City of Westminster

Westminster Health & Wellbeing Board

Date:	17 November 2016
Classification:	General Release
Title:	Dementia Joint Strategic Needs Assessment Progress Report
Report of:	Executive Director of Adult Social Care and Health
Wards Involved:	All
Policy Context:	To support the Health & Wellbeing Board statutory duty to deliver a Joint Strategic Needs Assessment
Financial Summary:	n/a
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1. Executive Summary

1.1 This report presents the progress made by the Three Borough (Westminster; Hammersmith and Fulham; Kensington and Chelsea) Joint Health and Social Care Dementia Programme Board in response to the 32 recommendations set

out in the Joint Strategic Needs Assessment (JSNA) on dementia. The report covers a six-month period up to September 2016. It aims to give the Health & Wellbeing Board assurance by setting out progress and the programme management approach to facilitate implementation.

2. Key Matters for the Board

2.1 To consider the progress made by the Three Borough Joint Health and Social Care Dementia Programme Board and the wider strategic implications for the three boroughs to develop and commission quality, person centred and cost-effective care.

2.2 To consider and endorse the Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' 2016/2017 that is contained in this report.

3. Background & Context

3.1 On the 1st October 2015, the JSNA on dementia and its recommendations was presented to and endorsed by to the Health & Wellbeing Board.

3.2 Since the publication of the JSNA on dementia in 2015, diagnosis rates have been consistently increasing, which will have an impact on the way that health and social care commissions post-diagnostic services, as it is expected that there will be a requirement for more services and a range of services in future. Each of the three CCGs are in the top performing category for diagnosis rates having exceeded the NHS England national target of 67% with Central London CCG at 78.1%, Hammersmith & Fulham CCG at 80.1% and West London CCG at 76.9%.

3.3 NHS England have recently strengthened the Quality and Outcomes Framework (QoF) 2016/2017 indicators on dementia care planning and post-diagnostic support to include the proportion of patients with dementia whose care plan has been reviewed in the preceding 12 months. All three CCGs currently fall within the 'needs improvement' category (<75.6%). However, Central London CCG and Hammersmith & Fulham CCG only require a small increase in the proportion of care plan reviews to meet the performing well target. West London CCG requires a little distance to travel to meet the performing well target and an action plan is in place to achieve improvements in this area.

4. Progress Report

4.1 Membership of the Three Borough Joint Health and Social Care Dementia Programme Board now includes clinicians, patient representatives, safeguarding leads, and subject matter experts, such as, the Alzheimer's Society as in Appendix 1 .

4.2 Considerable work is in progress to implement The Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' in Appendix 2 setting out the vision, performance standards and programme deliverables within the financial

year 2016/2017. To achieve this, the programme board agreed to use the NHS England 'Well Pathway': preventing well, diagnosing well, supporting well, living well and dying well, as a framework to better understand the stages in the pathway and the key interdependencies to deliver high quality health and social care.

4.3 Alongside this, the programme board recognised that implementing the 32 Tri-borough JSNA on dementia recommendations within the current financial year would be extremely ambitious given the limited resources and timescales. After in-depth discussion, the programme board agreed that facilitating implementation should be based on common themes across the three boroughs. The five overarching key recommendations are set out in Table 1 below, the aim is to prioritise (5 out 32) nearly 16% this year.

4.4 The programme board acknowledges that only through effective business intelligence gathered and triangulating information to produce the evidence base can effective implementation of the JSNA recommendations be realised. Considerable work is in progress to develop a performance management dashboard to give assurance to the Health & Wellbeing Board to monitor progress against these key deliverables.

Table 1:

Combined Targeted JSNA Priorities		
	Priority	**Progress**
1	• Addressing the supply of local care home beds in future local authority and CCG commissioning intentions.	• A multi-strategy approach has been pursued; this includes building commitment towards the Shared Lives Scheme and undertaking a strategic review to better understand the underlying drivers that contribute to the lack of supply of local care home beds that results in out of area placements.
2	• Ensure there are opportunities for coordinated training and support for people across the pathway to enable recognition of people with dementia and to improve confidence in care for people with complex needs and behaviours that challenge.	• Opportunities are being explored for public sector and private enterprise funding. Exploring partnership working with a range of stakeholders, and opportunities with Skills for Care and Health Education England (HEE). • The establishment of the Three Borough Nominated Dementia Lead Database provides a platform to disseminate information on training and safeguarding, and to receive returns from the care home sector.
3	• Exploit joint working with the police and community partners	• Opportunities are being explored for multi-agency working with the police

	to support appropriate and effective use of assistive technology/telecare with patients/service users with dementia.	and the Alzheimer's Society to pilot a radio frequency Identification (RFID) Wrist Band to locate missing people with a dementia diagnosis.
4	• Establish a joint dementia programme board to facilitate implementation of the JSNA and North West London Strategy.	• The dementia programme board has established a comprehensive Dementia 'Plan on a Page' to set out the direction of travel.
5	• The increasing numbers and needs of people with dementia and their carers are taken into account in the wider local authority and health strategies, especially, care settings and housing.	• Work is in progress to develop and implement patient metrics, I Statements', not only for the care hoe and housing settings, but for the whole system. • Work is progress to strengthen carers respite care to ensure they 'live well'

Source: Combined Target Priorities -2016/2017

5 Legal Implications

5.1 The Health and Social Care Act 2012 placed a joint and equal duty on local Authorities and clinical Commissioning Groups (CCGs) to prepare JSNAs through the Health and Wellbeing Board.

