ADDENDUM: Enhancements to the Dementia Care Pathway 2019/20

Increasing the Dementia Diagnosis Rate, enabling easy access to care, and providing post diagnostic support and advice are some of the key themes driving the strategy. Harrow has made great headway as a more Dementia friendly Borough.

At the close of March 2019 there were 68.7% people in Harrow diagnosed with Dementia in relation to the dementia prevalence for the borough. The dementia prevalence has increased 6% from 2433 in 2015 to 2569 by March 2019. The diagnosis rate has increased from 55.1% to 68.7% over the same period.

The key changes required to improve diagnosis were:

- Harrow CCG increased investment in key personnel within the MAS initially by using additional Consultants Psychiatrist (locums) and clinical nurses.
- The appointment of a permanent full-time Consultant Psychiatrist (vacant for an extended period) has helped to transform the MAS.
- Simplified the clinical pathway by removing the onus on GPs to undertake Magnetic Resonance Imaging (MRI) Scans, which are now mainly requested by the MAS consultant.
- Increased communication with GP practices around referral criteria for memory assessments, whilst sharing the challenge of increasing the diagnosis rate.
- Harrow CCG commissioned EMIS Specialist to review coding on all cases held on the Quality Outcome Framework (QOF) within each GP practice in Harrow. The specialist highlighted:

Building on the Harrow Whole Systems Integrated Care (WSIC) model for over 65s, Harrow CCG and local health and care partners made a decision in 2017 to formalise arrangements to work as an Integrated Care Partnership (ICP) and deliver integrated models of care to the whole population of Harrow. The ICP integration has enhanced the planning and provision for Admiral Nurses and a Community Specialist Dementia Nurse.

Initial scoping work was undertaken to identify drivers for change and what Harrow would need to do to deliver sustainable, efficient and cost-effective health and social care to our population now and in the coming years. This scoping highlighted the significant challenges relating to the increased demand for care caused by an ageing population (a doubling of over 65s in next 10 years), workforce challenges and financial pressures. The Integrated care Pathway (ICP), focusing on Frail Older patients 65 years plus, agreed an outcomes framework and we have been developing and testing new models of care in response to these challenges.

All partners have signed-off the outcomes from the programme, and the partnership is making good progress in strengthening new ways of integrated working. A new post-diagnosis pathway for patients living with a diagnosis of dementia is being developed and tested.

The Harrow joint dementia strategy has acknowledged the **NHS Long Term Plan (LTP)** through the work of Integrated Care Model and the Primary Care Network development. The LTP indicates new investment will fund expanded community multidisciplinary teams aligned with new Primary Care Networks based on neighbouring GP practices that work together typically covering 30-50,000

people. As part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow. The expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

The **Primary Care Networks** will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed. Based on individual needs and choices, people identified as having the greatest risks and needs, will be offered targeted support for both their physical and mental health needs. These will include; musculoskeletal conditions, cardiovascular disease, dementia and frailty.

The NHS Long Term Plan will go further in improving the care we provide to people with dementia and delirium, whether they are in hospital or at home. One in six people over the age of 80 has dementia and 70% of people in care homes have dementia or severe memory problems. There will be over one million people with dementia in the UK by 2025, and there are over 40,000 people in the UK under 65 living with dementia today. Over the past decade the NHS has successfully doubled the dementia diagnosis rate and halved the prescription of antipsychotic drugs.

Strategic working and planning for dementia and frailty has been multi-agency and supported by all stakeholders. London North West University Healthcare NHS Trust (LNWUHT) is committed to improving hospital care and community outpatient services for people living with dementia. The Trust pledged via Dementia Action Alliance to become a dementia friendly organisation by 2024. They have developed a dementia strategy to provide clear direction to drive implementation of the service and environmental developments required to achieve this aspiration.

LNWUHT operates both in-patient and community health services across Ealing, Brent & Harrow. The aim of the dementia strategy developed by LNWUHT is to outline the service provisions that all patients living with dementia, caregivers, families and friends can expect to receive whilst at LNWUHT. Both LNWUHT and Harrow Health and Social joint dementia strategies are informed by national and local strategies, guidelines and legislation to provide safe and effective care.

Key themes of the LNWUHT Dementia Strategy include:

- **Setting out vision for 2024** and key achievements by which the overall success of the strategy will be measured
- Collaboratively and partnership working with the Clinical Commissioning Groups (CCG), health and social care providers adopting the **Integrated Care Programme Strategy** to build on a seamless pathway for people living with dementia and their caregivers, families and friends

  Identifying **key actions** for the next 5 years which will be undertaken to further improve the support for people living with dementia and their caregivers, equipping staff involved in dementia care with the right knowledge and skills

In October 2019: A new post-diagnosis pathway has been designed and work has begun on testing the model before full implementation. There are three main areas to be trialled: 1) identification of patients for referral to the Memory Assessment Service (MAS) from the community 2) Single Point of Contact for dementia patients and their carers after diagnosis 3) direct referrals from the hospital to the MAS with a letter to the GP.

Harrow Council's second Dementia Hub at the Bridge Centre, Christchurch Avenue, launched on 16th April 2019. It has seen its average weekly attendance grow week on week. This compliments Harrow Council's first Dementia Hub, known as 'Annie's Place'.

Combined, the hubs are being accessed by up to 80 people per week. Currently the running costs are being met by Public Health's wider social determinants budget and are estimated to be £24k for the first year. At time of writing a 6 monthly review report is being prepared.

The Dementia Hub at the Bridge is a 'dementia friendly' meeting place where carers, family and friends are welcome.

Harrow Dementia Hub offers a weekly drop-in in a convenient location towards the east of the borough. There is opportunity to meet others living with Dementia in Harrow for a cup of tea or coffee, a chat and fun and varied activities in a relaxed environment.

Harrow Dementia Hub activities include:

- Information and advice sessions
- Expert guest speakers
- Support and training
- Refreshments
- Wellbeing and therapeutic activities e.g. cognitive stimulation, movement & exercise sessions, music, reminiscence, quizzes, poetry readings and more
- An opportunity to share experiences
- Social opportunities
- A garden space