NHS Waltham Forest

Waltham Forest

JOINT DEMENTIA CARE STRATEGY

2010 – 2015

Contents Page

SECTION1: INTRODUCTION AND BACKGROUND

1.1 Introduction

This joint Dementia Care Strategy between NHS Waltham Forest (NHS WF) and the London Borough of Waltham Forest (LBWF) describes how it will respond to the challenges set by the National Dementia Strategy ("Living well with Dementia: A National Dementia Strategy, 2009), to meet the needs of local people. The strategy has been developed during a very difficult and unprecedented financial climate; public spending has been significantly reduced. We recognise therefore that it will not be possible for NHS WF and WF Adult Social Care to deliver all of the objectives laid out in the National Dementia Strategy with such reduced budgets. The Strategy will concentrate on the priority objectives, which we will aim to align as far as possible to existing services, some of which may require re-configuration.

Delivery of the Dementia Care strategy should make significant improvements in terms of quality of Dementia services currently provided and promote a greater understanding of the causes and consequences of Dementia.

Healthcare for London: A framework for Action (2007) and the National Audit Office report 'Improving services and support for people with dementia' (2007), highlighted the fact that services were not provided consistently well across London for people with dementia and their carers. The strategy also recognises the need to provide advice and support to carers (from here on referred to as formal and informal carers) and families before they reach crisis point and the need for specialist respite care for Dementia in Residential and Extra Care homes.

1.2 What is Dementia?

The term dementia is used to describe a collection of symptoms, including changes in memory, reasoning and communication skills, with a gradual loss of ability to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer's disease[1].

There are a number of different types of dementia; with the most common being Alzheimer's disease that accounts for about 60% of cases[2].

i. Alzheimer's disease changes the chemistry and structure of the brain, causing brain cells to die. Over time the person will become increasingly dependent on others for help. They are likely to experience severe memory loss and become increasingly frail. They may have difficulty with eating, swallowing, continence and experience loss of communication skills such as speech.

ii. Vascular dementia is caused by strokes or small vessel disease, which affects the supply of oxygen to the brain. Vascular dementia affects people in different ways. It can cause communication problems, stroke-like symptoms and acute confusion. This form of dementia progresses in a similar way to Alzheimer's disease but progression is often 'stepped' rather than gradual.

iii. Frontotemporal dementia is a rare form of dementia affecting the front of the brain. It includes Pick's disease and most commonly affects people under 65. In the early stages the memory may remain intact while the person's behaviours and personality change.

[1] Healthcare for London: Dementia Services Guide
[2] Gupta et al. Rare and unusual dementias, Adv Psychiatric Treatment, 2009; 15: 364-371

iv. Dementia with Lewy bodies is caused by tiny spherical protein deposits that develop inside nerve cells in the brain. These interrupt the brain's normal functioning, affecting the person's memory, concentration and language skills. This type of dementia has symptoms similar to those of Parkinson's disease such as tremors and slowness of movement.

Dementia can affect anyone regardless of gender, ethnicity, socio-economic situation or residential status.

1.3 Our Vision for Dementia Care

Our vision for dementia is that people with dementia and their carers will be able to continue doing the things they enjoy for as long as possible through improved management of dementia care and the use of personalisation as an enabling tool.

1.4 Aims and objectives of the dementia strategy

The WF Dementia Care Strategy aims to provide a robust analysis of the health and social care needs of people with dementia and their carers and to guide decision- making for commissioning services that will enable people to continue living well with dementia.

1.4.1 Objectives

- Re-focus investment in earlier diagnosis and interventions to improve outcomes for people with Dementia and their carers to enable them to live better quality lives
- Empower people with dementia and their carers to shape their own lives and the services they receive
- Shift dementia care from acute settings to care closer to home and in familiar surroundings wherever possible
- Through re-ablement, reduce the number of people prematurely entering into long-term residential care
- Reduce emergency hospital admissions amongst dementia patients and ensure safe and timely discharges
- Prevent carers going into crisis
- Adopt a whole system focus beyond departmental boundaries so that services are seamless and organised around the user
- Development of a multi-agency integrated care pathway
- Identify commissioning priorities for dementia care
- Ensure safeguarding protocols are in place for people with dementia

1.5 How has the strategy been developed?

NHS Waltham Forest and LBWF have developed this strategy in close consultation and engagement with a range of stakeholders, users and carers.

