Item No: 6

Meeting Date: **Tuesday 12th December 2017**

Glasgow City
Integration Joint Board
Performance Scrutiny Committee

Report By: **Susanne Millar, Chief Officer, Strategy & Operations / Chief Social Work Officer**

Contact: **Ann Cummings, Service Manager**

Tel: **0141 276 4753**

GLASGOW DEMENTIA STRATEGY PROGRESS REPORT

Purpose of Report:	The purpose of this report is to provide an update on progress against the key actions set out in Glasgow City's Dementia Strategy and agreed by the IJB in May 2016.

Background/Engagement:	Following an 18 month programme of consultation and engagement, Glasgow City's Dementia Strategy was launched in May 2016.

Recommendations:	The IJB Performance Scrutiny Committee is asked to: a) note progress made against key commitments by GCHSCP Dementia Strategy; b) note the publication of the 3rd National Dementia Strategy; and c) agree the priorities for 2017/18 and subsequent progress reporting against these.

Relevance to Integration Joint Board Strategic Plan:

Supporting people with dementia is a key aim of the Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcomes:	Primarily supports Outcomes 1 – 6 & 9.

Personnel:	None

Carers:	Supporting carers who care for someone with dementia is central to the Dementia Strategy

Provider Organisations:	Alzheimer's Scotland are key partners in the dementia strategy and operational delivery.

Equalities:	The content of the document is underpinned by the Charter of Rights for Dementia. It seeks to address inequalities that may be experienced by people with dementia.

Financial:	Minimal. Resources to manage annual reporting can be managed within existing resources.

Legal:	None

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	None

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

1. Purpose

1.1 The purpose of this report is to provide an update on progress against the key actions set out in Glasgow City's Dementia Strategy and agreed by the IJB in May 2016.

1.2 The report also provides a summary of the key recommendations of the 3rd National Dementia Strategy 2017-20.

2. Background

2.1. The Glasgow City Dementia Strategy 2016-19 and overall vision was developed for Glasgow City Health and Social Care Partnership (GCHSCP) in collaboration with Alzheimer Scotland, and co-produced with people with dementia, their families, carers and a wide range of stakeholders.

2.2. The Strategy outlines commitments to improve health and social care services for people with dementia; recognising that a diagnosis of dementia should be the gateway to information, support, care and treatment.

2.3. The Strategy also highlights the aspiration of a Dementia Friendly Glasgow and aims to encourage and strengthen communities to ensure that over time, there is capacity to support people affected by dementia so they can enjoy the best possible quality of life.

2.4 Progress against the key actions highlighted in the Strategy can be found at Appendix 1.

2.5 In summary, good progress has been made across a range of initiatives. Further work is now required to ensure that GCHSCP commitments fully reflect the aspirations of the new National Dementia Strategy.

3. National Dementia Strategy 2017 – 20

3.1 The 3rd national Dementia Strategy launched by the Scottish Government on 28th June 2017 has a clear emphasis on the delivery of high quality health and social care services and supports for people with dementia, their families and carers from the point of diagnosis to the end of life. These should be timely, person-centred care, co-ordinated and flexible support for people with dementia and their carers across a range of settings, including hospital and the community.

3.2 The strategy contains 21 commitments, including ensuring timely diagnosis, continuing to ensure high-quality post post-diagnostic support through 5 Pillars model for those at early stage of condition, care co-ordination in the community through 8 pillars and a new commitment to Advanced Practice Coordinator for end of life care.

3.3 There are continued implications and significant challenges for OPMH services and the HSCP in delivery of the proposals around early diagnosis and open-ended post-diagnostic support. This commitment has significant resource implications and further scoping will be essential in determining how these commitments can be realistically achieved.

3.4 The key change is that there now needs to be two post diagnostic pathways – the 5 pillar pathway for people who are diagnosed at an earlier stage of the condition; and the 8 pillar pathway where people are diagnosed at a later stage and require more coordinated support.

3.5 Both pathways will be expected to provide open ended support from a link worker or a health and social care professional who will be expected to undertake the care coordination role. This is a significant change where previously the service user/patient could expect a link worker for a minimum of one year. It is important to highlight that many older people with dementia are often living with other life limiting chronic conditions and the wider impact on primary care, social care and AHP resources cannot be underestimated. It should also be noted that open ended support contradicts the ethos of the enabling and empowering approach of self-managed care and personalised approaches.

3.6 The commitments relating to palliative and end of life care will require to be considered within the palliative care programme of work currently underway. Similarly the commitment relating to telecare and its use with people with dementia could be referred to the Telecare Reform Program. The commitment related to the rehabilitation and enablement needs of people with dementia is underpinned by an enabling and preventative approach to support healthy and active living for people living with dementia and could be taken forward by the new Integrated Neighborhood Rehabilitation and Enablement Teams.

3.7 The provision of good person centred post diagnostic dementia support services is essential to shifting the balance of care and these services have a strong contribution to make. Staff learning and development is a key commitment and the HSCP will need to consider the ongoing identification of learning needs for all staff. The Workforce Development Plan (2013 – 2018) produced by the NHSGGC Dementia Strategy group can support this work.