Legal implications completed by Rhian Davies, Chief Solicitor (Litigation and Social Care)

6 Financial Implications

6.1 Westminster City Council:

Any funding implications for ASC arising from the implementation of these recommendations will need to be met from within the Adults revenue budget of £59.7m or the public health budget as appropriate,

Financial implications provided by: Michael Taylor, ASC Finance Manager, Westminster City Council; Tel: 0207 641 1469 email: mtaylor2@westminster.gov.uk.

6.2 Clinical Commissioning Groups:

Any future projects will be contained within the CCG budget

Appendix 1

The Three Borough Joint Health and Social Care Dementia Programme Board Membership			
Organisation	**Designation**	**Function**	**Name**
ASC	3B ASC (London Borough of Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea, Westminster City Council)	Director for 3B ASC Commissioning and Enterprise (SRO)	Mike Boyle
		Head of 3B Head of Complex Needs Older People (Chair)	Ben Gladstone
		Strategic Commissioner, Adult Social Care	Frank Hamilton
		Strategic Lead in Professional Development	Helen Banham
		Head of Quality Assurance and Professioanl Lead	Ann Stuart
		Senior Business Analysis	James Hebblethwaite
		Chair of Safegarding Board	Michael Howard
CCGs	NHS Central London Clinical Commissioning Group	Corporate & Mental Health Project Manager	Chris Longster
	NHS West London Clinical Commissioning Group		
	NHS Hammersmith & Fulham Clinical Commissioning Group	Head of Planned Care and Mental Health	Julie Scrivens
		Planned Care and Mental Health Programme Manager	Jessica Simpson
	3 CCGs	Dementia Clinical Lead	Farukh Malik, Ed Farrell, Calre Graley
Joint Commissioning Older People/Vulnerable Adults (OPVA) Team	Joint Clinical Commissioning Group	Senior Joint Commissioning Manager - Continuing Care and End of Life Care Joint Commissioning	Louise Maile
	Joint Commissioning Group / Adult Social Care	Strategic Dementia Review Lead	Lisa Cavanagh
	Joint Clinical Commissioning Group	Joint Commissioning Officer	Julie Willoughby
Central London, West London, Hammersmith & Fulham, Hillingdon and Ealing (CWHEE)	CWHHE Clinical Commissioning Groups Collaborative	Safeguarding Lead	Molly Larkin
Public Health	Public Health Representative	Mental Health	Marry Russell
Healthwatch	3rd Sector	Interim Director for Healthwatch	Carena Rogers
Alzheimer's	Subject Matter Expert	Delivery Manager	Karen McCrudden
K&C and Westminster (KCW) CNWL	Subject Matter Expert	Consultant Psychiatrists	Claudia Wauld
H&F WLMHT	Subject Matter Expert	Consultant Psychiatrists	Stephen Orleans-Foli

Appendix 2

Three Borough Joint Health and Adult Social Care Dementia 'Plan on a Page' 2016/2017

Strategic context – the scale of the challenge & vision

Vision

The Joint Health and Adult Social Care dementia vision is to develop, commission and deliver high quality, cost-effective services for the local populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster through population based commissioning, and by working in partnership with people living with dementia, carers and local stakeholders.

The vision is underpinned by the Joint Strategic Needs Assessment (JSNA) to:

- Increase understanding of local health and social care needs
- Raise awareness and understanding
- Support early diagnosis and post diagnostic support
- Promote prevention, personalisation, integration, and local services
- Enable sound financial and risk management
- 'Live well' with dementia

Where are the three boroughs now…

- The three boroughs generally perform well on health and social care indicators compared to national benchmarks, although in some aspects there is a distance to travel.
- The prevalence of dementia is due to rise by nearly a third (30%) over the next 15 years.
- The number of older people aged 65 has increased by a fifth (20%) and in the over 85 population it has increased by nearly a third (30%).
- Improvements in early diagnosis across the three boroughs has led to exceeding the NHS England benchmark of 67%.
- There are too many care home placements out of borough as a result of limited in borough capacity.
- Better workforce planning is leading to delivery of higher quality services.

