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Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.30 pm	Wednesday 11 April 2012	Town Hall, Main Road, Romford

Members 6: Quorum 3

COUNCILLORS:

Wendy Brice-Thompson (Chairman)
Jeffrey Brace
Pam Light
Keith Wells
Linda Van den Hende (Vice-Chair)
June Alexander

For information about the meeting please contact:
Wendy Gough 01708 432441
wendy.gough@havering.gov.uk

AGENDA ITEMS

1 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – received.

2 DECLARATION OF INTERESTS

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any time prior to the consideration of the matter.

3 CHAIRMAN'S ANNOUNCMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

4 MINUTES (Pages 1 - 6)

To approve as a correct record the Minutes of the meeting of the Committee held on 7 February 2012 and authorise the Chairman to sign them.

5 AGEING WELL REPORT (Pages 7 - 10)

Following the recent Ageing Well event considering priorities for older people in the borough, the attached report details some themes arising from the event that could be used as components of the overview and scrutiny committee's work programme.

6 REVIEW OF DEMENTIA STRATEGY TOPIC GROUP (Pages 11 - 50)

The Committee will receive an update on the progress of the recommendations as set out in the attached report which was agreed by this Committee on 2 March 2011.

7 SAFEGUARDING AND DIGNITY IN CARE - PRESENTATION

The Committee will receive a presentation from the Head of Adult Social Care.

8 COMMITTEE'S ANNUAL REPORT - REPORT TO FOLLOW

The Committee will receive a report on work carried out in the last municipal year.

The Committee are asked to agree the content and authorise the Chairman to sign off.

9 FUTURE AGENDAS

Committee Members are invited to indicate to the Chairman, items within this Committee's terms of reference they would like to see discussed at a future meeting. Note: it is not considered appropriate for issues relating to individuals to be discussed under this provision.

10 URGENT BUSINESS

To consider any other items in respect of which the Chairman is of the opinion, by reason of special circumstances which shall be specified in the minutes, that the item should be considered at the meeting as a matter of urgency.

Ian Buckmaster
Committee Administration &
Member Support Manager

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MINUTES OF A MEETING OF THE
INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE
Town Hall, Main Road, Romford
7 February 2012 (7.30 - 9.30 pm)

Present:

Councillors Wendy Brice-Thompson (Chairman), Linda Van den Hende (Vice-Chair), June Alexander, Jeffrey Brace, Pam Light and Keith Wells

Councillor Lynden Thorpe was also present

There were no declarations of interest.

20 **MINUTES**

The minutes of the meeting of the Individuals Overview and Scrutiny Committee held on 1 November 2011 were agreed as a correct record and signed by the Chairman.

21 **ROYAL JUBILEE COURT ASSESSMENT CENTRE**

The Committee received a presentation from the Service Manager for Preventative Services and the Reablement Homecare Manager on the Royal Jubilee Court Assessment Centre (RJC). The Committee were informed that reablement constisted of providing personal care; help with daily living activities and re-learning certain basic skills following an illness or hospitalisation.

The Committee noted that Royal Jubilee Court had 13 self-contained units of reablement accommodation. These units enabled people to be discharged from hospital and stay for a short period of time (usually six weeks) before returning to their own home. Staff at Royal Jubilee Court can explore Telecare and Telehealth type support for the client before they return home. The reablement service was also available remotely within clients own homes, this allowed them to remain living in their own homes. Following reablement at Royal Jubilee Court 73% of clients returned to their own homes, and 35% required no ongoing care support.

The Committee were given two case studies where the reablement service had successful outcomes. Both clients were in their 80s and had returned to their own homes.

From December 2010 to July 2011, a pilot scheme took place between Adult Social Care and St George's Hospital that saw 5 units dedicated for use by Health. The pilot successfully demonstrated that of the 82

discharges from RJC to home, 36 cases (43%) need no further ongoing care. This pilot had increased joint working via a daily provision of physiotherapy on the site, and provided a cost saving to St Georges as clients were discharged to home quicker.

The Committee noted that the Health and Wellbeing Board had agreed that a number of the empty sheltered housing bedsit units on the first floor of Philip House, at RJC, would be converted into 15 additional reablement units. This would double the capacity for reablement and therapy; contribute towards savings for Health and Social Care, as well as improving the quality of life and maximising the independence of Havering's residents. The building work was planned to commence in early March 2012, and was estimated to take between six to eight months to complete. This would be completely funding by Health.

Members informed officers that the reablement service was widely publicised and residents were aware of the service provided.

Officers explained that each client came with a Care Plan when they arrive at RJC. Upon arrival, the date of discharge was discussed and agreed together with any actions that needed to be put in place before that date. The clients' families were kept involved from day one, as reablement did not work without the support of families.

Members asked if there was sufficient capacity for reablement services, given the growing elderly population. Officers explained that there was no waiting list, with the exception of the five beds that Health had over the Christmas period, and stated that since the service had began they had supported 1,200 clients with reablement services at home and 150 clients at the reablement unit at RJC (up to a 6 week period).

The Committee noted that the RJC criteria were ideal for stroke victims, and they worked closely with the stroke liaison nurse. All clients who were referred from hospital could be accommodated within the reablement unit within 24 hours.

Members asked if other sheltered housing units across the borough were being reviewed to accommodate other reablement units. Officers confirmed that they were hoping to expand across the borough, but were also working with Health colleagues both for support and financial contributions.

The Committee were keen to visit the Reablement Unit at RJC, and it was agreed for a suitable date to be arranged.

22 **AUTISM PLAN - UPDATE**

The Committee received a report on the Autism Plan update. At its meeting in March 2011, the Committee had received a report outlining details of the national strategy for adults with autism in England. The report also outlined the key priorities for the first year of the national strategy and work needed to develop a local autism plan.

The officer informed the Committee that since the last report, a working group had been put together from the local partnership that had pulled together the local plan. An initial draft and an Easy Read version were prepared, and presented to the Learning Disability Partnership Board. The Board agreed the documents for a broader consultation, which had ended in January 2012, with a workshop event planned for February 2012. The Committee noted that the comments that had been received were in support of the plan.

In January 2012, NICE consulted on the guidelines on the pathway of how to make it easier for people with autism to access the services they need. The Government wished for Local Authorities to audit what they had done to put these guidelines in place. Havering was in discussions with neighbouring boroughs about cooperative working to minimise costs and share information.

The Committee raised concerns about the joint working with neighbouring boroughs, as it wished Havering to keep its own identity. Concerns that local residents would be acknowledged and were able to access local services were also raised. Officers stated that local support groups were involved, and this was a Havering Plan, which would benefit Havering residents. The partnership working would not be entered into unless there was a solid business case to do it. All practical services would be borough based, however the planning stage of the plan would be done in partnership.

The Committee was informed that there was a need for support for Adults with Autism, as within the voluntary sector there was only one organisation who provided support at the present time.

Officers stated that the Autism Plan would be a preventative strategy, as there was a lot of unmet need (risk). This would ensure that people with Autism could access information on employment, accommodation and general living needs. Autism was difficult to diagnose and affected each person differently. Health professionals need to be on board to diagnosis specific needs of the individual. The NICE guidelines set out the national framework for the diagnosis of Autism from referrals. Whilst Autism was present in children, it was often difficult for parents to accept and therefore this could mean a later diagnosis.

Whilst staff would have training on recognising the signs of Autism, the services was reliant on the medical profession for a diagnosis.

The Committee thanked officers for the update.

23 ADVICE AND INFORMATION - SIGNPOSTING

The Committee received a presentation on the new Information and Advice Service for Adult Social Care, from the Transformations Project Manager. It was explained that whilst there was a lot of information on the services and advice available to customers, this was not always easily available.

Research was carried out on existing good practices elsewhere on what "good" information and advice looked like. Reviews of recent local consultation with voluntary sector organisations and focus group were carried out and assessed across all sectors in Havering. The five key themes which came out of this were:

- Partnership working – a newly commissioned single service across provider organisations with a sustainable service structure.

- Easy Access – phone, website, physical premises supported by outreach where information needs are assessed at first contract.

- Face-to-face delivery – "shop type" premises in Romford with regular programme of face to face delivery around the borough.

- Branding and marketing – need to reflect thatit is a voluntary sector organisation independent of but supported by the Council.

- Good customer services – trained staff, robust performance management procedures to effectively measure the impact of service

The new Care Point shop was "soft" launched at 36 High Street, Romford on 31 January 2012, together with the new website (www.haveringcarepoint.org). The official launch would be around Easter 2012. The Committee met with the Care Point Manager who explained the types of enquiries and needs of the customers they had assisted since the shop had opened. The shop was in an accessible location, was purpose built, included three interview rooms, and internet café, with access to online information, a Changing Places toilet facility, telephone and email service, and was open on Thursday evening and Saturday morning.

The new service would deliver outreach services across the borough. The demand for this would be tested through the enquiries made at the shop. The outreach would be two-hour sessions every fortnight at difference locations across the borough.