3.8 There is an expectation that Integration Authorities will improve service delivery for people with dementia as part of as a key part of the wider agenda and key priorities of delayed discharge, reducing unscheduled bed days, improving palliative and end-of-life care and strengthening community care to support complex physical and mental health and social care needs to remain living well with dementia and other conditions at home.

3.9 Notwithstanding the challenges of the new national strategy, the transformation of the Older People's system of care and integrated multi-disciplinary older people neighborhood teams will provide real opportunities to work in partnership with Older Peoples Mental Health Services to deliver more joined up holistic support for people with dementia, their families and carers. The neighborhood approach will also provide opportunities for increased support to be developed and provided by and

within communities, with the voluntary sector, public and community sectors working together through a dementia friendly community approach.

4. Priorities 2017/18

4.1 Glasgow HSCP's priority should be to continue to develop and refine integrated post diagnostic dementia services through the 5 and 8 pillar approaches and end of life care. There will be increasing opportunities for integrated care pathways through the transformation underway within the Older People System of Care and the introduction of integrated service managers and the alignment of OPMH Services within this.

4.2 Another key priority for Glasgow's Dementia Strategy over next few years will be embedding carer identification and support to ensure that we can increasingly manage support for people with dementia to live well at home with carer and family support.

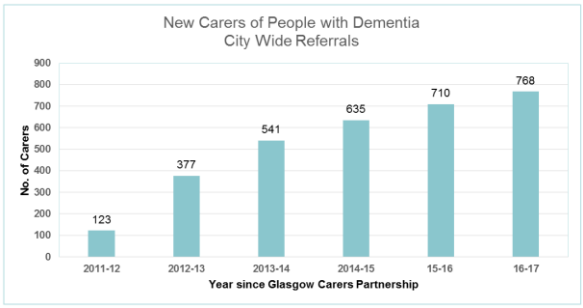
4.3 Additionally GHSCP will continue to work on the commitments outlined at Appendix 1 and provide an updated report to IJB/Performance Scrutiny Committee in autumn 2018.

5. Recommendations

5.1 The IJB Performance Scrutiny Committee is asked to:

a) note progress made against key commitments by GCHSCP Dementia Strategy;
b) note the publication of the 3rd National Dementia Strategy; and
c) agree the priorities for 2017/18 and subsequent progress reporting against these.

Appendix 1: Actions for GCHSCP
Leading on from the development of this strategy, GCHSCP makes the following commitments:

Action	Progress to Date
Continue existing work around diagnosis and post diagnostic support.	The HSCP contributed to evidence on diagnosis rates which informed the Scottish Government 'Diagnosed Incidence' report. Numbers of people diagnosed with dementia has continued at a steady rate. Over 2016/17 there are over 4350 people on local GP dementia registers against a target of 4210. This target is based on prevalence estimates. 827 people were given a new diagnosis of dementia over this period. There is ongoing work to improve the quality of the data collected, for example to include the stage of illness at which people are given the diagnosis. The HSCP has committed funding for the next three years for Post Diagnostic Support including a new commissioned service run by Alzheimer Scotland which commenced on 1st April 2017. The new model recognises the benefits of Post Diagnostic Support being embedded in local communities, and the emerging city-wide model ensures that link workers are well-placed to support people with dementia and their carers to remain connected to their local community. Work is ongoing to develop referral pathways and to ensure that people with dementia are supported through a partnership approach across health, social care and the voluntary sector. In 2016 509 people accepted and received Post Diagnostic Support delivered by link workers.
Maintain levels of carer support and information provision.	The number of people known with dementia is increasing and as a result Glasgow Carers Partnership (GCP) developed an Information, Training and Support Pathway for carers with both an anticipatory post diagnosis and crisis response. A further 768 new Dementia Carers were identified in 2016/17. This is an increase of 524% since it commenced in 2011/12 with a total of 3,154 Carers being offered support in that time. Key activities are the training courses and workshop delivered to ensure carers are skilled and equipped to care whilst maintaining their own health and well-being. Information around mood and emotions, challenging behaviors, sleep, stress and distress and more are provided through a variety of bespoke training sessions. To date there have been over 800 carers attending training, and over 150 carers per month attending one of 

