

LONDON HEALTH BOARD

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Agenda item:	6b
Title:	London ADASS dementia work programme
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Status:	Discussion
Classification	Public

1. Purpose of this paper

- 1.1 This paper updates the London Health Board (LHB) on the London Association of Directors of Social Services (ADASS) dementia work programme.
- 1.2 Board members are invited to:
 - Note the update and consider the challenges listed in section 4.2 and how they can use their leadership to unlock further progress.

2. Recommendations

- 2.1 The London Health Board is asked to support:
 - Increasing the number of dementia friends across London
 - Enhancing the personalisation of care of those with dementia.

3. Context

- 3.1 National Sector Led Improvement (SLI) for Care and Health
The Care and Health Improvement Programme (CHIP), the Local Government Association (LGA) and ADASS work together to provide support to the nine English ADASS regions through:
 - Department of Health and Social Care funding to support delivery of a SLI approach at regional level which includes: regional and specialist Care and Health Improvement Advisers, delivery of regional SLI improvement Programmes, regional and national networking on SLI and bespoke support to address resilience and support integration via a cadre of trusted professionals;
 - Commissioning national good practice, insight, research and data analysis;
 - Gathering and sharing good practice, innovation, insight and intelligence to support regional improvement and national policy development;
 - Provision of peer challenge processes;
 - Close working with strategic partners to mobilise social care professionals and support resilience in adult social care;

LONDON HEALTH BOARD

- Collection and dissemination of soft intelligence and insight through the ADASS regions, a network of Professional Advisers, CHIAs and regional expert practitioners; and
- Enabling collective sector experience to influence and inform national policy development.

3.2 ADASS is the Association of Directors of Adult Social Services in England. ADASS is a charity which aims to further the interests of people in need of social care by promoting high standards of social care services and influencing the development of social care legislation and policy. The membership is drawn from serving directors of adult social care who are employed by local authorities. Associate members are past directors and our wider membership includes deputy and assistant directors.

ADASS is comprised of nine regions:

- East Midlands
- Eastern
- London
- North East
- North Western
- South Eastern
- South West
- West Midlands
- Yorkshire and Humber

3.3 Regional ADASS Branches, Improvement Boards and associated Programmes are an essential element of the SLI system, providing constructive challenge where necessary and peer support and challenge to improve.

3.4 Each region has:

- A single SLI programme based on regional and national priorities;
- Shared approaches to assessing risks within Adult Social Care (ASC);
- Improved visibility, transparency and ways to share and compare performance;
- A Peer Review Programme in place which supports improvement by proving a safe environment for constructive challenge; and
- Networks/groups which support agreed SLI activity at regional and local level.

3.5 LondonADASS - the main aim of LondonADASS is to improve social care across London and to identify ways of doing this more cost-effectively. We do this by working with staff in Adult Social Services across London and with other bodies, such as NHS England, which are involved with the health and wellbeing of Londoners. We encourage collaboration through a number of networks and projects focussed on particular topics.

3.6 LondonADASS has six key priorities which include:

- Supporting further integration through devolved arrangements;
- Financial sustainability of social care;
- Supporting improvements in quality and safeguarding;
- Supporting development of the workforce;

LONDON HEALTH BOARD

- Housing; and
- Transforming Care.

3.7 The LondonADASS dementia work programme cuts across the six LondonADASS priorities.

4. London Dementia Diagnosis Rates – October 2018

<http://www.londonscn.nhs.uk/wp-content/uploads/2018/02/Dementia-Diagnosis-Rates-October-2018-table.pdf>

4.1 Achieving timely diagnosis of dementia is a national priority, identified in the National Dementia Strategy and championed by the Government. The London dementia diagnosis rate is currently 70.9%, which means it is predicted that there are approximately 20 thousand people in London who have dementia but no diagnosis (65+ years). There is a variation in diagnosis rates across London from 61.4% - 90.4%.

	Recorded	Estimated	Diagnosis rate (%)	Diagnosis required to meet ambition	Diagnosis required to reach 100%
Barking & Dagenham	757	1193	63.5%	39	436
Barnet	2805	3805	73.7%	n/a	1000
Bexley	1696	2710	62.6%	111	1014
Brent	1857	2487	74.7%	n/a	630
Bromley	2946	4130	71.3%	n/a	1184
Camden	1407	1557	90.4%	n/a	150
City of London	930	1335	69.7%	n/a	405
Croydon	2328	3429	67.9%	n/a	1101
Ealing	2203	2924	75.3%	n/a	721
Enfield	2032	2617	77.6%	n/a	585
Hounslow	1460	2082	70.1%	n/a	622
Greenwich	1120	1816	61.7%	91	696
Hammersmith & Fulham	868	1269	68.4%	n/a	401
Haringey	1238	1836	67.4%	n/a	598
Harrow	1670	2552	65.4%	32	882
Havering	2145	3452	62.1%	157	1307
Hillingdon	1860	2743	67.8%	n/a	883
Islington	1147	1268	90.5%	n/a	121
Kingston	1072	1745	61.4%	92	673
Lambeth	1446	1904	75.9%	n/a	458
Lewisham	1468	1946	75.4%	n/a	478
Newham	1015	1469	69.1%	n/a	454
Redbridge	1596	2449	65.2%	37	853
Richmond	1343	1981	67.8%	n/a	638
Southwark	1045	1529	68.3%	n/a	484
Merton	1281	1734	73.9%	n/a	453
Sutton	1323	1825	72.5%	n/a	502

LONDON HEALTH BOARD

Tower Hamlets	908	1113	81.6%	n/a	205
Waltham Forest	1320	1887	70.0%	n/a	567
Wandsworth	1680	2154	78.0%	n/a	474
West London	1252	1764	71.0%	n/a	512
Westminster (Central London)	1065	1431	74.4%	n/a	366
London	48283	68136	70.9%	n/a	19853

5. London ADASS Dementia work programme

5.1 Key elements of the LondonADASS work programme include:

- Increasing the number of dementia friends across London
- Enhancing the personalisation of care of those with dementia.

