NHS Grampian	**MORAY COMMUNITY HEALTH AND SOCIAL CARE PARTNERSHIP**	the moray Council

JOINT DEMENTIA STRATEGY

2013-16

Contents

PART ONE: INTRODUCTION

1.1 Introduction

Around 84,000 people in Scotland have dementia, which is a complex condition that not only impacts on the lives of those who have the illness, but also on the lives of their partners and their families and carers. The number of people affected by dementia is set to rise in future years, due to more people living longer and going on to develop the disease, coupled with improvements in diagnosis meaning more people are identified.[i]

Many people with dementia require residential care, with more complex or unplanned care often being provided in hospitals at significant cost and where this is often not the preference of the person with dementia or their family. Projected population increases mean that the cost of providing hospital-based or acute care in to the future is not sustainable and we have a wider policy ambition to shift the balance of care from acute to community-based settings.

1.2 Background

Moray took a shared approach to joint commissioning in the development of "Living Longer, Living Better" a Joint Commissioning Strategy for older people agreed in partnership with Health, Social, Voluntary and Independent sectors and older people themselves and their family/carers.

In the course of our extensive commissioning activities - policy research, service mapping, health needs analysis, workshops and consultation events with a wide range of stakeholders, **dementia was identified as a key priority in Moray** alongside six other priorities; community capacity building, carers, housing, frail elderly, modernising community services and embracing technology.

1.3 Development of the Strategy

A work stream was established and a local joint dementia strategy developed to reflect the needs of the people and their family/carers who are affected by dementia. The Working Group consisted of representatives from Moray Community Health & Social Care Partnership (MCHSCP) and was led by a GP from primary care.

This strategy shares the same principles, values, aims and objectives of the overarching older people strategy whose appendices provide details of the policy context in which the Dementia Strategy is set, analysis of the need for this client group and their carers, the current service details and the extensive engagement and consultation[ii] This strategy **aims to ensure that people with dementia and their family/carers have an improved quality of life with the care and support that meets their needs in a safe environment within the community.**

1.4 Scope

Dementia affects a wide range of people, not all of whom are fully covered within the Older People's Strategy. The strategy therefore addresses the needs of people aged both under

65 years and over 65 years with dementia. Strategic planning for those aged under 65 with memory problems falls within the scope of Moray's Mental Health Strategy. Similarly, there are strategic planning structures for carers and for people with a learning disability.

1.5 Financial Scope

The resources for this strategy will be included in the resources which are being mapped through the mechanism of the Integrated Resource Framework to support the Joint Commissioning Strategy for older people. Change fund monies will also be available for a further year to accelerate the pace of change and development of sustainable services for older people.

PART TWO BACKGROUND TO THE PLAN

2.1 National and Local Policy Context

Demographic and financial pressures have combined to ensure that the provision of care and support for older people is a current political and policy priority. The range of national and local strategies and policies highlighted as important drivers to our joint commissioning plan for older people can be found in Appendix 2 National and Local Policy Context.

The specific strategic documents highlighted as important drivers of our dementia strategy are as follows:

2.1.1 National Dementia Strategy 2010-2013

Scotland's National Dementia Strategy was published in 2010. The aim of this strategy was to deliver world class dementia care and treatment in Scotland, ensuring that people with dementia and their families are supported to live well with dementia. Two key change areas are identified for the next three years:

- Excellent support and information to people with dementia and their carers post diagnosis; and
- Improved response to people with dementia in general hospital settings, including alternatives to admission and better discharge planning.

2.1.2 National Dementia Strategy 2013-2016

The Scottish Government has published a new three year National Dementia Strategy aimed at improving standards of care for people with dementia. Palliative care, advanced care planning, the electronic palliative care summary and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are mentioned under the rights-based care section.