What we want to achieve…

- Raise awareness of healthy lifestyles through public health campaigns on prevention and risk reduction.
- Build capacity to support carers.
- Improve the quality of health and social care services for local people to meet their needs.
- Commission a joint health and social care system using the 'Well Pathway' that is based on local population needs.
- Commission services in the most effective way using the research and the evidence base.

The outcomes we want to deliver are to:

- Improve the patient, service user and carer experience.
- Prevent, reduce or delay people with dementia having hospital admissions, and permanently attending nursing or residential care homes.
- Reduce duplication by effectively working together across the system, with the aim to increase efficiency.

How we will deliver the vision: Priority areas

Combined JSNA Priorities

- Address the supply of local care home beds in future local authority and CCG commissioning intentions.
- Ensure there are opportunities for coordinated training and support for people across the pathway to enable recognition of people with dementia and to improve confidence in care for people with complex needs and behaviours that challenge.
- Exploit joint working with the police and community partners to support appropriate and effective use of assistive technology/telecare with patients/service users with dementia.
- Establish joint dementia programme board to facilitate implementation of the JSNA recommendations and North West London Strategy.
- The increasing numbers and needs of people with dementia and their carers are taken into account in the wider local authority and health strategies, especially, care settings and housing.

Performance Improvement

- Develop a robust performance management tool to track and monitor progress against the combined JSNA priority action plan, while mitigating risks.
- Ensure patient/service user safety and quality underpins every contact with people with a dementia diagnosis in contracts.
- Ensure provider contract schedules and performance requirements are outcome focused.
- Comply with National Institute of Health and Social Care Excellence (NICE) quality standards.
- Promote information sharing and agree minimum dataset (MDS) across the health and social care system.
- Adhere to the national outcome frameworks: Health, Adult Social Care, Public Health and Education.
- Improve triangulation of data across health and social care to produce the evidence base for future commissioning.

Governance

The Joint Health and Social Care Dementia Programme Board will report periodically into the Health and Wellbeing Boards on progress made against the 'Joint Dementia Action Plan', with the aim to give transparency on delivery. This Board will produce a dashboard to give visibility on the programme board's trajectory against deliverables.

Although the aim is to work at scale and pace, each local authority and CCG are subject to their own sovereignty and local governance arrangements for the dementia implementation plan.

Joint Health and Adult Social Care Dementia (JHASCD) Plans for delivery

	Outcomes	Key Joint Dementia Action Plans	Measure
Preventing Well	**The risk of people developing dementia is minimised**	• Expand the Dementia Action Alliance and dementia friendly campaigns to raise public awareness and understanding of dementia in the wider community. • Review the number of people that have vascular checks as part of NHS Health Checks that are at risk of dementia.	• The number of dementia friendly society registrations against proxy baseline
Diagnosing Well	**Timely diagnosis, integrated care plan and review within first year**	• Identify commissioning opportunities for hybrid working across care settings to enable staff to recognise dementia signs and symptoms in order to take the most appropriate action. • Ensure people in care homes and supported extra housing are appropriately supported through advice and guidance by the nominated dementia lead.	• The number of bid submissions • The number of care home registrations with dementia leads on the database
Supporting Well	**Access to safe, high quality health and social care for people with dementia and carers**	• Support and train the health and social care workforce to better support people with a dementia diagnosis in order to care for their physical, mental, and emotional needs. • Review hospital discharge data for people with a dementia diagnosis to improve care planning. • Ensure people with dementia have access to appropriate care and support through personal budgets. • Develop a delivery plan to address the supply of local care home beds in future. • Develop a delivery plan with key stakeholders and community safety partners to increase the use of technology.	• Percentage of the workforce with dementia training • Admissions rates • Percentage of people on personal budgets. • Developed plans
Living Well	**People with dementia can live normally in safe and accepting communities**	• Conduct audit of people with dementia living in care homes to ensure compliance with safeguarding standards. • Review sample of hospital and community survey results to improve services. • Develop and implement patient metrics, 'I Statements', in care home and housing settings. • Develop appropriate and effective respite care for carers (as and when they need it). • Ensure effective peer support and advocacy for people with dementia and carers to enable them to live well.	• Percentage of care homes compliant with safeguarding standards • Meta-analysis of surveys hospital and community survey data • Condensed set of questions
Dying Well	**People with dementia die with dignity in the place of their choosing**	• Undertake a review of people with a dementia diagnosis on the end of life care pathway through recording the place of death. • Review integrated advanced care plans and support people with dementia with advice and guidance with the powers of attorney arrangements. • Raise awareness of bereavement support, advice and guidance services for people with a dementia to ensure these people are treated with dignity and respect.	• Percentage of people with a recorded place of death • Sample of interviews

For further information on the Joint Dementia 'Plan on a Page' 2016/2017, please contact Frank Hamilton at frank.hamilton@lbhf.gov.uk or Lisa Cavanagh on lisa.cavanagh@nw.london.nhs.uk

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

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