The signposting consortium had emerged from HULO, with the lead organisations being Age Concern Havering, Citizens Advice Bureau and Crossroad Care Havering. Enquiries from other local and national organisation about joining the consortium had been received. The initial

period of 14 months, ending in April 2013 were grant funded, however a tender of four years would make the service more financially viable across the life of the service.

The Committee noted that the Care Point shop was an advice and signposting service. They did not offer solutions to problems, but had advice and information about organisations that can assist. The service was about giving clients an informed choice about the options available to them. Care Point would contact all clients to get feedback on if the services/ advice received was helpful.

Members raised concerns that the strap line for Care Point was "Independent information and advice for adults", and asked if there would be a similar service for children and youths. Officers stated that there were the family services, but agreed that there may be a possibility of the two services coming together in the future.

Officer stated that they hoped the referrals from Care Point to the voluntary sector organisations would be beneficial to them, and may in the future encourage others to become part of Care Point.

The Committee thanked officers for their presentation and asked that an update be given to the Committee in 6 months time, once the official launch had been done.

24 OVERVIEW OF RESIDENTIAL AND NON-RESIDENTIAL DEBT

The Committee received an overview presentation on residential and non-residential debts from the Financial Assessment and Benefits Team Leader. The officer explained that there were two areas of service that were charged for in Adult Social Care:

- Residential Care – this is any care provided to an individual in a residential or nursing home, including long term and short term placements and respite care
- Non-Residential care – this relates to all types of home care services as well as day opportunities and travel to and from the day centres.

The Committee noted that there were three types of debt relating to residential and non-residential care, these were Secured debt – where a charge was placed on the debtors property which ensured it can not be sold without the Council being reimbursed in full first; Bad debt – monies that it was anticipated would not to be recovered; and Ongoing debt – unsecured arrears where collection was anticipated. The details of the debt were shown to the committee in the form of a graph. Officers explained that there had been an improvement over the last year with collection of debt having risen by 3%, which equated to approximately £250,000

Due to a change in approach, both total debt and bad debt had fallen. There had been a reduction in the number of debtors and the average age of the debt (reductions in the number of days since the first invoice was issued). There had also been a steady improvement in the collection of invoiced care fees. Officers explained that there had also been a pro-active/ preventative approach to debt collection, so rather than waiting for debt to reach a certain size before taking action, all new debtors were sent a robust intervention letter if three of more invoices with monies outstanding were sent.

The Committee were informed that there was a closer working relationship with the Legal Department, and a member of the legal department was based full time within the Financial Assessment and Benefits Team to deal with debts outstanding after standard recovery process had failed. Deferred Payment Agreements were now used as standard for any Residential care users with a property, which means a greater sum of debt was now secured with a charge on a property. All new users, as part of the financial assessment process, were offered a direct debit facility. This was growing and was hoped to be at 50% of users within two years.

Members asked when invoices were sent. Officers informed the Committee that these were four weekly, however after 2 months (2 invoices) then the debtor would be contact, unless the Council were aware of any situation which could cause the debt, to ascertain the reasons for the non-payment.

The Committee thanked the officer for the overview.

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Chairman

Havering
LONDON BOROUGH

REPORT TO ALL OVERVIEW AND SCRUTINY COMMITTEES, MARCH-MAY 2012

Subject Heading:	Potential Work Programme Themes Arising From Ageing Well Event
CMT Lead:	Ian Burns, Acting Assistant Chief Executive, Legal and Democratic Services
Report Author and contact details:	Anthony Clements, Principal Committee Officer Tel: 01708 433065 anthony.clements@havering.gov.uk
Policy context:	The Council's overview and scrutiny powers and the need to ensure an effective overview and scrutiny process.
Financial summary:	No implications arising directly from this report.

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	[]
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[X]
Valuing and enhancing the lives of our residents	[X]
Delivering high customer satisfaction and a stable council tax	[]

SUMMARY

Following the recent Ageing Well event considering priorities for older people in the borough, this report details some themes arising from the event that could be used as components of the overview and scrutiny committees' work programmes.

RECOMMENDATION

That Members consider the themes raised by the Ageing Well event and decide which, if any, should be added to the work programme of their Committees.

REPORT DETAIL

1. Members will be aware that, in January 2012, an event was held considering the implications for Havering of the growing elderly population and the Ageing Well agenda generally. The event was well attended with a number of Members and other stakeholders present. Groups and organisations dealing with the elderly who were represented included Age Concern, Havering Police and local NHS organisations.

2. The event produced a great deal of discussion and ideas from the delegates about what were considered the priority areas for older people (a number of members of the Havering Over-50s forum also attended and gave valuable input to the discussions). The results of these sessions are summarised in the appendix to this report.

3. Shortly after the event, several of the Overview and Scrutiny Committee Chairmen, assisted by officers, met informally to consider the outcomes from the event. A number of general themes emerged and these, along with some further suggestions, are listed below. It should be noted that this is not an exhaustive list and Members are welcome to use any of the information below or in the appendix to consider what items could be added to the Committees' work programmes.

   - Security and fear of crime including data protection issues
   - Lifestyle and social inclusion
   - The impact of housing and planning on older people
   - Accessibility and transport
   - Bereavement support
   - The impact on young carers
   - Safeguarding issues

4. Issues affecting older people are often wide ranging and it is likely that many of the issues listed above (or any others chosen by Members) may cover the remit of more than one Overview and Scrutiny Committee. This should not be seen an obstacle to undertaking the work but Members may wish to give consideration to co-opting members from appropriate

other committees onto any topic group set up in response to the Ageing Well work. For example, a review of security and fear of crime led by the Crime & Disorder committee may find it useful to co-opt a member from the Towns & Communities overview and scrutiny committee in order to more fully consider the security aspects of housing design and related areas.

IMPLICATIONS AND RISKS

Financial implications and risks:

None arising directly from this report. Any financial implications arising from individual reviews would need to be considered as part of the report of the specific topic group.

Legal implications and risks:

None.

Human Resources implications and risks:

None, this work would be supported within the existing committee administration team.

Equalities implications and risks:

The ageing well event was specifically focussed on issues affecting older people and hence sought to improve scrutiny of an area (age) that is a protected characteristic under the Equality Act 2010. Further scrutiny work in this area will assist in meeting the Council's equalities obligations.

BACKGROUND PAPERS

Appendix: Feedback from Ageing Well Event Breakout Sessions, 19 January 2012, Havering Town Hall

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INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE

REPORT

Subject Heading:	Review of Dementia Strategy Topic Group Report
CMT Lead:	Lorna Payne Group Director Adults & Health 07508 852359
Report Author and contact details:	David Cooper Head of Service, Adult Social Care 01708 433069 Fiona Weir Operational Director 0844 600 1150
Policy context:	National Dementia Strategy

SUMMARY

The report outlines developments in Havering following the Individual and Health Overview Committee's review of the national Dementia Strategy, which took place in 2010 and report presented to your committee on 12 April 2011.

RECOMMENDATIONS

Members are asked to note the progress in Havering of the implementation of the National Dementia Strategy.

REPORT DETAIL

1.0 Background

1.1 At their meetings on 29 June 2010 and 8 July 2010, the Individuals Overview and Scrutiny Committee and Health Overview and Scrutiny Committee respectively agreed to establish a joint topic group to scrutinise the Dementia Strategy in Havering.

1.2 The following Members formed the topic group at its outset: Councillors Linda Trew (Chairman), June Alexander, Wendy Brice-Thompson, Linda Hawthorn, Lynden Thorpe and Fred Osborne.

1.3 The joint topic group met on four occasions and carried out two visits. One was to the Alzheimer's Society Dementia Café, and one to visit sessions run by Age Concern Havering.

1.4 The group took evidence from a number of expert witnesses.

1.5 Scope of the review: To consider the following areas as part of the National Dementia Strategy as it is applied in Havering, but to focus on five main issues and their impact on the local Havering population. The three main themes reflect those of the National Dementia Strategy.

1.5.1 Raising awareness and understanding

I. To gather accurate information on the numbers of people affected by dementia in Havering.
II. To consider the role of informal carers in Havering and their views of local dementia services

1.5.2 Early Diagnosis

III. To consider the role of the dementia care advisors and how this meets the needs of Havering residents

1.5.2 Living well with Dementia

IV. To investigate the range of dementia therapies available locally.
V. To investigate the role of Admiral Nurses and the work they undertake in Havering.

2 High level findings from the review.

See Appendix One: Dementia Strategy Topic Group Report.

2.1 The Alzheimer Society, describe Dementia as:

" An umbrella term. It describes the symptoms that occur when the brain is affected by certain diseases or conditions. There are many different types of dementia although some are far more common than others. They are often named according to the condition that has caused the dementia". Some of the more common types include, Alzheimer's Disease, Vascular Dementia, and Fronto-temporal dementia"

2.2 In Havering, the numbers of people over 65 years of age with dementia is expected to increase by 33% by 2025. Over the next 15 years the biggest impact overall for Havering will be in the change in the over 65s (23% growth compared to London 19.2%) and the over 85's (49% growth compared to London 38.1%).

