ISLINGTON

Corporate Resources
Town Hall, Upper Street, London N1 2UD

Meeting of:	Date	Agenda item	Ward(s)
Health and Wellbeing Board	20 March 2013		All

SUBJECT: Supporting Dementia in Islington

1. Synopsis

1.1 Improving Mental Health and Wellbeing is one of three priorities set out in the Joint Health and Wellbeing Strategy 2013-16. Dementia care is an important area to consider particularly within the older population.

1.2 This report sets out our progress and achievements since "Living Well with Dementia" was published in 2009 as well as some challenges and plans for the future.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to:

- Note the achievements in Islington to support dementia care
- To note the current developments to improve dementia care in the community

3. Background

3.1 Data shows that although Islington has a lower prevalence rate than national comparators, because of the relatively low number of 65+ population, we have high rates of diagnosis with 759 diagnosed cases. Islington has been recognised as a national leader in diagnosis with 70% of the expected population being diagnosed compared to a national average of 44%.

3.2 94% of Islington's diagnosed cases are over 65 with an average diagnosis age of 79. More women have dementia than men (4.4% compared to 2.7%)

3.3 Dementia is more common in social housing than other tenures with 5.8% in areas with a high concentration of social housing and 4% in other areas.

3.4 In 2010/11, 82% of diagnosed cases were reviewed by GP's compared to a London wide figure of 80%. This means 127 people with dementia did not have their care reviewed.

3.5 People with dementia in Islington are twice as likely to have a stroke or have depression. They are also more likely to have a long term condition.

4. Key findings and actions

4.1 NHS Islington responded to Living Well with Dementia by increasing investment to support dementia.

Key service developments included;

- Setting up the Memory Assessment Service delivered by Camden and Islington FT (CIFT)
- Development of dementia advisors (currently provided by the Alzheimers Society)
- Mental Health liaison nurses working across acutes and care homes (currently provided by CIFT)
- Improved services for carers, for example, Cecelia's café run by the Alzheimers Society

4.2 These developments mean that the borough benchmarks well against the recommendations set out in the strategy as well as against the NICE dementia pathway.

4.3 In September 2012 the Older Adults Integrated Care Group received a report highlighting achievements against the 12 recommendations as well as setting out further work required. In summary:

1 Improving public and professional awareness and understanding of dementia

We want to gain a better understanding of the impact of our services in improving awareness. This will be through promoting the dementia advisor role more widely, particularly within primary care, to expand referral sources. We will also work with the Alzheimers Society to promote Dementia Week in late May across Council and other services.

2 Good quality early diagnosis and intervention for all

Islington has very good outcomes in terms of volume of diagnosis and this figure is likely to increase further due to Acute CQUIN targets around diagnosing dementia and the new 75+ Health Checks LES. What is missing though is information regarding how patients are supported around the time of diagnosis. We want to look at this through a qualitative analysis of patient experience through the Older People's Reference Group as well as setting outcomes for the Mental Health Liaison Service around diagnosis of depression.

3. Good quality information for those with diagnosed dementia and
4. Enabling easy access to care, support and advice following diagnosis

Information services appear adequate, particularly given the dementia advisor service which provides useful case studies regarding its work. However, we want to see more referrals to this service from sources other than the Memory Assessment Service so that we can be assured the wider community knows how to access information and support. We also want to consider whether to make the dementia advisor service more of a case management role, proactively working with people following diagnosis.

5. Development of structured peer support and learning networks

Existing training provided by the Council is comprehensive and open to staff and external providers. The Dementia Café provides a safe place for people with a diagnosis and their carers to come together for support. Social workers already have monthly 'complex case' forums and this will be further supported by the multi disciplinary approach being developed as part of the CCG's integrated care programme.

One area for further work is the single point of access so that when residents contact health or social care services they can more easily access support networks (and information highlighted in number 4 above).

6. Improved community personal support services

Islington Council is at the forefront of delivering personal budgets so that service users can have

choice and control in how their care is delivered. The borough has a range of experienced home care providers who can support people with dementia in their own homes and two specialist day centres. Respite can be purchased from local care homes or in different ways through personal budgets and the borough has recently gained an advocacy service for people with dementia through the success of a Big Lottery bid by the local organisation Advocacy Plus.

However, GP's tell us that once a patient has a diagnosis "what then"? Similarly, within social care service users may have minimal contact following diagnosis until a crisis occurs and this may result in costly long term care solutions. We are keen therefore to review the community support on offer to people post diagnosis. This will include a review of the dementia advisor role and the mental health liaison. We want to consider a more proactive case management approach post diagnosis that could extend into hospital settings so that if people are admitted there is a service that knows the patient and can support an effective discharge.