Method of consultation and engagement	What we were told
Research into the development of the Carers Strategy	In March 2010 the Council commissioned extensive research across the Borough to support the development of a Draft Carers Strategy. A number of face-to-face interviews were conducted with a range of Carers which identified the following issues they faced or concerns they had: ➢ Inadequate levels of provision of services for carers & the cared for ➢ Inconsistencies in quality and provision of services ➢ Lack of awareness of available services ➢ Carers 'having to fight' at each step of their journey to get services in place (even during periods of crisis when energy and stamina is at its lowest) ➢ Lack of joined up working between different services ➢ Absence of central point of contact for information, advice and advocacy Specifically, the research found that limited attention was being paid to people with dementia and their carers.
Dementia Workshop	A Dementia workshop involving professionals [health, social care, voluntary and third sector] people with dementia and their carers, formed part of the consultation and involvement process. The workshop aimed to address the following and to help us develop our dementia strategy: 1) What health input do we need for people suffering from dementia? 2) Models of good practice and areas of improvement in service provision 3) The next step forward for dementia care in WF The issues that emerged from this workshop are discussed further in Section 3
Prevention strategy Consultation Workshop	This workshop held in May 2010 was an opportunity to share with stakeholders early on the issues that were emerging from the evidence base for our strategies, from service mapping and needs analysis.
Voluntary Sector Sub-group	Voluntary Sector Providers have told us they want to be involved in shaping this Strategy but prefer to have a first draft document on which they can comment. This group also suggested how service users might be involved in the process; a reader group consisting of service users has been set up to read the draft documents and to give the Council their views.
Review of Extra	The Council carried out a review of its extra care Services in 2009,

Care Services	including dementia support in the schemes. Interviews were held with staff and residents across all of the six schemes. Feedback from residents in schemes that were staffed 24 hours a day said that they felt safe knowing they had support 'on hand'. As a result the Council increased the capacity to the schemes to include 24-hour support across all the schemes.
Voluntary sector consultation event	This event was led by LBWF corporate services for voluntary and third sector organisations. Organisations were given an opportunity to comment on the Council's priorities.

SECTION 2: THE DRIVERS FOR CHANGE

2.1 The National Policy Context

Living well with dementia: a National Strategy for Dementia - provides a framework of seventeen objectives (see Appendix 1) to help organisations develop dementia services, from which seven key priorities for implementation have been identified. The National Dementia Strategy (NDS) also brings together national priorities identified across a range of key policy documents:

Forget Me Not (Audit Commission, 2000), which recognised that:

- Only half of GPs believed it important to look actively for signs of dementia and make early diagnosis
- GPs felt they did not receive sufficient training
- There was a lack of clear information, advocacy and support for people with dementia and their families;
- There was insufficient specialist home care.

Quality, Innovation, Productivity and Prevention (QIPP)

The NHS has to respond to the challenge of making major improvements in productivity and efficiency while continuing to improve the quality of patient care. Central to NHS Waltham Forest's planning will be the 'QIPP', the programme to improve quality, innovation, productivity and prevention. This is the name given to the overall approach of the NHS to the economic downturn and is the means by which NHS Waltham Forest will seek to improve health and provide high quality care, whilst at the same time increasing its efficiency to reduce costs.

National Institute for Clinical Excellence (NICE) / Social Care Institute for Excellence (SCIE) Clinical Guidance [2006], key recommendations included:

- Integrated working across agencies
- Memory assessment services as a point of referral for diagnosis
- Assessment and support for carers
- Assessment and treatment of non-cognitive symptoms and behaviour that challenges
- Dementia care training for all staff working with people
- Improvement of care for people with dementia in hospitals.