2.3 The most recent records held indicate that, there are approximately 1015 patients registered in Havering PCT as having some form of Dementia. This represents only a third of the number that would be expected to have dementia in Havering, based on the prevalence data. This under diagnosis reflects the national picture. The patients registers represents 0.4% of all registered GP population, which is a total of 250,662, which is below the England national average of 1.1%. There was also a higher prevalence of dementia in women, partly due to a generally longer life expectancy for women than men.

2.4 NICE guidelines confirmed that the prevalence of dementia increased sharply with age. Throughout the UK there were approximately 700,000 cases of dementia and the prevalence of the condition was set to more than double in the next 30-50 years.

2.5 A significant burden of care can fall on carers of Dementia patients, particularly adults in the 50 plus age group. This may lead to an increase in mixed anxiety and depression and the generalised anxiety for the 50 plus age group. The proportion of people who identified themselves as carers in the 2001 Census was 10.4% of the total population (highest in London), compared to 8.5% for London as a whole.

2.6 The group were informed of the range of services and expenditure provided by statutory and voluntary organisations in Havering for 2010/11.

2.7 The joint topic group scrutinised in detail the impact of the National Dementia Strategy on the population of Havering.

2.8 The Topic Group made a number of recommendations arising from the review:

- That the relevant Cabinet Member liaises with NELFT with a view to future provision for borough dementia services.

- That NELFT recruit Social Workers to fill the current vacancies and ensure that collaborative working with the Adult Social Care Reablement Team, on dementia services, is put in place.

- That Havering join the Memory Network.

- That the Commissioners continue to develop the local market to increase opportunities for day support for people with dementia and their carers.

- That the Council work with Age Concern to find further premises which meet requirements to provide additional sessions.

- That work is undertaken to develop more robust financial and performance information, linked to JSNA, to aid future planning of services.

- To encourage early diagnosis of dementia by GP's, and provide training and public awareness of the sign of early dementia.

- To encourage partnership working group to assist in the provision of public information on signs of dementia in the form of leaflets, DVD's or checklist of symptoms.

- To encourage the GP Consortia (now Clinical Commissioning Group) / Health and Wellbeing Board to continue the commissioning of the Dementia Advisory Service current run by Age Concern.

- That the Borough Director of NELFT develop an action plan from these recommendations and report back to the relevant Overview and Scrutiny Committees in 6 months regarding progress.

3 Headline progress since the topic Group Review.

3.1 However, since the review there has been significant progress under the leadership of the Lead Member of Adult Social Care, in raising the profile and taking forward improvements in services for people with dementia and their carers. The Joint Strategic Needs Assessment is being reviewed, and a revised Health and Wellbeing Strategy is being prepared. Dementia will form a key priority in the strategy.

3.2 A Dementia Implementation Group (DIG) has been set up to coordinate the implementation of the National Dementia Strategy across Havering and includes representatives from Social Care, Health and Third Sector organisations. Work is also underway to develop a new care pathway. Appendix Two: Implementation of National Dementia Strategy.

3.3 The Topic group received evidence, anecdotally, that the skills, practice and knowledge around dementia in care homes in Havering and nationally could be less well developed than is desirable. It therefore was requested that an audit of skills and knowledge be undertaken within the care homes in the borough. The audit was subsequently completed between July and September 2011, and a report was tabled for your committee at a meeting on the 1st November 2011. Appendix 3: Results of Audit of Skills and competencies in Mental Health.

3.4 **Support for Carers**
In November 2011, the Havering Health and Wellbeing Board agreed to receive a regular report from clinical commissioners and local authority commissioners

covering the main areas of commissioning activity which support our Health and Wellbeing priorities. A key area was dementia.

3.4.1 Peer Support

The Peer Support service will provide support for people with dementia and their carers by recruiting and matching volunteers, and matching people with dementia and their carers to others on the basis of shared needs and preferences. The service is being delivered by the Alzheimer's Society and a Peer Support Facilitator has been appointed to take the service forward. The first peer support sessions are taking place in March 2012 in Romford and Upminster and offer:

- Singing for the Brain - a stimulating activity designed to enhance wellbeing and bring fun and confidence to lives affected by memory problems. This is a 12-week programme with two programmes being run three times a year over two years. Each programme will accommodate a maximum of 30 people so up to 360 people with dementia could benefit over the lifetime of the service; and

- Peer Support Groups for people with dementia/and or their carers. There will be eight sessions a month with a maximum of 12 people per session.

Both of these activities will cost £3-£5 per person, per session and those on pension credit will be exempt.

The Peer Support service will enable people with dementia to remain independent in their own homes and allow carers to continue caring for longer, reducing the financial demand on health and social care departments, particularly through residential care admissions and delayed discharges through acute care settings.

3.4.2 **Information & Advice Outreach Service**

This service will also be delivered by the Alzheimer's Society and will improve knowledge and awareness of dementia and available dementia services among residents increase the number of patients referred onto the dementia pathway and support our preventative approach by giving people early access to relevant information. Social inclusion will be promoted via travelling 'surgeries' throughout the borough at venues such as supermarkets, post offices, sheltered accommodation units and faith groups.

The service will run for 18 months. The outreach service will be targeted and flexible to local needs and will average four hours of direct community information provision per week with the opportunity for follow up support from an Information Worker for specific information requests. We anticipate delivering over 100 information sessions over the project period, meeting more than 500 direct requests in that time. The service will also tie in to the Care Point resource and may hold some of its information sessions there.

3.4.3 **Additional Support for Carers**

This service will be provided by Crossroads Care and will offer a specialist, carer-needs led and client-centred service, in the main to people who have a diagnosis of moderate to advanced stages of dementia by way of home-based respite support. It starts on 2nd April 2012, will run for 18 months and will support up to 80 carers for up to six hours every four weeks including an out-of-hours service. The service aims to reduce residential care admissions and improve health and wellbeing.

These services meet our Health and Wellbeing priority of 'Supporting Older People'

4 Finally, the Committee requested that the Borough Director of NELFT develop an action plan from those recommendations outlined in the topic group report and update the relevant O&S community within six months.

A progress report is attached for Members attention. Appendix Four: Action Plan for the Joint Overview and Scrutiny Committee Topic Group on the Dementia Strategy for Havering.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no direct financial implications arising from this report, which is for information only. The financial implications and risks related to any proposed initiatives referred to in this report will be addressed by the Lead Member through the Health and Wellbeing Board, as the need arises. New initiatives will be subject to the appropriate authorisation processes and the availability of funding.

Legal implications and risks:

As this report is for information only there are no apparent legal implications or risks.

Human Resources implications and risks:

As this report is for information only there are no human resource implications or risks.

Equalities implications and risks:

As this report is for information only there are no equality implications or risks.

BACKGROUND PAPERS

Appendix One	Dementia Strategy Topic Group Report
Appendix Two	Implementation of National Dementia Strategy
Appendix Three	Results of Audit of Skills and Competencies in Mental Health
Appendix Four	Progress on Action Plan for the Joint Overview and Scrutiny Committee Topic Group from Operational Director NELFT

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Havering
LONDON BOROUGH

8

INDIVIDUALS/ HEALTH OVERVIEW & SCRUTINY COMMITTEE

REPORT

12 APRIL 2011

Subject Heading:	Dementia Strategy Topic Group Report
CMT Lead:	Ian Burns Acting Assistant Chief Executive 01708 432442
Report Author and contact details:	Wendy Gough Committee Administration 01708 432441
Policy context:	Findings of the Dementia Strategy Joint Topic Group

SUMMARY

This report contains the findings and recommendations that have emerged after the Joint Topic Group scrutinised the subject selected by the both the Individuals and Health Overview and Scrutiny Committees in June and July 2010 respectively.

The financial, legal and HR implications are addressed within the topic group's report.

RECOMMENDATIONS

That Members:

1. Note the report of the Joint (Individuals and Health) Overview and Scrutiny Committee Topic Group (attached);

2. Decide whether to refer the recommendations of the Joint Topic Group to Cabinet, the North East London NHS Foundation Trust (NELFT) or other bodies as appropriate.

REPORT DETAIL

1.0 BACKGROUND

1.1 At their meetings on 29 June 2010 and 8 July 2010, the Individuals Overview and Scrutiny Committee and Health Overview and Scrutiny Committee respectively agreed to establish a joint topic group to scrutinise the Dementia Strategy in Havering.

1.2 The following Members formed the topic group at its outset: Councillors Linda Trew (Chairman), June Alexander, Wendy Brice-Thompson, Linda Hawthorn, Lynden Thorpe and Fred Osborne.

1.3 The joint topic group met on four occasions and carried out two visits. One was to the Alzheimer's Society Dementia Café, and one to visit sessions run by Age Concern Havering.

2.0 SCOPE OF THE REVIEW

To consider the following areas as part of the National Dementia Strategy as it is applied in Havering but to focus on these five main issues and their impact on the local Havering population. The three main themes reflect those of the National Dementia Strategy.

<u>Raising awareness and understanding</u>

- To gather accurate information on the numbers of people affected by dementia in Havering.

- To consider the role of informal carers in Havering and their views of local dementia services

Early Diagnosis

- To consider the role of the dementia care advisors and how this meets the needs of Havering residents

Living well with Dementia

- To investigate the range of dementia therapies available locally.
- To investigate the role of Admiral Nurses and the work they undertake in Havering.

