Healthcare Improvement Scotland | ihub

Flash report

Improvement Hub

Inverclyde care co-ordination for people with dementia programme

Learning Session 4
Thursday 27 May 2021

his.focusondementia@nhs.scot

@ihubscot
#Focusoncoordination

Join in the conversation!

Thank you for joining Learning Session 4

We were delighted to host 51 professionals at our fourth learning session via MS Teams on Thursday 27 May 2021. The aim of the session was to:

- **Explore the role of care co-ordination**
- **Examples of care co-ordination in practice**
- **Explore the different levels of care co-ordination**
- **Identify and agree areas for improvement**

The session was chaired by Gillian Neal (Mental Health Programme Manager, Inverclyde HSCP). Presenters were Jill Carson (Public Policy Consultant, Alzheimer Scotland) and Brenda Friel (Associate Improvement Advisor, Inverclyde HSCP).

Lynn Flannigan (Improvement Advisor, Healthcare Improvement Scotland) started the discussion of care co-ordination in practice in Inverclyde with Debbie Maloney (Service Manager, Innovation and Independent Living). Debbie underlined the emphasis that the HSCP puts on good care coordination throughout the organisation. Lynn then led a discussion panel with Sharon Logan (Occupational Therapist), Graeme Services (Social Worker) and Neil Cree (District Nurse Team Lead) talking about their roles, thoughts and experiences of providing care co-ordination in Inverclyde.

Your Role in Dementia Care Co-ordination

Co-ordinating care for people living with dementia is part of everyday frontline working. A shared understanding of roles, responsibilities and relationships underpins good care co-ordination. This can be single episodes of care to more long term co-ordination involving a number of workers, teams and services. Regardless of the duration, as a frontline worker, you will be looking holistically at the management of care and support for that individual and carrying out care co-ordination activities such as:

- Assessments
- Care planning
- Signposting
- Referrals

Frontline staff bridge the gap between the individual and the systems and services that support wellbeing and independence.

Successful co-ordination needs active engagement from individuals at the core to include person with dementia, their carer and care co-ordinator.

Action Planning

The final session provided an opportunity for small group discussion and ideas to improve care co-ordination in Inverclyde that will inform programme action planning.

Here are some of the suggestions:

- Clearer roles and responsibilities of services and supports
- Clearer pathways to services and supports
- Improve communication between services and supports
- Improve information sharing across various data systems
- Consistency of care provider/care co-ordinator

Questions for breakouts

1. We know there is a lot of great work happening in Inverclyde, but following on from today's session what is **one** thing you would like to do differently or would like to change in relation to care co-ordination in Inverclyde?
   - At individual level
   - At service/ organisational level
2. How do we ensure Staff know which other services are supporting people living with dementia and their carers? Where an episode of care co-ordination is coming to an end how do we ensure that someone else takes over that role?
3. How do we ensure People living with dementia and their carers know who co-ordinates their care? How do they get in touch?

Feedback

Thank you to those who completed our evaluation, sharing thoughts on what was good and what could be improved.

> hearing from those who provide care co-ordination was great, applying evidence into practice

> the break out sessions open for discussion was beneficial

> The fact that all the different professionals gave an insight into their jobs, and how they support the patient/client. Also the ideas they gave on ways to improve the coordination of care

> breakout rooms could have been smaller

> there needs to be a clear definition (of care co-ordination) so that we know how to implement care coordination

99% agreed
they were confident about what care co-ordination is

62% agreed
they know how their role supports care co-ordination for people living with dementia and their carers

62% agreed
their knowledge and understanding of care co-ordination has improved

Next steps

We'll be in touch in due course about the next learning session. In the meantime please visit our website or keep in touch by email