Improving Services and Support for People with Dementia (the National Audit Office, 2007). This report was critical about quality of care for people with dementia and their carers. It advocated a 'spend to save' approach with upfront investment in services for early diagnosis and intervention, improved specialist services, community services and care in general hospitals resulting in long-term cost savings from the prevention of transition into care homes and reduced hospital stays. It also recognised that the confidence in GPs in spotting the symptoms of dementia was lower that it had been in 2000; people weren't being diagnosed early enough and early intervention was needed to improve quality of life.

The White Paper: 'Our health, our care, our say' a new direction for community services (January 2006) - The longer-term aim of the White Paper is for realignment of health and social care systems to deliver more services, in settings closer to home and for people to have real choices in both primary care and social care.

Putting People First (Transforming Social Care 2007) – making a strategic shift towards prevention and early intervention is one of the central objectives of Putting People First, which identifies that "the time has come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement and high quality personally tailored services".

The recent coalition agreement of 20th May 2010 positively impacts on the Dementia Strategy. It contains a commitment to prioritise dementia research within the health research and development budget.

Key points emerging from recent national studies and consultations[3]

- Dementia is poorly understood, it remains a stigmatised condition and those affected often experience social exclusion and discrimination
- Seeking help is frustrating; access to services typically includes contact with the NHS, local Councils and the third sector; sometimes being referred elsewhere and often duplicating activities
- Current services do not meet the needs of people with dementia
- Services are fragmented and lack robust integration and strong partnership working
- There are gaps in service provision and the quality of specialist services remains inconsistent
- Reliability and continuity of services are compromised because many staff lack the requisite knowledge and skills to respond appropriately to those affected
- Most health and social care services are not delivering the outcomes that are important to people with dementia: early diagnosis and treatment, easily accessible services, information and advice and high quality support.

2.2 The local context

The vision of Adult Health and Social Care Services links directly to the wider vision for Waltham Forest, and to the Transformation Programme. The seven key planks of the vision are: -

- To develop a modern and strategically strong service
- Personalisation
- Prevention
- Health and social care integration
- Partnerships
- Community-Based Healthcare

[3] Healthcare for London: Dementia Services Guide

- Quality and value for money.

Our social care and community healthcare services are very significant strategically for the delivery of the Vision for Waltham Forest, in the context of the national well-being agenda.

WF Sustainable Communities Strategy

Sustainable community strategies (SCS) provide the overarching strategic framework for Local Authority areas. The Waltham Forest SCS sets out locally agreed priorities for long-term development. The SCS recognises the need to look at the wider determinants of health, to provide care close to home, for community engagement and social inclusion. The Council expresses a clear commitment to 'supporting and empowering vulnerable residents to live independent, active and enjoyable lives.

NHS Waltham Forest Commissioning Strategic Plan

This plan describes the context in which NHS Waltham Forest (NHS WF) is currently operating, the outcomes and initiatives to be delivered and how they will be implemented in the eight Health Care for London Care Pathways, locally. It also gives the rationale for health outcomes and alignment to the Polysystem.

Complimentary Strategies

A number of other local strategies have a significant contribution to make to the Joint Dementia Strategy including the following:-

Joint Prevention and Early Intervention Strategy - this overarching strategy establishes the framework and rationale to support the shift to preventive and early intervention services for vulnerable residents in LBWF. The strategy identifies the priorities for health and social care and demonstrates how we can make a shift in investment from reactive services, to early intervention and preventative services for the whole population, over the next five years. This includes provision for long-term conditions such as dementia.

The Joint Carers Strategy - the Joint Draft Carers Strategy sets out a long-term plan for developing and providing services that will assist in achieving the best outcomes for carers. The Strategy looks at the needs of carers as separate from the needs of those whom they look after.