3 FINDINGS

General overview

3.1 The Alzheimer Society, describe Dementia as:

" An umbrella term. It describes the symptoms that occur when the brain is affected by certain diseases or conditions. There are many different types of dementia although some are far more common than others. They are often named according to the condition that has caused the dementia. Some of the more common types include, Alzheimer's Disease, Vascular Dementia, and Fronto-temporal dementia"

3.2 In Havering, the numbers of people over 65 years of age with dementia is expected to increase by 33% by 2025. Over the next 15 years the biggest impact overall for Havering will be in the change in the over 65s (23% growth compared to London 19.2%) and the over 85's (49% growth compared to London 38.1%).

3.3 The most recent records held indicate that, there are approximately 1015 patients registered with NHS Havering as having some form of Dementia. This represents only a third of the number that would be expected to have dementia in Havering, based on the prevalence data. This under diagnosis reflects the national picture. The number of dementia patients registered represents 0.4% of the entire registered GP population (a total of 250,662) giving a prevalence below the England national average of 1.1%. There is also a higher prevalence of dementia in women, partly due to a generally longer life expectancy for women than men.

3.4 NICE guidelines confirmed that the prevalence of dementia increases sharply with age. Throughout the UK there are approximately 700,000 cases of dementia and the prevalence of the condition is set to more than double in the next 30-50 years

3.5 A significant burden of care can falls on the children of Dementia patients, particularly adults in the 50 plus age group. This may lead to an increase in mixed anxiety and depression and generalised anxiety for the 50 plus age group. The proportion of Havering residents who identified themselves as carers in the 2001 Census was 10.4% of the total population (highest in London), compared to 8.5% for London as a whole.

3.6 The Topic Group were informed that there was a multi-agency group that had been formed to take forward the three themes identified in the group's scope. These included London Borough of Havering, Age Concern Havering, North East London Foundation Trust (NELFT) including psychiatric representatives, the Alzheimer's Society, Health Commissioners, Public Health, BHRUT and the medicines management lead. This group also has carer's representatives. NHS Havering had commissioned services at Queen's Hospital to improve the quality of care for people with dementia. A project was also underway at Queen's Hospital to improve the focussed care of older people, including basic training for nurses in dementia issues.

3.7 The Topic Group were alerted to concerns regarding the implications for Community Mental Health Services, of the Coalition Government plans to transfer responsibility for Commissioning to GP Consortia. Evidence has been presented indicating the under representation of Dementia cases by GPs. Work would be needed with GPs and Practice Nurses about identifying signs and symptoms of Dementia.

3.8 Work was needed with GPs and practice nurses about identifying the signs and symptoms of dementia. Officers informed the group that the local memory service us under review to improve the service and its capacity to see a high volume of people with memory problems. It is likely that this will include working with GPs to improve care pathways and detection protocols. GPs did have different levels of experience with mental health generally. Research had shown that ten years ago GPs were more likely to use standard dementia tests but were less confident with how to manage the condition. It was important that GPs were able to refer dementia sufferers on for support at an earlier opportunity.

NELFT

3.9 The group met with Professor Orrell - an Old Age Psychiatrist as well as a professor at UCL. He also carried out a research role, with the main area being in dementia care for which he had developed a treatment technique – cognitive stimulation therapy. The group were provided with copies of the "Making a difference – An evidence-based group programme to offer cognitive stimulation therapy (CST) to people with dementia".

3.10 Professor Orrell was also involved with developing the Camberwell Assessment of needs for the elderly; he chaired the National Accreditation Panel and also undertook clinical work, including home visits, in-patient work and a range of duties related to old age psychiatry.

3.11 The group also met with Dr Stephen O'Connor, who was also an Old Age Psychiatrist and an Associate Medical Director. He explained to the group that the Community Mental Health Team is comprised of a range of professionals, including Occupational Therapists and Admiral Nurses, who support carers of people with dementia with complex/ challenging behaviour. It was dependant on the needs of the client as to the type of carer they needed. The clients were assessed on the basis of their physical health and wellbeing to ensure that the correct support was in place. Carers were also provided by Social Services in partnership with NHS Havering, if the client lived in their own home.

3.12 The group noted that the main base for the Older People's Mental Health services was currently sited at Suttons House at St. Georges Hospital, and following the closure of Mascalls Park, the medical staff would be relocated to Church Road as an interim measure. Since they were however unable to run clinics from this site, suitable accommodation for the medical staff was being sought. A range of clinics are provided at the Petersfield centre, however NELFT are in discussions with a view to future provision for borough dementia services, since additional resources have been provided for the further development of dementia services by NHS Havering. (See recommendation 5.1)

3.13 The group were pleased to note that the transfer of wards from Mascalls Park to the new facility at Sunflowers Court at Goodmayes Hospital was proceeding on schedule.

3.14 The group noted that NELFT were working closely with London Borough of Havering, Human Resources to recruit to current Social Worker vacancies. (See Recommendation 5.2) NELFT had signed a Section 75 document which agreed that Older Peoples Social Care Staff will be recruited by NELFT. Social Workers in the Older Peoples Mental Health Team are not dedicated to working in dementia services and therefore NELFT were also in discussions with the Adult Social Care Reablement Team in regard to future collaborative working within Queens Hospital and the new liaison team being developed.

3.15 The group were concerned that Havering had not joined the Memory Network. The Memory Network is a network to share information with colleagues on the resources in shaping memory clinics. It also enables colleagues to learn from each other, share worries and difficulties and enable professionals to speak with a united voice. (see Recommendation 5.3)

3.16 Officers stated that there was an excellent memory service in Havering with specialist staff and NHS Havering did have an early intervention and treatment theme as part of their dementia strategy. NELFT confirmed that it is their intention to become a member on completion of the development of their redesigned memory service.

Overview of Expenditure for services for people with dementia

3.17 Officers provided details on Local Authority and Primary Care Trust expenditure on services for people with dementia, which included:

- Funding for commissioned dementia specific services, i.e. Age Concern;
- Estimates of funding for generic social care services that include provision for people with dementia, i.e. Reablement team dealing with dementia as well as other medical issues;
- Estimates of funding for older person's mental health community and inpatient services that include provision for people with dementia, i.e. NELFT.

3.18 Officers explained that there were also a number of hidden costs included in primary care/ GPs and acute hospital care which included dementia, but were services provided on a generic basis and therefore broad assumptions based on population, prevalence and typical case mix were made to estimate dementia specific costs.

3.19 The group were informed that the estimated costs for 2010/11 were:

£1,478,018 for all specialist dementia community activities, £636,625 for dementia related inpatient activities and £425,000 for Dementia Collaborative care hospital liaison team to develop an in-reach service for people with dementia and other mental health problems. Officers explained that these were block contract and therefore included different elements. These were estimated as 50% of clients with dementia.

3.20 Officers explained to the group that there was forecast expenditure for 2010/11 of £1,200,610 for the 30 dementia beds at Heatherbrook Nursing Home (Care UK) and for individual "spot" purchased placements of which, on average, this would be 65 at any one time with a budget of £1,747,793. The forecast expenditure for 2010/11 was £2,934,000 - an overspend of £1,186,207 compared with an outturn in 2009/10 of £2,204,000.

3.21 The group were informed that places within care homes are rated. These were dependant on the rating of the client as to whether the funding came from the NHS or Local Authority. The group were informed that there were a lot of voids in care homes, therefore there were more beds than people. They were further informed that there had been a 25% decrease in the take-

up of care home beds, due to the Memory Centre and Dementia Service Advisors providing services which lead to less admissions to care homes or hospital and keep the services within the community.

3.22 Officers explained to the group that the growth of medical costs had risen between 2004/5 and 2008/9. Whilst the medication prescribed was not a cure, it did slow down and delay the progress of the symptoms. This medication can only be initiated and prescribed by a Psychiatrist following an assessment by a specialist first; however the GPs then have to monitor the progress.

3.23 The group felt that there needed to be more robust monitoring of financial and performance information so that this could aid future planning of the services available to people with dementia. This would link with the Joint Strategic Needs Assessment which describes the stages of the process, including stakeholder involvement, engaging with communities and recommendations on timing and linking with other strategic plans. (see Recommendation 5.6)

London Borough of Havering Services

3.24 Officers explained that the cost of services provided by the London Borough of Havering were difficult to give accurately, since people with dementia only made up a small part of the overall cost. The group were informed that the Council pay a higher rate of dementia care for approximately 122 service users in residential nursing homes. The total cost of this care is £3,124,000. For care in a residential home, the cost is £7,252,000 for approximately 270 service users.

3.25 The group were informed that there were approximately 89 users identified as having dementia who received homecare packages, the estimated total cost for these users was £1,190,000. There were approximately 39 users identified as having dementia who receive day opportunities; the estimated cost for these users was £154,000.

