REPORT TO: **Health and Wellbeing Board**

DATE: **29th March 2017**

REPORTING OFFICER: **Strategic Director, People**

PORTFOLIO: **Health and Wellbeing**

SUBJECT: **Dementia Update**

WARDS: **All**

1.0 PURPOSE OF THE REPORT

To provide an update to the Board on Dementia diagnosis rates, services and priorities.

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 Dementia Strategy and Dementia Delivery Group

The Halton Dementia Delivery Group is a multi-agency group that represents health, public health, social care, voluntary/community sector and carers and is responsible for the delivery of the 'Living Well with Dementia in Halton' Strategy. This strategy aims to encourage early, accurate diagnosis and to ensure health, social care services and the community/voluntary sector are organised so that those living with dementia, and their carers, have access to care and support that is informed by best practice and meets local demands. The Dementia Delivery Group reports to the overarching Mental Health Oversight Group.

The strategy runs from 2013-2018, with the delivery plan being updated in early 2017, in line with the refresh of the overarching All Age Mental Health Strategy. Actions in the delivery plan will also take into account recommendations from the ADASS North West Dementia Perspectives report.

3.2 Dementia Diagnosis Rate in Halton

There is a target set locally by NHS Halton Clinical Commissioning Group (CCG) of a diagnosis rate of 75% by March 2017.

Halton reached a diagnosis rate of 72% in April 2016, however following this, the tool used for data capturing was changed, meaning only people aged 65+ with a diagnosis contributed towards the rates, excluding all those identified with early onset. As Halton practices had a significant

number of patients with early onset, this resulted in a sudden drop in the diagnosis rate. From April 2016, the prevalence figures for Halton were also increased, resulting in another drop of the diagnosis rate. The latest available (October 2016) had the Halton diagnosis rate for people over the age of 65 at 72%.

Work has been done locally to focus efforts on improving diagnosis rates, including regular contact with practices by NHS Halton CCG to raise awareness of the use the Dementia Quality Toolkit (DQT) and maintaining data quality through regular cleansing. The DQT consists of a series of reports and queries run directly on GP systems to identify patients who may have dementia, but who are not coded as such within the practice.

It is now widely accepted that diagnosing dementia enables individuals to gain access to care and support, and therefore support better outcomes for people. Whilst dementia is an incurable, progressive disease, a diagnosis as early as possible and that is done in a timely manner, allows people with the disease to have the opportunity to make decisions about their future care and support, whist they are able. Work has been undertaken locally to ensure that post diagnosis support within the community is varied and responsive to people's needs, working alongside clinical treatment and support to enable people to live well with dementia for as long as possible. Work has been underway to inform Primary Care of positive changes to the Halton Post Diagnosis Community Pathway, further encouraging practices to diagnose dementia through reassurances that there is access to appropriate, quality community provision that is in line with NICE recommendations.

A care home screening pilot took place over a 4 week period in March 2016, with the Later Life and Memory Service Care home Liaison Team (CHL) screening patients in care homes (where families gave consent), who did not have a diagnosis of dementia. This resulted in 18 people being diagnosed. Due to the success of the pilot, the CHL has rolled this out to all other care homes from September 2016.

In April 2017 the calculation that NHS England uses to derive the local diagnosis rates will change again. However, NHS Halton CCG expects that this will have a positive impact on Halton's diagnosis rate; therefore the target of 75% will remain for 2017/18.

3.3 Later Life and Memory Service Performance (LLAMS)

The revision of the The Halton Later Life and Memory Service (LLAMS), delivered by 5 Boroughs Partnership in 2013, has offered rapid access to specialist cognitive assessment, diagnosis and intervention and treatment for those living with dementia, and for those with a functional mental illness who have later life needs. The service model provides the following:

- A single point of access
- Same day screening & prioritisation of all referrals by a senior nurse
- Same day face to face assessment for urgent referrals
- Face to face assessment within 10 working days for all non-urgent referrals
- Crisis intervention and rapid response where deemed necessary following assessment

Since 2013, the LLAMS pathway has seen an increase in referrals. Ninety eight percent (98%) of referrals are being offered an appointment within 10 days of referral, 99% of all urgent referrals are seen within 24 hours.