The main challenges reflected from the national dementia dialogue and our own local findings are:

- care and support which promotes wellbeing and quality of life, protects their right and humanity should be offered
- Improved services and support across the continuum of care, person centred and outcome focused must continue
- We must recognise the challenge and embrace redesign and transformation of service

The Key aims of the strategy reflecting the dementia dialogue are:

- More people with dementia living a good quality life at home for longer.
- Dementia-enabled and dementia-friendly local communities, which contribute to greater awareness of dementia and reduce stigma.
- Timely, accurate diagnosis of dementia.
- Better post-diagnostic support for people with dementia and their families.
- More people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness.
- Better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment.
- People with dementia in hospitals or other institutional settings always being treated with dignity and respect.

Dementia is crosscutting in **other commissioning themes in the Joint Commissioning Strategy (JCS) i.e. Carers, Frail Elderly, Housing, Modernising Community Services, Community Capacity Building and Embracing Technology.**

2.2 Demographic Change (extracted from JCS for older people 2013-23)

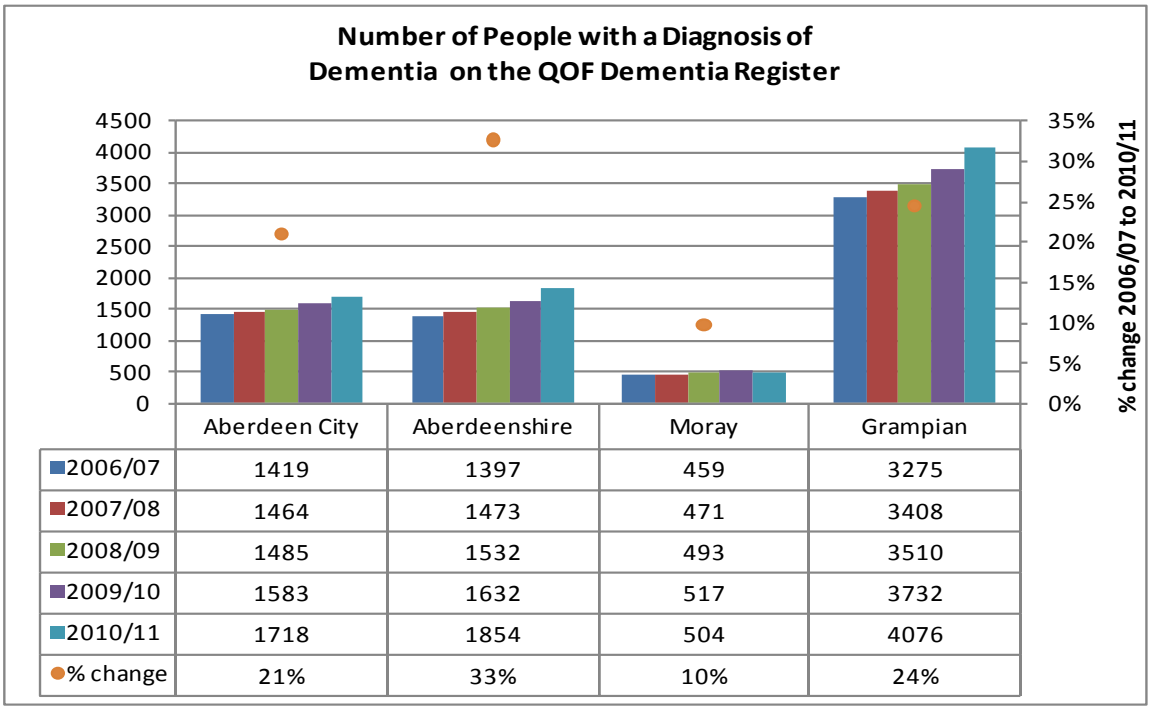
Nationally, as our population ages, the number of people with dementia will increase and it is expected that the number will double over the next 25 years. Prevalence of dementia increases with age; around 1.5% of the 65 to 69-year-old population are affected, increasing to about one in three of the 90-plus age groups.