3.26 The reablement service is a short term intervention service to enable vulnerable adults to maintain their level of independence, usually following a major incident such as hospital admission or significant deterioration in health or home circumstances e.g. for a person with Dementia. On average 14% of the general population over the age of 65 will suffer from a level of dementia. On this basis, the estimated general cost of reablement services for those with dementia is approximately £322,000 per annum. Officers stated that there would be some clients of the reablement services who may go on to need additional support, however some may only need short intensive support just to overcome the significant event.

3.27 Other services that may be provided to those with dementia included respite, direct/self directed payments and occupational therapy, however at the time, it is not possible to estimate the costs specifically linked to

dementia. Officers explained that the Resource Allocation Calculator is being developed to assess people's social care needs in order to allocate sums of money to achieve identified outcomes. The roll out of this system should provide more accurate information on specific client groups and service user needs.

3.28 Officers explained that previously places had been commissioned for providing day opportunities, however many of these took place in care homes, which are no longer in council possession. They could stimulate the market for other provisions, however service providers would have to be specialists to deal with the needs of the users, but there was no reason why this could not work on a "spot" purchase basis. (see Recommendation 5.4)

3.29 The group found that throughout the scrutiny review there was a lack of evidence of early diagnosis from GP's and that information available to the public to spot the signs in their relatives was also lacking. (see Recommendation 5.7) The group found that there was information leaflets and advice available; however there was an issue in the public accessing this information and knowing the symptoms. The group thought it would be useful if leaflets/ DVD's or a checklist of possible symptoms could be displayed in GP surgeries and libraries. (see Recommendation 5.8)

Age Concern

3.30 The group met with the Director of Development from Age Concern Havering. The group were informed that there were three clubs running for the Young Onset Dementia Group, these ran in different areas of the borough, however there was in excess of 120 people on the carers list and even though a new club had recently opened they were still not meeting the demand. The aim of these clubs is to provide respite for carers by facilitating clients with early onset dementia who are under the age of 65. The cost to Havering is £12,000, and this is a voluntary contribution and forms part of a grant. The group were informed that there is still a growing need for advice and assistance, given the growth of older people in Havering. As a result Age Concern Havering had doubled its capacity.

3.31 Age Concern has been commissioned by the PCT to run a Dementia Advisory service, building on the long standing early intervention dementia team. This has enabled them to double their existing capacity, recruit new advisors, and re-model the service based on the objectives of the national dementia strategy. This service will aim to allocate an advisor to everyone diagnosed with dementia. Working closely with the memory service, the advisers will ensure people with dementia and their carers have access to information and advice from the point of diagnosis onwards. The group discussed the proposed Government changes and who would be responsible for this in 2013. The group felt it should be a clear transition and that support of the GP Consortia and the Health and Wellbeing Board was vital. (see Recommendation 5.9)

3.32 The group were informed that there were some areas of the borough where the need for services was greater. As a result there were over 40 people on the waiting list. The main problem was finding suitable premises to run sessions, as they would need to be secure, have comfortable seating, and a kitchen; however cost would be a big implication. (see Recommendation 5.5)

3.33 Age Concern Havering were currently recruiting in Havering to educate the GPs on early diagnosis and NELFT and Age Concern had been working well together on a number of projects over the last 3-4 years. The current project is where an experienced carer can assist a new carer and is called "Shield". Age Concern carry out CRB checks for all volunteers that are recruited. They also undertake full induction and dementia training before commencing any sessions with clients. They were currently registering for a pilot "sitting" service, this would be available daytime, evening and weekend but was literally a sitting service and would not provide any personal care.

3.34 The group were informed that Age Concern Havering was currently piloting "self-funding" clubs to see how these worked. At the moment there had been some uptake, however they found that clients were often reluctant to part with their money and felt that spending their allowance on a day opportunity was a waste of money. It was explained that a whole day peer support group, with the correct ratio of client/ staff would cost £45 per client per day.

3.35 The group carried out a visit to a number of sessions run by Age Concern Havering to see them in progress, and to speak with carers about their experiences. The group felt that these sessions were very worthwhile, and found that all the staff and volunteers who ran the sessions were very passionate and enthusiastic about the clubs and the service provided. The clients that were attending on the day of the visit were very relaxed and enjoyed the clubs. The staff informed the group that these are regular clients who take ownership of the clubs. The activities included were coffee clubs, lunch clubs, dancing, reminiscence and keep fit.

Alzheimer's Society

3.36 The group met with the Support Services Manager for Redbridge and Havering Alzheimer's Society. She informed the group that the Alzheimer's Society provide a more national level of information, through advertising on television and radio, campaign literature and also contributed to the Dementia Strategy Group. The group were informed that the local office had recently produced a dementia pack on how to get a referral in Havering; this had been developed jointly with Public Health as part of the National Dementia Strategy implementation group tasks.

3.37 She informed the group that there were a number of peer support and social inclusion groups for carers and people with dementia. These groups included a monthly social inclusion group with access to outings and social

activities, a monthly lunch support group, held at Jackson's Café, a Saturday Social Support Group which was specifically for those families that worked during the week but were weekend carers to families and the Dementia Café, which was held on the last Friday of the month, supported by Admiral Nurses and was an information and social event for carers of, and people with a diagnosis of dementia. The total cost to Havering for all these projects was £43,000, and came from the Carers Grant.

3.38 The group were informed that there was also an online forum for carers and early diagnosed clients to discuss their thoughts and feelings. This forum was well used and was an electronic peer support network.

3.39 The group attended the Alzheimer's Café to see it in progress, and to speak with carers about their experiences. The group were informed that the café met on a monthly basis, with on average between 30 and 40 attendees, with this being a drop-in centre it was difficult to specify exact numbers and therefore hard to plan for numbers attending. The Alzheimer's Café also had speakers on specific subjects, which were relevant to both carers and clients.

4.0 CONCLUSIONS

4.1 As outlined above, the joint topic group have scrutinised in detail the impact of the National Dementia Strategy on the population of Havering.

5.0 RECOMMENDATIONS

5.1 That the relevant Cabinet Member liaises with NELFT with a view to future provision for borough dementia services.

5.2 That NELFT recruit Social Workers to fill the current vacancies and ensure that collaborative working with the Adult Social Care Reablement Team, on dementia services, is put in place.

5.3 That Havering join the Memory Network.

5.4 That the Commissioners continue to develop the local market to increase opportunities for day support for people with dementia and their carers.

5.5 That the Council work with Age Concern to find further premises which meet requirements to provide additional sessions.

5.6 That work is undertaken to develop more robust financial and performance information, linked to Joint Strategic Needs Assessment, to aid future planning of services.

5.7 To encourage NELFT and Havering PCT to encourage early diagnosis of dementia by GPs, and provide training and public awareness of the signs of early dementia,

5.8 To encourage partnership working groups to assist in the provision of public information on signs of dementia in the form of leaflets, DVDs or checklists of symptoms.

5.9 To encourage the GP Consortia/Health and Wellbeing Board to continue the commissioning of the Dementia Advisory Service currently run by Age Concern.

5.10 That the Borough Director of NELFT develop an action plan from these recommendations and report back to the relevant Overview and Scrutiny Committees in 6 months regarding progress.

ACKNOWLEDGEMENTS

During the course of its review, the topic group were supported by, met and held discussions with the following people:

David Cooper – Head of Adult Social Care
Peter Keirle – Head of Mental Health Commissioning, NHS Havering
Fiona Weir – Operational Director, NELFT
Professor Martin Orrell – Old Age Psychiatrist, NELFT
Adrian Dorney – Assistant Operational Director, NELFT
Dr Stephen O'Connor – Associate Medical Director, NELFT
Carol Kathro – Alzheimer's Society
Dora Hill – Director of Development, Age Concern Havering

IMPLICATIONS AND RISKS

Financial implications and risks:

The figures as provided within the body of this report are as submitted by Adults Services and are based on current (2010/11) costs. Havering's current cost implications are as at 3.24, 3.25 and 3.26.

As per recommendation 5.6 there is the need to project service user need and related financial implications to ensure consideration can be given to deployment of available resources on a timely basis.

There is a pooled budget Section 75 agreement in place between NELFT and the Council. Consideration may need to be given to the scope of this arrangement as a result of the Dementia Strategy in Havering.

Ongoing changes within the Health Service, with regard to structures and GP Commissioning, may have resultant financial implications which will need to be considered as they arise.

Legal implications and risks:

No implications or risks identified

Human Resources implications and risks:

The recommendations in this report include reference to the need to ensure that the services to support delivery under the Dementia Strategy are appropriately resourced in terms of professional social care staff and that there is clear communication and effective collaboration between Adult Social Care and NELFT social care workers.

The action plan to support the requirements of the Dementia Strategy needs to be robust in terms of workforce planning and development in order to set in place the right staff with the right skills to implement the agreed areas of responsibilities and bring about expected outcomes for people with dementia in the Havering community.