3.4 Post Diagnosis Community Pathway

The pathway underwent review during 2015/16, with a Prime Provider model being adopted for 2016/17 on an initial 2 year contract, with an option to extend for a further year. The pathway offers a single point of access, information upon diagnosis and at each stage of the person's dementia journey, ongoing navigation support through the dementia pathway through the Dementia Care Advisor service, signposting to appropriate support provided by pathway partners, community and voluntary sectors and other sources of dementia specific and universal information and support, access to recreational groups, peer support and on-going support for carers – including information, activities and caring skills training and the Halton Admiral Nurse Service providing specialist support for the most complex and/or severe cases.

3.5 Later Life and Memory Service Care Home Liaison Team (CHLT)

The Care Home Liaison Team (CHL) are commissioned by NHS Halton CCG through 5BP, to improve patient care, reduce the level of psychiatric morbidity within care homes and prevent inappropriate admissions/readmissions into acute and secondary care. This includes assisting and supporting care home staff, families and carers to understand the journey of dementia through education, training, supervision and role modelling.

3.6 START (Strategies for Relatives)

START is an eight session manual based intervention aimed at promoting the development of coping strategies for carers of people with dementia. The intervention equipping carers early on in their caring journey with acceptance and positive techniques. The University College London (UCL) trial of START showed that this intervention reduced depression and anxiety for family carers of people with dementia. Even up to two years later people who received this support were able to manage their caring role and changes they may face, with less anxiety and symptoms of depression than those who didn't receive the support.

A small local pilot was undertaken in 2015/16 to test the need and suitability of the intervention in Halton. From January 2017 Halton Carers' Centre include START as part of their offer to Dementia Carers, with supervision from Halton Positive Behaviour Support Team.

3.7 Living Well Memory Screening Training

After a small local pilot, training to screen for memory problems using the NICE recommended 6CIT tool has been developed by Halton's Integrated Health and Wellbeing Team. Training on awareness and undertaking screening is now available to front line staff in partner organisations. The intervention supports the 'every contact counts' approach by the use of non-clinical community based staff in identifying signs of possible memory or cognition problems, and the use of the 6CIT tool and referral pathways. The aim is to promote awareness of dementia amongst front line professionals and increase dementia diagnosis rates through early intervention. The pilot, and subsequently developed training programme, also incorporates falls risk assessment and assessment of social isolation/loneliness.

3.8 Halton Dementia Action Alliance (DAA)

Since late 2014 the Halton DAA has gained 30 active member organisations representing health, social care, voluntary, community, recreation, retail, faith, housing and emergency services. All of which have action plans detailing what actions they are taking to improve the lives of people living with dementia, and their carers. However, the wider DAA network is growing, with between 60-120 people representing a range of organisations attending the quarterly events. DAA members and those participating in the wider DAA network have contributed to the Dementia Chapter of the Joint Strategic Needs Assessment, the START pilot and subsequent roll out of the intervention by Halton Carer's Centre, the Living Well pilot and subsequent development of the training programme and service developments such as the formation of a younger carers Dementia support group delivered by Halton Carer's Centre and the revision of the post diagnostic community pathway.

The DAA has provided the vehicle for Halton to achieve 'Working towards becoming a dementia friendly community' status, which it has held since early 2015.

3.9 Healthy New Town Project

One aspect of Halton's Healthy New Town (HNT) development is the redesign of health and social care services, using innovative approaches, to meet current and future needs. One such involves Runcorn Shopping Centre (RSC) to deliver a dementia-friendly environment. This will use digital technology to support individuals to shop and socialise safely and with confidence. In addition, RSC staff will

be skilled to identify and address individuals with dementia as a means of further developing our 'safer in town approach.'

If successful, the hospital site within the planning area will be linked with GP practices and will deliver integrated health and social care teams to provide in-reach and out-reach support across the community. This will be in existing health venues, in people's homes and in community spaces and in outdoor 'clinical' facilities. These teams will incorporate a range of disciplines from doctors to domiciliary support, community psychiatry to holistic therapists and health improvement specialists. This will ensure provision can address challenges such as dementia through the provision of good quality residential and home care services, alongside wellbeing enhancing activities and support.

3.10 Halton Admiral Nurse Service

Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges. The team provides families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

The service comes with an element of a *given* remit to work with those patients and families with the most complex needs as a result of coping with a diagnosis and the associated behaviours. However, the Admiral Nurse Service has been tailored to the needs identified in Halton, and complements the range of existing community provision within the borough.