Dementia is a key health issue facing Moray in the coming decades. As our population ages there is a projected 50% increase in the number of those affected by the disease. Dementia is a major cause of disability in people aged 60 and over. It contributes 11.2% of all years lived with disability, which is more than stroke (9%), musculoskeletal disorders (9.8%), cardiovascular disease (5%) and all forms of cancer (2.4%).[iii]

2.3 Dementia prevalence

In Moray there were 504 people on the QOF (GP Quality Outcomes Framework) dementia register in 2010/11, representing a 10% increase from 2006/7. This compares with 21% and 33% in Aberdeen City and Aberdeenshire respectively.

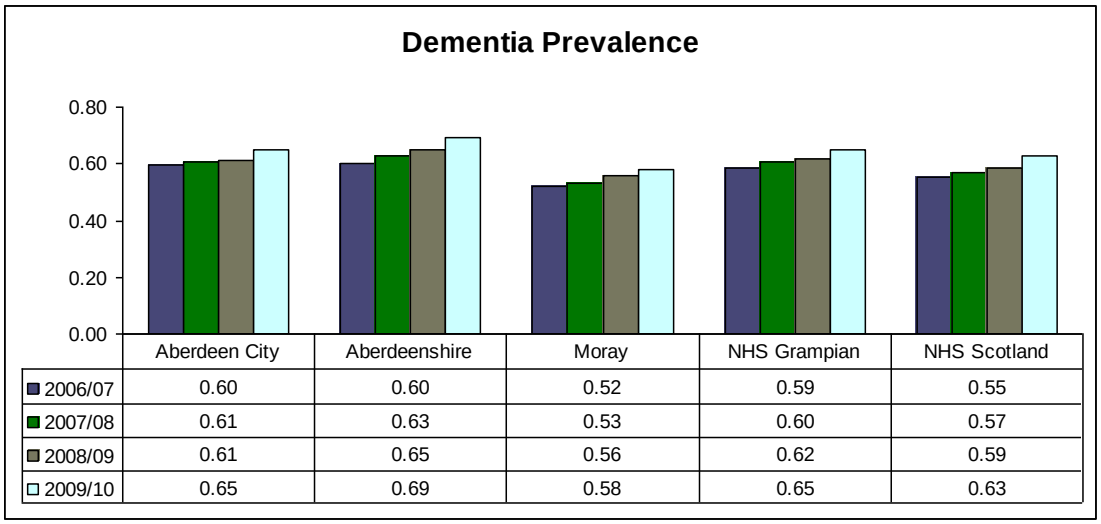
Figure 1: Number of people with a diagnosis of dementia on the QOF dementia register



	Aberdeen City	Aberdeenshire	Moray	Grampian
2006/07	1419	1397	459	3275
2007/08	1464	1473	471	3408
2008/09	1485	1532	493	3510
2009/10	1583	1632	517	3732
2010/11	1718	1854	504	4076
% change	21%	33%	10%	24%

Prevalence of dementia rose in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 0.68 per 100, up again on previous years and up by 0.16 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.40 to 1.30 (Glenlivet and Fochabers).

Figure 2: Dementia prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	0.60	0.60	0.52	0.59	0.55
2007/08	0.61	0.63	0.53	0.60	0.57
2008/09	0.61	0.65	0.56	0.62	0.59
2009/10	0.65	0.69	0.58	0.65	0.63

Latest data shows Moray has a slightly higher raw prevalence of Dementia Diagnosis than Scotland. In 2011-12 there were 683 patients on the QOF register listed as having Dementia. This has risen in 2012-13 to 709 though the rate has not yet been officially published it is expected to be approximately 0.79.