BACKGROUND PAPERS

Notes of Dementia Strategy Joint Topic Group Meetings:

4 November 2010
16 December 2010
31 January 2011
14 March 2011

Implementation of National Dementia Strategy, Havering

Current position in Havering

- POPPI data estimates that there are currently 3,044 people aged 65+ in Havering who have some form of dementia. This is projected to rise to 4,116 by 2025, an increase of just over 35% (higher than the London average)

- Recent records indicate that there are approximately 1,015 patients registered with NHS Havering as having dementia; suggesting a significant under diagnosis of 2,029 undiagnosed cases. At 0.4%, the recorded prevalence of dementia in Havering is statistically significantly lower than the expected prevalence of 1.3%. Wide variation exists between practices and the prevalence ranges from 0.0% to 1.5%[1]

- It is estimated that 61 people in Havering are affected by early onset dementia in 2011 (aged 30-64), and approximately 8 people will have both dementia and Down's Syndrome, all of whom are expected to be aged between 45 and 65 (PANSI data)

- The proportion of Havering residents who identified themselves as carers in the 2001 Census was 10.4% of the total population (highest in London), compared to 8.5% for London as a whole

- Dementia represents a huge cost: in 2010/ 11, the LA spent £2,934,000 on residential care placements, £1,190,000 for homecare packages, and £154,000 for day opportunities for people with dementia.

Headline Progress

- The Dementia Advisory Service (Age Concern Havering) and the Collaborative Care Team, Psychiatric Liaison for Older People (NELFT MHS) have both bedded in well across the Borough and are producing good results

- Significant work has been undertaken as part of Havering's response to the National Dementia Strategy in auditing knowledge/ training of both care home staff and BHRUT staff – this is forming the basis of a new training strategy

- Increased outreach and information & advice work is underway and being further developed to help Havering achieve earlier identification and diagnosis rates – GP input desired here

- New Peer Support groups, including new 'Singing for the Brain' groups, have been commissioned, achieving Objective 5 of the National Dementia Strategy.

[1] ONEL Dementia Analysis, 2010

- The current care pathway has been mapped and is currently being reviewed/ actions taken to improve the patient experience, and increase identification and diagnosis rates.

NHS Support for Social Care Programme funding

The table below lists the projects being delivered under the title of "Additional Support for Carers" funded by the joint NHS Support for Social Care programme funding 2011-13 (as at 9th February 2012). All projects have been jointly developed and agreed by the Havering multi-agency Dementia Implementation Group.

Project/Service	Outcomes Sought	Deliverables	Organisations involved

Peer Support (service is operational)	• Improved quality of life
	• Reduction in access of statutory services due to :
	  ○ Independent living retained for as long as possible
	  ○ Reduced risk of carer breakdown
		• 8 new Peer Support groups established across Havering providing a total of 96 group meetings per year for 2 years
		• 2 Singing for the Brain groups established running in 12 week terms, totalling 72 meetings a year.
		At capacity, after two years the service will aim to support an estimated 250 residents with dementia and their carers. It will also recruit (and train if necessary) up to 20 volunteers to support these groups.
			• LBH
			• Alzheimer's Society

Information and Advice (procurement in progress – service expected to be live from April 2012)	• Improved quality of life • Increased numbers known to Dementia Advisory Service • Increased numbers of referrals to GPs for diagnosis	• Rotating/ travelling weekly dementia information surgery The development and provision of dementia 'out-reach surgery' service across the Borough for 18 months from April 2012 to September 2013.	• LBH • Alzheimer's Society, Age Concern Havering *(competitive process in progress)*
Additional Support for Carers (procurement in progress – service expected to be live	• Improved quality of life (specific focus on carers) • Reduction in access of statutory services due to : ○ Independent living retained for as long	Service definition to be confirmed by 28th February 2012, but broadly as outlined below: • Increased 6 hours respite per 4 week period for up to 80 carers for people with dementia who have high-end needs to give them a break from their	• LBH • Crossroads Care Havering

Project/Service	Outcomes Sought	Deliverables	Organisations involved
from April 2012)	as possible ○ Reduced risk of carer breakdown	caring responsibilities, to be allocated and used flexibly by the Carer • Tailor-made support service which will encourage reablement and social interaction • Carers will have access to the out of hours On Call service seven days per week from 8pm – 12am	
Review of Care Pathways (in progress)	• Increased awareness of the care pathway • Self-recorded improved knowledge amongst staff • Increased referrals for diagnosis • Favourable reduction in variation of referral levels from GP practices • Increased number of people with dementia in care homes receiving diagnoses • Increased number of patients recorded on the dementia register	• Clearly defined and understood Dementia care pathway for Havering	• LBH • NHS ONEL / CCG • NELFT • Alzheimer's Society, Age Concern Havering, Crossroads Care Havering
Training and Development (in progress)	• Self-recorded improved knowledge amongst staff • Increased referrals for diagnosis • Favourable reduction in variation of referral levels from GP practices • Increased number of people with dementia in care homes receiving diagnoses • Increased number of patients recorded on the dementia register • Reduced delays in acute discharge • Reduction in inappropriate anti-psychotic prescriptions in care homes	• Development and implementation of Dementia Care Home training strategy • BHRUT training strategy • Further work with GPs to identify a range of practical and developmental support and educational action to address identified issues	• LBH • BHRUT • NHS ONEL

Dementia Implementation Group: Terms of Reference (as at December 2011)

Introduction

The Dementia Implementation Group (DIG) has been set up to coordinate the implementation of the National Dementia Strategy across Havering, and includes representatives from Social Care, Health and third sector organisations.

Objectives

The main roles of the Group will be to:

- Work towards the delivery of Havering's National Dementia Strategy (NDS) implementation plan
- Provide a forum for communication for all stakeholders who are involved in the implementation of the NDS across Havering
- Provide direction for the allocation of NHS Support for Social Care funding with regards to the Additional Support for People with Dementia and their Carers projects
- To approve developments to dementia projects and allocation of funding, with decisions made by the DIG to be submitted for final approval by the Adults' Transformation Programme Board
- Provide a forum for feedback surrounding the developed projects.

The main responsibilities of members will be to:

- Attend all DIG meetings, and nominate a representative to take their place if they are unable to attend for any reason
- Keep the Group updated on any dementia-related work taking place within their organisations separately from the DIG, to ensure communication across the Borough remains strong
- Communicate and maintain awareness of the NDS implementation within their organisations, and act as DIG 'champions'

Membership

The following will be core members of the Dementia Implementation Group. However, other partners and stakeholders may be invited to specific meetings as appropriate:

- Alice Williams, Dementia Project Manager, LBH

- Andy Haines, Chief Executive, Age Concern Havering
- Bernard Hannah, Mental Health Contracts Manager, ONEL
- Caroline O'Haire, Manager of the Collaborative Care Team, NELFT
- Coral Kathro, Support Services Manager, Alzheimer's Society
- David Hamilton, GP
- Ethne Watts, Dementia/ Stroke Services Manager, Age Concern Havering
- Jackie Philips, Commissioning Lead (Prevention), LBH
- Janet Carter, NELFT
- Julie Brown, Transformation Programme Manager (Adults, Children's and Families), LBH
- Kathy Verges, Manager, Crossroads Care Havering
- Louise Dibsdall, Acting Associate Director of Public Health Improvement
- Ron Adur, GP
- Rinaldo Meza, Service Manager Preventative Care, LBH
- Sarah Haspel, Assistant Operational Director, NELFT
- Stephen O'Connor, Consultant in Old Age Psychiatry, NELFT

There must be an appropriate number of attendees at each meeting in order to agree decisions taken forward – this will be determined by the Chair. In the event that there are not enough core members present to make a decision, this will be communicated to all members following the meeting and feedback upon which to make the decision will be sought.

Reporting and Governance Arrangements

The DIG will report to the Adults' Transformation Programme Board for final approval for decisions relating to funding and major decisions relating to the progress/ direction of the projects.

The progress of the DIG will be reported to the Adults' Transformation Programme Board monthly, in the form of highlight/ exception reports.

The Health and Wellbeing Board will be the ultimate decision-making body for all NHS Support for Social Care programme projects.

