out of this model is required. Identification of suitable sites and workforce requirements. Primary care case study.	Yes - Develop business case for consideration at CCC

	Development and implementation commenced within Shropshire Care Closer to Home (SCCtH) Phase 2.		No – Already within the design of SCCtH.
Living Well Good post diagnostic support to promote functional independence and wellbeing. Ensuring care feels more joined up at the point of delivery. The dementia companion as the integral role coordinating this.	Two Dementia Companions in post serving Ludlow and Oswestry towns only Three Dementia Support workers (by referral only for specific issue then discharge.) Serving North Shropshire, Shrewsbury/Central and South Shropshire. CCG funding third sector run day services peer support groups and cafes. Focus group in place on person centered Care planning for dementia.	Further development of the Dementia companion role with evaluation criteria that measures for the person centered approach. Develop template for person-centered-profile Develop template for post diagnosis services information pack Evaluation and review of DSW service. Evaluation and of day services and cafes	Yes - Develop business case for consideration at CCC No No No No
Supporting Well A service that can respond out of hours, to people living with dementia and their carers who are in crisis. This will result from having a properly specified crisis resolution service for people with dementia. Robust and effective early discharge arrangements. This will result from dementia support workers working together with Dementia Companions, independent sector providers and home treatment services to ensure that adequate community-based support is provided.	Partnership trust implemented pilot admission avoidance scheme resulting in a reduction of crisis beds. Out of hours service. One dementia support worker in post in each hospital site PRH and RSH signed up to dementia friendly hospitals charter and 2019-21 trust implementation plan.	A Business case for pilot expansion of specialist dementia nurse service providing crisis prevention and resolution, with community visit and telephone support	Yes - Develop business case for consideration at CCC
Dying Well Palliative care arrangements that are more responsive to the needs of people with	Dementia Companions distributing support for	A Review report to include:	No

dementia. This will result from closer working with local palliative care specialists, and development and delivery of strategic intentions towards making this happen.	people to make advance end of life wishes and navigate legalities of LPA. NB - The rate of People in Shropshire with dementia dying in their usual place of residence is above the national average.	Coverage of dementia training and End of life training programmes in Shropshire Dementia expertise in care home, respite homes, hospices and acute settings.	

17 The Board is asked to note the progress against the Dementia strategy and updates in relation to national guidance.