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