Figure 3: QOF register Raw prevalence rate

QOF Register raw prevalence rate (per 100 patients)		
Indicator	**Benchmark**	**Report Date**
0.76	0.73	2011-12
0.68	0.70	2010-11
0.58	0.63	2009-10

2.4 Current mapping – across the dementia standards

2.4.1 I Have the Right To A Diagnosis:

- NHS Grampian has lead on the development of an Integrated Care Pathway (ICP) for Dementia and this is expected to have a substantial impact on the diagnosis, treatment and management for people with dementia. It is currently being implemented across Grampian
- The Liaison Psychiatric Service continues to provide a service within the acute general hospital setting. Referral is made to the relevant Community Mental Health Teams, Voluntary Organisations, Post Diagnostic Support or any agency the Multi-Disciplinary Team (MDT) feel is required to support discharge.
- We have improved our diagnosis rate of dementia by working closely with GPs. Grampian is one of the better performing Boards in Scotland and achieved 67% of the EuroDem incidence against the standard of 61%. This year the indicator changes to EuroCoDe and the next report on progress will be available early in April13.
- Alzheimer Scotland's 5 Pillar Model for Post Diagnostic Support is being rolled out across Scotland. Reporting will commence against the new HEAT Target in May 2013. This will ensure that all who receive a diagnosis are allocated a Link Worker who will coordinate support for a minimum of 12 months post diagnosis and create a personal support plan for the future within a self management approach. (See appendix A)
- We have commissioned a post diagnostic support service with Alzheimer's Scotland for a one year period with Change Fund monies to ensure all newly diagnosed persons and their family carers have access to post diagnostic support based on the five pillars model.

- Grampian does not have dedicated memory clinics and the differential diagnosis of dementia is seen as a fundamental part of the Old Age Consultant Mental Health Team (OACMHT) role.

2.4.2 I Have The Right To Access A Range Of Treatment, Care and Supports:

- The Specialist Psychiatric Service for Older People in Grampian has a highly regarded and widely understood model for service delivery. There are 9 OACMHTs based on the RCPsych model for multidisciplinary and multi agency working. These teams provide the backbone of assessment and treatment for people with dementia and act as a vehicle to enable other non specialised elderly health and social care services to develop their expertise.
- The Liaison Psychiatric Service for those over 65 years of age is available within Acute General Hospital for assessment, advice and support.
- A wide range of telehealthcare solutions is available in Moray to support people at home e.g. door sensors, bed sensors, medication prompts
- We are working towards improving the standards of care for people in hospital with dementia by implementing the "butterfly scheme" at Dr Gray's Hospital which identifies people with dementia and focuses staff around their needs. The scheme will be rolled out to community hospital staff
- Change fund investment in the role of dementia development nurse to work at the interface of primary and secondary care
- Community care has a single point of access to assessment and care which signposts clients appropriately to a range of care and supports in the community
- We have developed the role of dementia champions across health and social care, which are trained within the promoting excellence framework. There are six trained in Moray
- Agreement in the Acute General Hospital Setting (as part of the Older People in Acute Care (OPAC) Collaborative) has established the use of the AMT 10 as a screening tool for all people over 65 years old who are admitted to the Acute General Hospital Setting.
- A delirium pathway has been developed and is being tested in Dr Gray's Hospital as part of the OPAC work
- The Acute General Hospital setting – physical environment has seen the recent purchase of the dementia design for general hospitals and emergency departments audit tool/checklist. This will be carried out by trained auditors within the Older Adult Directorate and the Dementia Champions and Best Practice in Dementia Care Nurses will support this programme of work.
- The inclusion of the Therapets service within the Acute General Hospital setting.

- Alzheimer Scotland's 8 Pillar Model for ongoing support is likely to be rolled out across Scotland in the next financial year. (See Appendix 2)

2.4.3. I Have The Right To End Of Life Care That Respects My Wishes:

- Some of the Mental Health Services Staff are educated in the Alzheimer Scotland Palliative Care Programme.
- The DNACPR documentation is included in Safety Briefs in clinical settings in the Acute General Hospital Setting.
- Currently there is development of a Pan Grampian Pain Guideline, to identify assessment tools for use to support identification and management of pain for those with dementia.
- Grampian Integrated Palliative Care Plan – this has been created to be used across primary and secondary settings. Plans include advanced care planning, anticipatory prescribing and individual end of life care. This is being cascaded to primary care settings, care homes and community hospitals.
- End of life care plans are developed with the patient and family/carer in the community when palliative care needs are identified
- Modernising community services is a priority in Moray. Change Fund investment has allowed us to build the capacity of community services to meet the needs of older people with a particular focus on Health promotion and self care, on recovery, rehabilitation and re-ablement, management of long term conditions, anticipatory care , palliative and end of life care.(JCS modernising community services).