Extra Care Strategy - the draft Extra Care Strategy sets out the key role extra care housing has in enabling older people to live independently in the community and improving health and wellbeing. Extra Care is a positive contributor to the Dementia Strategy, with dementia support services operating in schemes for Extra Care tenants and the wider community. The care and support is sensitive to the needs of clients with early onset of dementia and mobility issues and so meets complex needs.

Safeguarding of vulnerable adults - Safeguarding Adults is a high priority for Waltham Forest; we've adopted the standards of good practice and outcomes in adult protection work contained in the National Framework for Safeguarding Adults Policy. Our policy is also in line with the "No secrets" guidelines issues by the Department of Health and ministerial guidance, "Dignity in Care". Both NHS WF and LBWF are committed to safeguarding vulnerable adults and this will be embedded in dementia care services that we deliver under this strategy.

2.3 Dementia in the UK

The National Dementia Strategy highlights the need for prioritisation of dementia by health and social care services. Latest figures for the UK show:

- There are approximately 700,000 people with dementia
- Within 30 years, the number of people with dementia is expected to double to 1.4 million
- Dementia is predominantly a disorder of later life, but there are at least 15,000 people under the age of 65 who have the illness
- The level of UK diagnosis and treatment of people with dementia is generally low, with a two-fold variation in population prevalence between the highest and lowest PCTs in London
- Forecasts show there will be a 14% increase in the number of people with Dementia in London over a 16-year period.

2.3.1 Cost of dementia in the UK

The Dementia UK report (2007) calculated the cost of dementia in the UK as £17.03 billion per annum for 2005/6. This equates to an average cost, per person, of £25,472 per annum. Costs increase with the progression of the disease; direct costs are higher for people with severe dementia as the table below shows.

Figure 1: Annual costs of services used by people with late onset dementia (per person), 2005/6

Service	Mild dementia - Community	Moderate dementia - Community	Severe dementia - Community	Dementia in Residential Care setting
NHS	£2,508	£2,430	£2,639	£1,334
Social Services	£4,935	££6,224	£7,738	£378
Informal care	£9,246	£17,223	£27,096	£938
Accommodation	£0	£0	£0	£28,646
Total Cost	£16,689	£25,877	£37,473	£31,296

Source: dementia UK 2007

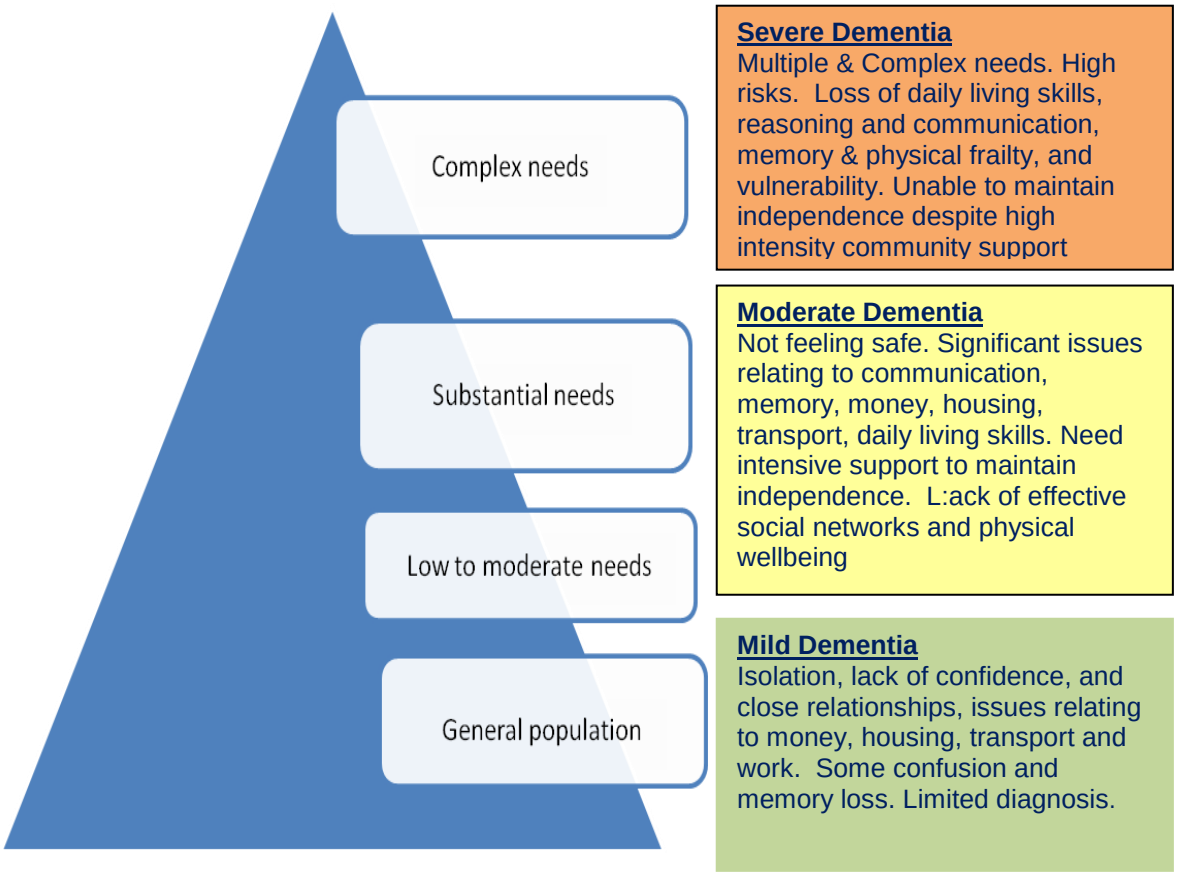
Costs in London are likely to be higher than those listed in Table 1, mainly due to additional staff costs, but also due to higher residential care rates in London:-