5.2 Increasing the number of dementia friends across London:

A Dementia Friend is someone who has learnt more about what it is like to live with dementia and the small things that can help those with the condition. They then turn that understanding into positive action. From telling friends about Dementia Friends to visiting someone you know living with dementia, every action counts.

5.3 This element has two components:

- A call to action to Health and Wellbeing Boards (HWBs) to become dementia friends by end April 2019– at present 94% of boards have agreed to support this initiative.
- The expectation that all members of the dementia commissioners network become dementia friends by the next network meeting (17/01/2019). The dementia commissioners network brings together commissioners of dementia services in Local Authorities and Clinical Commissioning Groups (CCGs). The key aims of the network are to:
 - Evaluate Memory Service Provision across London;
 - Explore approaches to post diagnostic support services;
 - Explore use of NICE guidance within commissioning cycles;
 - Promote Dementia Action Alliances;
 - Share best practice and provide real life examples of innovative dementia commissioning where services have been redesigned; and
 - Support a pathway approach to commissioning across both health and social care.

5.4 The Dementia annual conference is scheduled for 2 May (afternoon). It is anticipated that 50% of delegates will have a diagnosis of dementia or have a caring role.

5.5 The conference will focus on increasing awareness of dementia across the generations. Nearly a third of young people know someone with dementia. As the population ages and the number of people living with dementia increases, more and more young people are likely to be affected through family and friends. In collaboration with the Alzheimer's Society, LondonADASS wants to create a

LONDON HEALTH BOARD

dementia friendly generation; supporting young people to understand dementia today and empowering them as they reach adulthood.

- 5.6 Educating young people about dementia can help reduce stigma and increase understanding. Changing attitudes and building knowledge can help to reduce the loneliness and social isolation that many people with dementia experience.
- 5.7 By educating young people about dementia, they can learn about protecting their own health and the importance of a healthy lifestyle including diet, exercise and alcohol abuse – all of which have been shown to be risk factors for dementia. Through learning, young people will become more aware of the importance of care roles, ethical issues, and issues connected with an ageing population. It will also encourage them to become active and responsible citizens.
- 5.8 The conference will explore innovative ways of increasing awareness of dementia with a focus on digital solutions.
- 5.9 Developing a digital resource to promote a personalised approach for those with dementia Personalised care and support planning (PCSP) is a systematic process based around 'better conversations' between the person and their health and social care practitioners. The overall aim is to identify what is most important to each person for them to achieve a good life and ensure that the support they receive is designed and coordinated around their desired outcomes.
- 5.10 Personalised care and support planning is a 'meeting of experts'. It brings together those with lived experience and those with technical expertise to identify all the issues, develop solutions and initiate actions. This may be carried out by the individual and/or the statutory or voluntary community services. Essentially, PCSP builds on the person's assets and resources, ensuring they are in the driving seat of decision making.
- 5.11 In order to enable championing a personalised approach, LondonASASS is:
 - Working with a specialist IT company to mock up a virtual case called Martha. For Martha's characteristics – see Appendix A;
 - Exploring developing a second virtual male character – Arthur; and
 - Launching both Martha and Arthur at our digital event on the 13 February 2019.
- 5.12 Challenges to delivering these outcomes:
 - Assumptions, about what is possible and right for people with dementia, which may restrict choice and limit the scope for living as good a life as possible.
 - The need to raise awareness and offer training to a workforce which operates across many and very different agencies in the statutory and independent sectors, and which is made up of a wide range of knowledge and skills.
 - The state of the public-sector finances and the impact on social care, which will need to play a full role in finding savings.
 - The need to maintain and improve integrated arrangements with NHS partners for commissioning and delivery, at a time when these partners are undergoing significant structural change.

LONDON HEALTH BOARD

Appendix A: Pen picture - Martha

Age: 64

Date of birth 14/02/1954

Female

Current medications: - Metformin 500mg tds, Sertraline 100mg daily

Past Medical History

- Type 2 diabetes
- Suffers bouts of depression

Personal history

Born and raised: London

Education level: Secondary school (O levels)

Marital status: Widowed (six months ago)

Current occupation: Secretary (part-time, three days a week, 21 hours)

Family history

Mother had diabetes. Brother and sister have diabetes. Mother had dementia

Social history

- Three grown up children – one lives in London with two children (divorced two years ago);
- One lives in Glasgow and the other lives in Cornwall;
- Seven grandchildren (between ages 4 – 16);
- Married 37 years and husband died six months ago following battle with Parkinson's Disease. Gave up work (was full time) for three years to act as main carer to her husband;
- Went back to work part-time three months ago. Been forgetting things at work recently and manager has been hinting that may be in Martha's interest to take retirement;
- Really appreciates social engagement from work;
- Looks after two of her grandchildren every Friday (girl 4 years of age and boy 14). Grandchildren have started to notice that Martha is getting their names mixed up but feel it is her playing with them;
- Hasn't seen GP since husband died – previous GP appointments were for the husband needs;
- Hasn't had blood tests or BP check at GP for 2 years – was too busy when carer for husband and hasn't been back since; and
- Used to enjoy line dancing with friends but gave it up when husband was ill and she was carer. Rarely sees friends now – they found it difficult when she couldn't leave her husband home alone and he couldn't come out with them.

Ambition of the personalised approach: Build a system and empower and enables Martha to live as independently as possible.