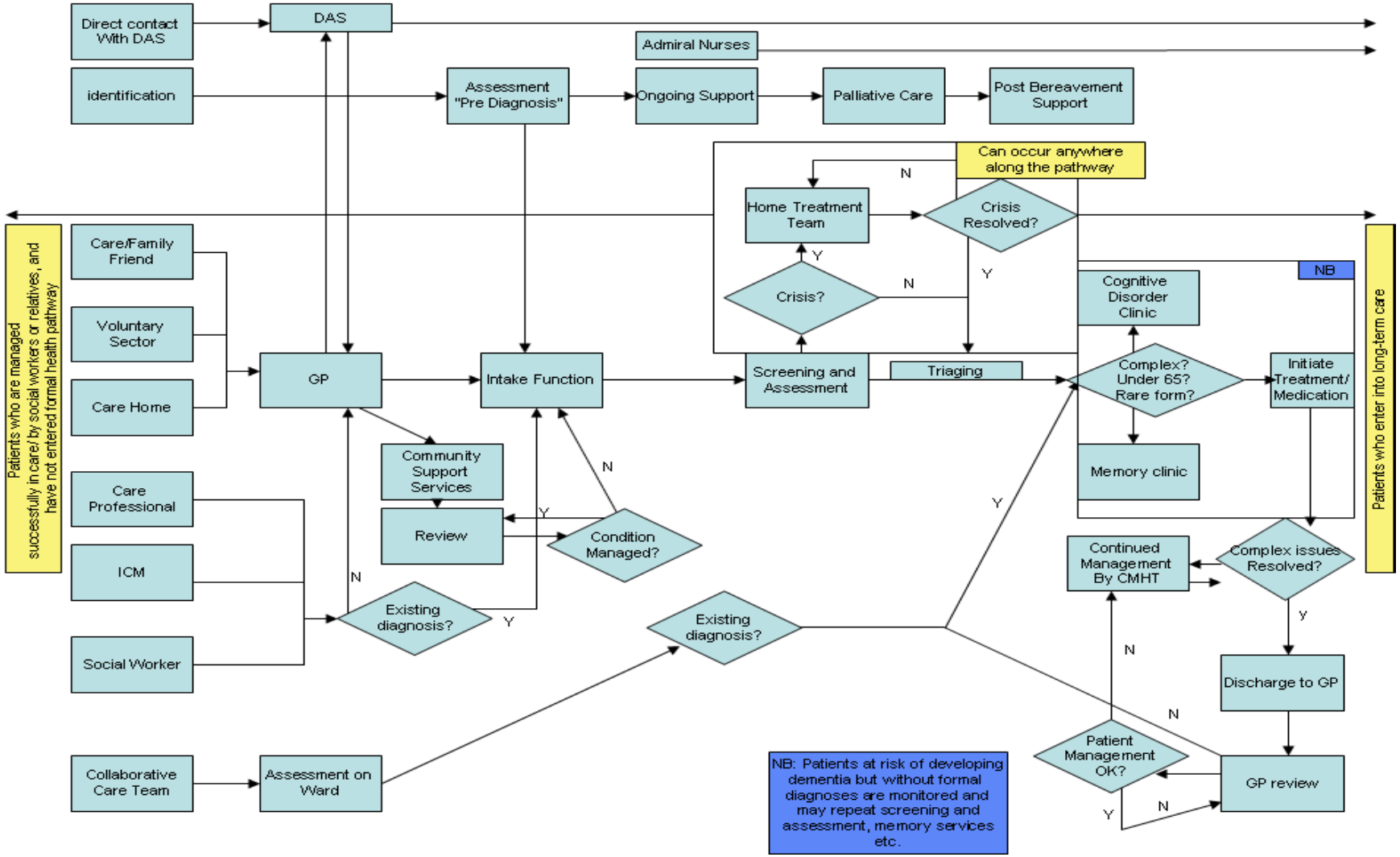
Working Arrangements

Julie Brown (Transformation Programme Manager - Adults, Children's and Families) will chair the Group on behalf of Joe Coogan (Assistant Director for Commissioning). The Group will meet monthly, to be reviewed annually and frequency altered if necessary.

Terms of reference may be altered by the Group at any time.

Appendix A:

The diagram below outlines the current 'as-is' pathway in Havering



Appendix B:

The document below outlines current issues which have been identified during the mapping process, alongside actions, and individuals responsible where assigned

Dementia Pathway – Identified Issues

Havering LONDON BOROUGH

NHS Havering

Issue	Action	Priority	Who	When
1. Lack of data to be able to assess: a. Activity b. Cost c. Outcomes d. Capacity	Alice Williams flagged up at ATPB on 06/10/11 to raise issue Collect as much information as possible from stakeholders as way to further develop pathway – this has been collated for LBH services and voluntary orgs, and a lead identified to collate NELFT/ ONEL data where it is still outstanding Ensure that all sections of pathway are accurately capturing their data – combined work between Social Care and Health to ensure this. Agreement needed at DIG/ ATPB level.	1	AW Bernard Hannah	Ongoing
2. Need to define services to ensure consistent understanding and enable informed decision making. Definition to include: a. Purpose b. Interventions	Collect all information from stakeholders as part of building pathway and produce central document outlining this, ensure everyone is aware and can access copies Ensure that all sections of pathway are accurately recording and capturing their data – combined work and	1	AW	Ongoing

c. Referral criteria d. Outcomes e. Capacity f. Contact information	agreement again needed.			
3. Need for improved public awareness of dementia to support earlier identification of possible problems, enabling earlier intervention (under diagnosis is around 65%). A coordinated awareness programme is required using multi media channels.	Public awareness campaign already taking place as part of the DIG work – dementia 'surgeries' project which has been absorbed into Info and Advice project Existing Outreach work taking place by Alzheimer's Society, ACH'S DAS etc.	3	All	Ongoing
4. GP performance in identifying patients and adhering to the pathway is highly variable.	GP consortia agreement with aims of DIG and establish plan to ensure joint working. S256 DoH money to be invested in improving GP diagnosis rates, with action plan/ targets to be developed jointly with input from CCG.	1		March '12
5. Quality/ awareness of dementia care and training within care homes is also highly variable – this is a major training issue	Care home audit results have been collated, and are due to be taken to an Overview & Scrutiny committee meeting. Recommendations to be discussed at November DIG meeting, and training strategy developed. This is ongoing, and a multi-agency Training & Development sub-group has been arranged for February to finalise the way forward.	2	Reps from LBH, ONEL, NELFT, BHRUT	Feb '12
6. Other pathways need to be reviewed (e.g. vascular) to ensure they incorporate opportunities to aid prevention through early identification of risk factors	Louise Dibsdall (Public Health) to develop action plan for this item, update will be given when this is received.	3	LD	

7. Medicines management needs to be addressed – shared care guidelines are currently being updated to ensure they reflect change in NICE guidance	Link in with existing ONEL development work – BK's meds management audit – identify best practice, and agreed formula for medicines. Disseminate to care homes, GPs, hospitals and community-based services to unify med prescriptions.	2		
8. Training of frontline staff across whole pathway) needs to be reviewed to reflect new pathway	Care home audit and NELFT audit to be reviewed and results to form basis of new training strategy/ pathway. Multi-agency Training & Development sub-group meeting in February to identify other training needs.	1	Reps from LBH, ONEL, NELFT, BHRUT	Feb '12
9. Common data recording required and pragmatic solutions identified to enable data sharing for those who do not have access to either SWIFT or RIO. Health Analytics will be a long term solution, but a common sense solution is required in the interim.	Derek Hoddinott to flag up to Health Analytics that a consistent template is required	2	DH	Dec '11
10. Need to consider interface with integrated case management	DH to brief Community Matrons to understand pathway and their role in it.	2	DH	Dec '12

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Havering
LONDON BOROUGH

OVERVIEW & SCRUTINY COMMITTEE

REPORT

01/11/2011

Subject Heading:	Results of Audit of Skills and Competencies in Mental Health
CMT Lead:	Joe Coogan 01708 431950
Report Author and contact details:	Jackie Phillips 01708 434012
Policy context:	National Dementia Strategy Implementation

SUMMARY

A brief summary of the content of the report, outlining its proposal and the intended outcome.

1. The purpose of this report is to present results of the audit of skills and knowledge around dementia of care home staff.

RECOMMENDATIONS

2. Members are asked to note the content of this report.

REPORT DETAIL

3. Background

3.1 As part of Havering's response to the National Dementia Strategy, the authority has set up a multi agency Implementation Group encompassing three 'theme leads', supported by multi agency working groups. The third theme, 'Living Well with Dementia' is a wide theme focusing on improving the experience of those with dementia and their carers in the community.

3.2 At the meeting of the Implementation Group in November 2010, it was agreed that, anecdotally, it was believed that skills, practice and knowledge around dementia in care homes, not just in Havering but nationally, could be less well developed than desirable. It was therefore decided that an audit of skills and knowledge on the subject within care homes in the borough should be carried out.

4. Methodology

4.1 The 'Living Well with Dementia' working group held a session to discuss what issues it would like to cover in the audit. A subsequent questionnaire was developed and circulated to the group for comment/amendment.

4.2 It was decided that the audit would cover all residential and nursing homes into which the authority placed individuals. This amounted to 34 homes. Initial research elicited type of home (i.e. dementia registered or otherwise) and numbers of places at each.

4.3 It was felt that a passive survey by internet or post would not achieve a sufficient return so the approach utilised was to complete the questionnaire by telephone or face to face during a visit. In the event, most managers were interviewed by telephone and staff by personal visit. The member of staff who carried out the visits was a trained social worker.

4.4 It was decided that the manager of each home would be interviewed, together with approximately one staff member for every 10 residents.