3.11 Joint Strategic Needs Assessment (JSNA)

The dementia chapter of the Older People's JSNA was published in September 2016, which outlines the current and projected level of need of people living with dementia in Halton. The JSNA goes some way to identify emerging issues and key priorities. The JSNA chapter can be viewed at http://www4.halton.gov.uk/Pages/health/JSNA.aspx

3.12 Emerging Issues:

Reviewing Dementia Priorities

NHS Halton CCG are looking to focus their next set of dementia priorities around working with Halton Council Quality Assurance Team to identify ways of training all care home staff in how to recognise the signs of dementia and screen patients appropriately. The CCG are also keen to explore technology based support if it is available and has evidence base and plans to expand the Dementia Friends initiative and increase membership of the Halton Dementia Action Alliance.

Secondary Care Data

Continue working with GP practices and secondary care in the sharing of information between primary and secondary care, particularly around diagnosis.

North West Coast Strategic Clinical Dementia Network Group

Continued participation in the Dementia Clinical Network provides targeted support, tools and resources to aid better understanding and improvements in local dementia diagnosis rates and post diagnostic care and support. This network has representation from NHS Halton CCG and Halton Borough Council.

Beyond the Front Door

Halton DAA are supporting Life Story Network (part of Liverpool DAA) in the Department of Health funded 'Beyond the Front Door' project, which will explore issues relating to the concept of 'home' to better understand the sense of identity and wellbeing for people living with dementia in order to improve post-diagnostic and multi-agency support. The objective is to develop a set of products that support staff in working with people affected by dementia across the range of agencies (Housing, NHS Trusts & NHS and LA Commissioners), with responsibility for both commissioning and providing meaningful post diagnostic care and support. From August 2016, representatives from Halton have been present in several focus groups of older people via Halton Housing Trust, along with two Halton Housing Trust staff participating in the focus group session for the housing sector. Multi- Disciplinary work-shops took place in December 2016 to progress this work.

4.0 POLICY IMPLICATIONS

There are a number of policy drivers for the work of the Dementia Delivery Group, namely:

'Living Well with Dementia: A National Dementia Strategy' aimed to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.

The Prime Minister's Challenge on Dementia 2020 aims to deliver major improvements in dementia care and research by 2020.The Prime Minister's Challenge provides a framework which directs national and regional action. The goal is to make a real and positive difference to the lives of people affected by dementia.

The Care Act 2014 is designed to create a principle where the overall wellbeing of the individual is at the forefront of their care and support. To

promote individual wellbeing, their needs, views, feelings and wishes should be considered in all aspects of their wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation. Whilst the Act incorporates care and support across the board, when thinking about how dementia services are developed, the Local Authority and health care partners need to consider the following:

• access to services that help prevent their care needs from becoming more serious
• access to good information to help them make informed choices about their care and support have a range of good care providers to choose from
• the public know how to access independent financial advice
• the public know how to raise concerns over the safety or welling being of someone with care needs

Living well with dementia in Halton ‘local strategy and implementation plan compliments other work programmes including the Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton Health and Wellbeing Strategy, Carer’s Strategy Action Plan, Falls Strategy and Loneliness Strategy.

Halton Health and Wellbeing Strategy prioritises Mental Health across the life course, including dementia and organic cognitive decline.

Care and Support services in Halton are in line with recommendations out lined in **NICE Quality Standards and Guidance for Dementia:**
NICE Pathway for Dementia
NICE Quality Standard 1: Standards of care for people living with dementia
NICE Quality Standard 30: Supporting people to live well with dementia.
NICE guidance Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset?

Halton Dementia Delivery Group contributed to the 2016 ADASS ‘Dementia Perspectives, State of the Region Report’. The report made a number of recommendations, many of which Halton could demonstrate that progress was already being made locally. The ADASS report findings; best practice and recommendations will be considered in the refresh of the Halton Dementia Strategy Delivery Plan.

5.0 FINANCIAL IMPLICATIONS

The resource implications of the activities outlined above have been approved through the appropriate boards i.e. Operational Commissioning Committee (OCC), Service Development Committee.

6.0 RISK ANALYSIS

None identified at this time

7.0 EQUALITY AND DIVERSITY ISSUES

None identified at this time.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972.

None under the meaning of the Act.