	7 Dementia Cafés and/or 5 peer support groups. A new advanced caring dementia course has been piloted in south and will be rolled out across the city from February 2018 with 6 courses running over the year. This course is targeted at those caring for someone with advanced dementia and we aim to have 8-10 carers on each course. Over 2016/17, Carers have received approximately 25,000 hours of Short Breaks , and over 800 Emergency Plans have been put in place over the last 4 years, with 1285 plans being completed with 378 being done over 2016/17. Over this same period, 473 carers received Health Reviews and 881 Carers were referred for and attended attend 88 courses and 1041 carers attended 21 different peer support groups.
Support workforce development including Promoting Excellence training.	GCHSCP continues to support staff achieve registration qualifications as stipulated by the Scottish Social Services Council Registered staff numbers are approx. 2355, Residential 1100, Day Care, 230 and Fieldwork 1025 In addition a range of staff development opportunities are available to registered staff to support the maintenance of their registration. A training pathways tool is in development to provide accessible information that residential staff can use to check the training requirements for their post. Promoting Excellence is included in the pathway for residential care staff, and Service Managers have rolled out promoting excellence training for all grade 9 service managers and grade 8 operations managers within older peoples residential care services. The grade 8 managers will now cascade this training to senior social care workers who will in turn cascade to care staff by April 2018. There are various Learn Pro Modules available to staff including the Dementia Skilled - Improving Practice Learning Resource and Dementia Supplementary Information module. In addition, there are two NES ELearning resources relating to delirium - An Introduction to Delirium and Delirium - Prevention, Management and Support. NHSGGC's Workforce Development Plan 2013-18 provides a reference point for training requirements for different staff groups, and signposts to a wide range of resources.
Increase the use of technology including telecare.	Technology enabled care is being increasingly used to support the shift to a focus on how we can help people who have been diagnosed with dementia to live as full a life as possible. This can enable people with dementia to have the best chance to live independently and well in their own home with greater choice about their care. Technology has the capacity to reduce the stress and distress of people living with dementia and enhance their quality of life at all stages of dementia.

	A range of telecare devices is now available to support people with dementia. The use of GPS devices and exit / door sensors supported by responder services, for example, has assisted more people with dementia to stay at home safely. The Partnership is exploring further improvements on available equipment and services over the coming year. This plans to include raising awareness of other equipment available commercially to support individuals and families. Over the past 2 years mainstream technology such as tablets has also been used to support people who have recently been diagnosed with the condition. This initiative is supported by Dementia link workers. This multi-functional resource has also been used within care homes to enable residents to maximise their potential within a supported environment. Alzheimer Scotland's telecare project has included iPad classes for carers and a GPS locator trial. A product testing group has also been established. Virtual Reality trials are ongoing in the Dementia Resource Centre.
Continued integrated working with acute services.	The HSCP is developing a new 'Home is Best' service to support integrated discharge planning for older people with dementia to ensure safe transfer home or to long term care.
Maximising the benefits of voluntary sector and independent representation within the GHSCP and Integrated Joint Board.	The voluntary and independent sectors are fully represented on the Strategic Planning groups which have been established within the city and are represented on the Integrated Joint Board. Representatives from a variety of voluntary and independent sector organisations are members of the Older People's Strategic Planning Group, which were engaged with in the development of Glasgow's Dementia Strategy.
Increased engagement with Glasgow Community Planning Partnership recognising the opportunities for wider stakeholder contribution to the strategy	Glasgow has established Locality Engagement Forums within each of the city's three localities to support stakeholder engagement and participation in service planning activity. Workshop held with Community Planning colleagues to explore opportunities for joint working between HSCP / IJB and the CPP, using the resources each partner has collaboratively to support joined up stakeholder engagement.
Continue to raise awareness of dementia in communities through dementia friends and an awareness campaign.	New Dementia Resource Centre opened at Bridgeton Cross (a city wide resource) opened in September 2016. The number of Dementia Friends in the city since the inception of the programme 2 years ago is 4,000+ Dementia Friends in and 2,000 of these became Friends during 2016/17. 733 people have been seen by Alzheimer Scotland Dementia Advisers over the past year via the Centre's 'drop in' sessions. Development activity has continued at Silverburn Shopping Centre, including a programme of Dementia Friends sessions; Dementia Awareness Week displays (which included the

	involvement of local health and social care staff); an environmental audit undertaken by people with dementia and their carers. An environmental audit has been undertaken at the People's Palace.
Engage with people with dementia and their carers in decisions that will affect them, including service provision and development.	A review of Post Diagnostic Support across the city has been completed, and the report is awaited. A key part of the review was engagement with service users and their carers. Alzheimer Scotland Carer Reference Group meets bi-monthly. Self-Directed Support sessions are regularly delivered to people with dementia and their carers.
Provide more integrated support to people living with dementia and their carers.	The 8 Pillars model of support for people with dementia who are at a more advanced stage of the illness was piloted in South Glasgow as part of a Scottish Government improvement programme. A report of the pilot has just been completed and it is anticipated that a model of support based on 8 Pillars will be rolled out across the city. One of the key benefits of this approach is a partnership approach to supporting people with dementia and their carers. Another initiative undertaken in South Glasgow is the 415 Project, which is being developed as a model to increase safety, reduce isolation, improve health and develop partnership engagement and closer working to improve outcomes for older people. This will enable the development of a wider range of technology based support to residents and inform the city on digital infrastructure required when the analogue telephony system is transferred to digital. A demonstrator flat within the project has provided a valuable base to illustrate how a variety of technologies can assist with daily living with a particular emphasis on supporting older people with dementia.
Implement current dementia work plans in the city	Following publication of the new National Dementia Strategy, there is a city-wide Dementia Strategy Group will be developed. This group will develop and take forward an implementation plan to ensure the aims and objectives of the national strategy are met.
Produce an annual report on what has been achieved.	The contents of this update will inform an annual report, to be produced for the period Jan – Dec 2017.
Community based dementia supports	A range of initiatives have been started or continued including Football Memories Groups, Dementia Cafes, Walking Groups and various sporting/games groups.