4.5 The questionnaires were all completed between July and September 2011.

5. Characteristics of the responding cohort:

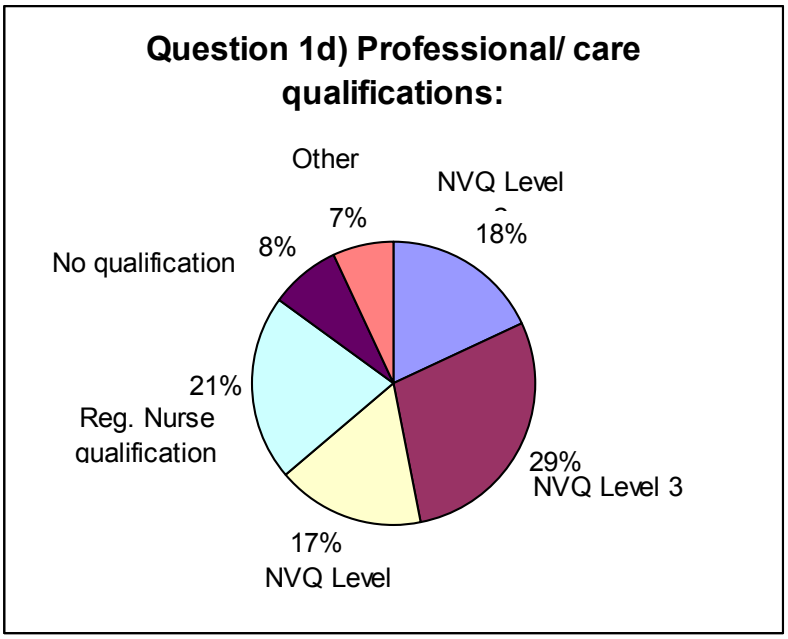
5.1 Of the 34 care homes approached, we managed to include 30 (3 did not co-operate and one was being redeveloped and could not spare the time); giving, in the end, completed questionnaires from 29 Managers, 26 Senior Carers/Team Leaders, 32 Care Assistants and 11 Nurses. A reasonable

cross section of those working directly with residents was therefore achieved.

5.2 The time in the industry of the cohort, together with the length of time they had worked at the home at which we questioned them, is mapped below:

5.3 A high percentage of those questioned, 84%, had worked in the care industry for more than 4 years which means that investment in training is worthwhile as, despite the *perception* of poor working conditions and low wages, staff retention compares favourably with domiciliary care agencies which suffer, in London,[1] from persistent job vacancies, a high turnover of staff, a low skills base and a reliance on migrant labour.

5.4 Qualifications of interviewed staff, recorded by highest qualification (where more than one qualification exists), are mapped below:



[1] Home Care in London, Institute for Public Policy Research July 2011

This diagram shows that 85% of staff have NVQ Level 2 or above or registered nurse qualifications. Only 8% had no qualifications whatsoever.

6. Specific Mental Health Knowledge

6.1 Respondents were then asked which of a number of statements around subjective perception of skills and knowledge of mental health issues most accurately reflected their position, as follows

Question 1e) The following question is about your perception:

	Responses (in percentages)			
	1	2	3	4
I have a good knowledge of mental health issues affecting older people	28	71	1	0
I have had training in identifying mental health needs in older people	34	56	10	0
My knowledge of mental health has been obtained mainly in my workplace	49	46	4	1
My knowledge of mental health is sufficient to meet the requirements in my workplace	48	49	3	0
I am aware of the impact physical health can have on a persons mental health	61	38	1	0
I have knowledge of dementia screening	25	48	21	6
I have knowledge of dementia care	56	43	1	0

Key
1 - To a very great extent
2 - To a great extent
3 - To a very small amount
4 - Not at all

6.2 These perceptual statements scored very highly across the board with no statements attracting fewer than 90% at “to a great or to a very great extent” with the exception of the question about dementia screening. Without making generalisations about individual care homes, the extremely high scores may have been influenced by the face to face nature of the questions; it is possible that an anonymous approach might have elicited slightly less confidence.

7. Incidence of Dementia

7.1 The questionnaire then attempted to establish the incidence of dementia both diagnosed and undiagnosed. The answers are based on what managers told us in relation to the number of residents across the 30 homes.

7.2 765 residents out of 1057 (72.3%) were perceived by staff to have dementia, of which 609 had a formal diagnosis. This latter figure gives a formal

diagnosis percentage across all residents of 58% and 79.6%.of those suspected of having dementia.

8. Organisational Culture and resources

8.1 Staff were then asked whether they thought their organisation took dementia seriously, had a corporate approach to dealing with dementia, had specific policies and procedures and had sufficient resources to support people with dementia. The first three attracted 89% or above positivity and the last question 79% positivity. The most popular suggestions with regard to enhanced resources related to increased staffing, more training and more dementia specific activities.

9. Diagnosis and onward referral

9.1 98% of respondents said they would seek a diagnosis if they suspected a resident of developing dementia but only 50% knew how to contact specialist dementia teams or other teams capable of intervention.

9.2 Taking the former percentage into consideration, this should mean that the 42% of 'undiagnosed' cases mentioned in 7.2 above are within the process of seeking a diagnosis but this does seem improbable so this high percentage may not be a true figure and may be influenced by the lack of anonymity.

10. Activities

10.1 Staff were then asked about activities for people with dementia within the homes. 89 staff said 'there was a vigorous timetable of activities in the home" but only 63 agreed that activities were dementia specific. Examples of dementia specific activities included music and dancing, reminiscence, memory games, rummage boxes, sensory activities and old films.

11. Training

11.1 89% of staff said they had received induction training but the occurrence of dementia specific training in induction packages was very rare and only 50% of managers stated that dementia experience was expected for new staff.

11.2 77.3% of staff had undergone a basic dementia awareness course but frequency of training varied between more than once a year to every 2 to 3 years, with a majority having training accessed annually.

11.3 96.9% staff said they felt confident dealing with people with dementia but 100% of respondents said they would like to access further training on dementia.

11.4 32% wanted in house training, 26% wanted external training, 13% wanted a combination and 12% had no preference. E-learning was not a popular option for learning more about dementia.

11.5 24% of respondents said they needed more training on challenging behaviour and 48% said that challenging behaviour was the greatest challenge to staff dealing with people with dementia.

11.6 There are a significant number of homes that have no specified dementia lead.

12. Summary:

12.1 Most staff felt they had a good knowledge of dementia. The proportion feeling confident dealing with dementia, having had training, is higher than previously thought but more training is obviously needed with 100% of respondents saying they would like more. The lack of dementia specific areas in induction training is a concern as staff are likely to encounter those with dementia from day 1.

12.2 A high proportion of homes had residents either diagnosed or suspected as having dementia, regardless of whether the home was perceived to be dementia specific. The figures suggest higher rates of dementia in the borough than previously thought.

12.3 Key issues identified as resource issues were activities, training and staff; homes that do not currently utilise volunteers to help with dementia specific activities perceived it to be a good idea when it was suggested to them.

12.4 50% of respondents did not know how to contact specialist dementia teams; work around pathways needs to be improved.

12.5 One third of homes did not have dementia specific activities. Activities and the promotion of dementia leads and champions, as well as volunteers could assist in this respect.

12.6 There is no minimum common training undertaken by homes – it varies enormously; this needs to be developed and the aversion to e-learning taken on board. Further attention to training around challenging behaviour is needed.

13. Conclusions

13.1 Knowledge and training was higher than expected and confidence of staff was remarkable. Further training, particularly around challenging behaviour, would be useful and the need to keep up to date with dementia specific training is clear as is the need to include such training within induction. More work is needed around dementia specific activities and homes could usefully improve volunteer networks. A dementia lead and/or champion would be a useful disseminator of good practice and would allow sharing of learning. Further work on making information about specialist teams more readily available is needed.

13.2 The results of the survey will be made available to the Dementia Implementation Group to guide resources to gaps and to inform development of useful assistance to homes.

13.3

IMPLICATIONS AND RISKS

Financial implications and risks:

7.1 There are no financial implications arising from this report which is for noting only. The financial implications arising from any proposed initiatives referred to in this report will be addressed through the appropriate channels as the needs arise, and will be met from within available resources.

Legal implications and risks:

7.3 As this report is for information only there are no apparent legal implications or risks.

Human Resources implications and risks:

7.4 As this report is for information only there are no human resource implications or risks.

Equalities implications and risks:

7.5 As this report is for information only there are no equality implications or risks.

APPENDIX 4

Progress on Action Plan for the Joint Overview and Scrutiny Committee Topic Group from Operational Director NELFT

Action	Progress
1. That the relevant Cabinet Member liaises with NELFT with a view to future provision for borough dementia services.	The Lead Member is pursuing this with partner agencies.
2. That NELFT recruit Social Workers to fill the current vacancies and ensure that collaborative working with the Adult Social Care Reablement Team, on dementia services, is put in place.	Recruitment is ongoing.
3. That the Commissioners continue to develop the local market to increase opportunities for day support for people with dementia and their carers. 4. To encourage early diagnosis of dementia by GP's, and provide training and public awareness of the sign of early dementia. 5. To encourage partnership working group to assist in the provision of public information on signs of dementia in the form of leaflets, DVD's or checklist of symptoms. 6. To encourage the GP Consortia (now CCG) / Health and Wellbeing Board to continue the commissioning of the Dementia Advisory Service currently run by Age Concern 7. That work is undertaken to develop more robust financial and performance information, linked to JSNA, to aid future planning of services.	This will form part of the work of the DIG. The Joint Strategic Needs Assessment is being reviewed, and a revised Health and Wellbeing Strategy has been prepared. Dementia forms a key priority in the strategy. These services meet our Health and Wellbeing priority of 'Supporting Older People'
8. That Havering join the Memory Network.	NELFT have made a commitment to join the network and are working towards accreditation.

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