7. Implementing the carers strategy

The Carer's Hub are considering how they can support people with dementia alongside the current offer from the Alzheimers Society. We also want to deliver more START courses (strategies for relatives) to help carers in their role. This is currently under consideration for additional investment by the CCG.

8. Improved quality of care for people with dementia in general hospitals

This area appears under developed, despite having mental health liaison posts within both the Whittington and UCH. These services will be reviewed as part of the community based provision in tandem with the work at the Whittington supported by the Burdett Trust and at UCH as part of the 30 day readmission investment.

We also want to understand the patient experience through the new CQUIN.

9. Improved intermediate care for people with dementia

The innovative Enhanced Reablement service is aiming to increase provision of intermediate care for people with dementia in their own homes. This approach will be evaluated as part of the newly expanded Intermediate Care Pooled budget hosted by the Council from April 2013. This approach aims to ensure we invest in provision across health and social care that improves outcomes for patients and makes better use of resource across the pathway.

10. Considering the potential for housing support, housing related services and telecare to support people with dementia and their carers

Islington's telecare offer is well developed, but further take up is desirable. The Services for Ageing and Mental Health (SAMH) are leading on a pilot project to provide telecare alarms for people at risk of wandering. This needs to be evaluated to ensure we understand the impact.

Islington does have extra care housing that supports people with dementia, although we could do more to ensure people can move to supported housing earlier in their care journey.

11. Living well with dementia in care homes

There is good support for Islington residents with dementia in care homes, including training available for care home staff and support from the Care Homes Nurse specialist, Mental Health Liaison service and the CCG's Medicines Management Team. We hope to augment this further with the Community Geriatrician role which will provide clinical leadership and additional support for primary care and others.

12. Improved end of life care for people with dementia

	The CCG's End Of Life Steering Group has supported the funding of an additional post in the Memory Assessment Service to support advanced care planning in 2012/13. It is hoped that this will be funded again through the CCG's investment round for 2013/14. In addition the Elipse service (Islington's community palliative care team) has key workers for each care home and provides specialist care to residents and advice to staff to care for residents at the end of life.
5.	**Next steps**
5.1	In 2012 NHS London supported a Dementia Leadership Development Programme to support the development of clinical leadership within commissioning. Two Islington GP's applied and were successful in getting onto this programme.
5.2	We have been keen to use the expertise that they are developing to support the improvement of dementia services locally.
5.3	As highlighted in the report one area of further work we would like to explore further is how to improve the pathway within the community. We want to make the best use of the resource currently invested in dementia advisors and mental health liaison to support a more proactive case management approach that could identify deterioration in people's conditions so that appropriate supports can be put in place.
5.4	Similarly, having a clear pathway back into the community from acute care settings would have the advantage of reducing lengths of stay and delivering better patient outcomes. Whether we do this through the development of a virtual team that spans primary and secondary care or another approach is yet to be determined but will be considered at a local event on 6th March.
5.5	Another area of work to develop is a performance dashboard so that we understand more easily the impact that services are having. This will be augmented by patient experience measures that can help commissioners target investment - a strategy that will be more important as we go forward within a reducing financial envelope.
6.	**Conclusions and reasons for recommendations**
6.1	Across health and social care the CCG and the Council have worked well to develop a range of services along the patient pathway. These have contributed to Islington being top of the league table for England in terms of dementia diagnosis.
6.2	Improvements have continued since the launch of the national strategy in 2009 with new innovations such as the development of advanced care planning within the Memory Assessment Service which we know can support people to experience better care at the end of life.
6.3	We now wish to focus attention on improving care in community settings, particularly for people who live with carers at home.
6.4	Bringing together providers, commissioners and experts from the voluntary sector, including Carers UK, we want to look at how to improve support for people post diagnosis that will provide better outcomes for the patient and a more managed approach to care going forward.
6.5	We will also investigate whether there are more opportunities for the council and the CCG to work together in a more integrated way, particularly through further pooling of budgets that can lead to more co-ordinated and joined up care at the front line
6.6	This will support not only the Health and Wellbeing Boards priority to improve mental health and wellbeing but will also support our Joint Commissioning Strategy and Care Closer to Home strategies that highlight the importance of working together to improve the health outcomes for Islington residents.

Received by:		
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