2.4.4 I Have The Right To Have Carers Who Are Well Supported And Educated About Dementia:

- Moray has 8 Dementia Champions and 1 Best Practice in Dementia Care Nurse who meet on a 6 weekly basis with the Alzheimer Scotland Dementia Nurse Consultant. A role descriptor has been developed for this staff group. A further cohort of Dementia Champions will commence training in April 2013. These posts are supported by the "Promoting Excellence" framework.
- Unpaid Carers are a key priority in Moray they will require support to continue in their caring role in the future The support for carers will be key in developing a community model, a number of development have been funded by the change fund in Moray to support this: (JCS Carers)
    - Development of short breaks bureau to provide creative flexible respite for carers. With a focus on the interdependent carer role
    - Peer support for carers who care for someone with dementia

- Education programme at SVQ level for those carers that want to pursue a formal qualification
- We intend to work with partners to develop joint bids for future funding around identified pieces of work taken forward by the joint commissioning group in this area

- Digital reminiscence units were rolled out to care homes, day services, libraries, elderly mental health assessment ward to support carers to engage with people with dementia with positive outcomes
- Development of a dementia profiling group within GMHS to identify current training in relation to dementia, highlight any gaps and align future education and training to the Promoting Excellence Framework. This work will inform the overall training for the workforce.
- Development of a Dementia Development Nurse post. This post is a 10 month secondment (funded by change fund); the post holder is based within Dr Gray's hospital to support the implementation of the Dementia Standards and Strategy across the Moray hospitals.
- Development of joint training plan across all sectors in Moray to ensure the workforce meets the needs of our growing older population
- The link workers within the PDS service will be responsible for supporting people to understand dementia and its symptoms.

2.4.5 I Have The Right To Be As Independent As Possible And Be Included In My Community:

- The majority of people with dementia live at home, either with a carer or alone. Support from family, friends, neighbours and support services is essential to enable people with dementia to live independently in their own homes for as long as they can and wish to do so.
- We have two successful dementia cafes running in Moray, which provide peer support and advice. Change fund investment has been allocated for further groups to be set up.
- Recent developments lead by the Alzheimer Scotland Dementia Nurse Consultants and AHP Consultants on the development of national signage to support dementia friendly environments.
- Recent developments lead by the Alzheimer Scotland Dementia Nurse Consultants and AHP Consultants on the development of a national personal profile document "Getting To Know Me". This will be piloted in board areas in the coming months.
- The development of a successful volunteering service in Moray and a wide range of community groups are available across Moray to support older people

- The use of technology to support older people's health and wellbeing is now common in Moray. Moray is part of the Scottish project "Living it Up" which is driving innovation to improve the way that products and services meet the needs of older people. Along with housing they are investigating the potential of technology enriched housing. A further telehealthcare strategy will be published in Moray to align with national *dallas* objectives. (JCS embracing technology)

- Moray will continue to work with housing as partners to ensure that we have the right mix of housing and support services to meet the needs of older people. Developments from the housing work stream include: new build extra care housing, investment in joint equipment store, development of community resource hubs and improvement in housing adaptations service (JCS housing)

- Moray has a clear intention to build community capacity to facilitate earlier intervention and a preventative approach. Co-production and community capacity building will involve working with older people and the voluntary sector to build an approach to providing care and based on co-production principles, develop new community driven models of care provision to help older people maintain their independence wherever possible. (JCS community capacity building)

2.4.6 I Have The Right To Be Regarded As A Unique Individual and To Be Treated With Dignity and Respect:

- There is a guideline in place within the Acute General Hospital to ensure that those people over 70 years of age are not moved unless for sound clinical reasons which will positively impact on their care.

- Recent development of documentation to support staff with identification, assessment , support and management for those people with cognitive impairment, dementia and delirium across Grampian hospitals

- Recent development of an NHSG policy on Covert Medication.

- The availability and use of personal profiles to support delivery of person centred care in Dr Gray's Hospital

- NHSG guidance on reducing poly-pharmacy in frail older people was finalised in September 2012.

- Dignity and respect has been identified as a priority for older people. The older peoples reference group (OPRG) will lead a user led group to focus on targeted areas.

2.5 Conclusion of analysis

A significant rise in the older population and in related mental health problems is predicted in the next 10-15 years. Addressing the wider determinants of health is essential in order to address mental wellbeing in later life.

Dementia is most common in older people, with prevalence rising sharply in people over 65 years. It is one of the main causes of disability in later life. As the numbers of older people rise, so will the numbers of people with dementia. It is recognised that current levels of diagnosis are low.

Early diagnosis of dementia and support to enable people to live well with the condition are the keys to delaying admission to long term care and to help people remain independent for longer.

Supporting carers to continue in their caring role will be vital to supporting people with dementia in their communities

Dementia friendly communities which provide care and support co-produced by people with dementia within an eight pillar support model the recommended strategy for the future

There remain some main challenges as we progress the development of the 8 pillar community model of support for people with dementia and their family/carers relating to changing the culture of communities to understand and be aware of the needs of people with dementia and that all that work with this client group become more skilled in meeting these needs. It must be acknowledged that implementation will be constrained by available resources and priorities identified by the joint commissioning process.

PART THREE: OUR STRATEGY

3.1 Introduction

Our strategy is based on the following hypotheses agreed during the course of our commissioning activities. It builds on what we have and progresses our delivery of an eight pillar community model of support in Moray with care and support services which meet the range of needs which people with dementia will have during the life course of their illness during the course of their illness.

This strategy will enable health and social care, the third sector and independent sector partners to implement local plans for making better use of combined resources to build dementia friendly communities which meet the needs of people with dementia and their carers for older people's services.

3.2 Our Strategic Aims

- Raising public awareness about dementia, and increasing understanding of the benefits of healthy living as a dementia risk reduction, will have a positive impact on quality of life and demand for services.
- Ensuring there is information available about dementia and about the range of support services available for older people and their carers will improve their ability to manage the condition and its impact on daily living.

- Early diagnosis of dementia and support to enable people to live well with the condition will contribute to delaying admission to long term care and to help people remain independent for longer.
- Ensuring all GPs/GP practices are confident in their diagnosis of dementia and in the appropriate referral pathways will mean older people will receive an appropriate diagnosis and access appropriate services in a timely fashion.
- Ensuring there is access to post diagnostic support service will enable people with dementia to live better with dementia.
- Providing (or ensuring there is provision of) consistent training on dementia across health and social care staff, and the range of providers, will improve the outcomes for older people and their carers.
- Having home care services (both mainstream and specialist) which have the expertise to support people with dementia will enable more to remain within the community for longer.
- Introducing dementia friendly design into buildings (e.g. care homes, specialist housing, care settings) and increasing the amount of extra care sheltered housing in Moray will improve the ability of older people with dementia to living independently.(Housing work stream JCS)
- Building community capacity to facilitate earlier intervention and a preventative approach with the third sector and older people will build new community driven models of care provision. (Community Capacity Building work stream JCS)
- Supporting carers of people with dementia will allow them to continue in their caring role for longer. (carers work stream JCS)
- Modernising community services to focus on early intervention and prevention, rehabilitation, reablement and recovery and end of life care will improve outcomes for people with dementia and reduce admissions to hospital (Modernising community services work stream JCS)
- Focusing on the identification of frail elderly and embedding specialist practice in the community will improve the interventions for those with complex needs (Frail Elderly JCS
- Embracing technology and driving forward telehealthcare solutions and the living it up project will improve the experience of people with dementia and their carers within the wider integrated network of services (Embracing Technology work stream JCS

3.3 Personal Outcomes for Older People

The above will contribute to the achievement of our wider personal outcomes that older people in Moray have told us is important to them. Older people in Moray will…

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control

- Have reduced feelings of isolation
- Have a range of housing options available to them
- Have unpaid carers/families who are supported to continue in their caring role

3.4 Long term commitment (10 years, JCS)

The JCS states:

"We want to ensure that people with dementia and their family/carers have an improved quality of life with the care and support that meets their needs in a safe environment within the community."

We believe that this can be achieved by engaging with the population of Moray so that the profile of dementia can be raised. This will enable individuals with dementia, their families and carers to be informed and have choice and control about the services available to them.

With increased under standing in the community there will be more confidence in the services that are available and a lessening in the uncertainty as to how to access the appropriate level of care for the individual or their carers. In the longer term this will lead to a system wide change in healthcare expectations and improve the efficiency of the care and support network.

This will enable an educated, motivated health and social care network to enhance the level of care and support given to people with dementia enabling people with dementia and their carers to have increased confidence in knowing that their needs will be seamlessly met throughout their journey. That locus of care will increasingly be in their homes

3.5 Key Areas of priority (3 years)

- Development of dementia strategy in Moray
- Publicity/Awareness/information sharing and profile raising across all sectors
- Continue to engage and involve carers and people with dementia
- Ensure all staff have the skills to recognise the potential for early diagnosis allowing identification of the needs of people with dementia across all sectors
- Continue to shift the diagnosis of dementia in Moray to primary care with a corresponding increase in post diagnostic support available in the community
- Ensure that people receiving a diagnosis of dementia are offered one year of diagnostic support
- Consider the development of specialist dementia units in the independent sector
- Explore an integrated community model of care which considers the range of care and support required throughout the progression of the symptoms of dementia
- Development of smooth pathway of care across disciplines with clear communication structures
- Work with Alzheimer's Scotland to provide access to post diagnostic support via their hub
- Increase the number of dementia cafes across Moray

- Development of anticipatory care plans with links to out of hours to minimise the risk of a hospital admission
- Continue work in secondary care around improving standards of care for people with dementia e.g. dementia champions, butterfly scheme, including the improvements of The pathway of those patients in acute care who do not have a diagnosis

An action plan will be developed by the dementia strategy work group to detail how the developments will be progressed, activities and timescales and the agreed outcomes for older people with dementia that we aim to achieve. It will be a working document to progress the implementation over the next three years.

3.6 Monitoring and reporting framework

Progress within this strategy will be reported to the established joint commissioning group for older people who oversee and monitor the implementation of the overarching joint commissioning strategy for older people and its priority areas within a shared joint commissioning framework. The Moray joint commissioning group is responsible for ensuring the actions are progressed and the group reports on progress to the Moray Community Health and Social Care Partnership.

3.7 Joint Performance

The joint performance monitoring group for older people has developed a basket of improvement measures for older people which include the following specific measures for dementia

- improving the early diagnosis and treatment of patients
- reducing the proportion of older people admitted to hospital as emergency in-patients
- Increasing the number of people who receive PDS
- Providing more care at home for older people with complex needs
- Another target relating to meeting the longer term and ongoing needs of people with dementia based on the **8** Pillars model is anticipated in years to come.

This group will monitor the performance against the delivery of the strategy and exception report to the MCHSCP leadership group.

[i] National Dementia strategy refresh 2013

[ii] "living Longer Living Better" a joint commissioning strategy for older people 2013-13 MCHSCP

[iii] Living longer living better 2009-13