- Residential placement for people with dementia (in WF) is currently £560.71 per week compared to £378 nationally
- Social worker salary – 10% higher in London
- Approved Social Worker (Mental health) – 20% higher
- Local authority day care – 30% higher in London

- Community nurse salary – 19% extra in London

By applying the various degrees of late onset dementia to the Department of Health's model (Figure 4) we can see that a broad range of interventions will be required as the disease progresses.

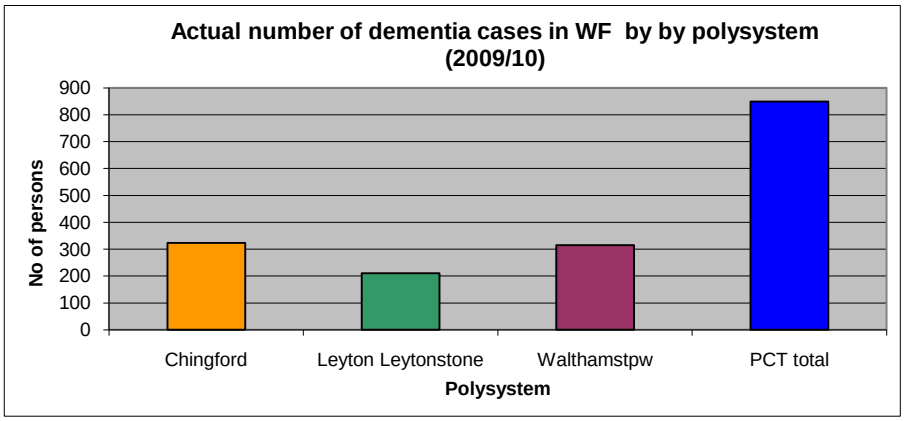
Figure 2



2.3.2 Waltham Forest: The local picture

- Dementia is an under-diagnosed condition in Waltham Forest. The estimated number of people with dementia in 2007 was 1849 with a prevalence of 1.4% among 50+ age group and 7.3% among 85+. This figure is anticipated to rise, with increase predicted at 37% in the 50+ age group in our population.

Figure3



- Waltham Forest has an estimated total population of 224,800 and this is predicted to increase by 9% by 2031 bringing the population to 245,032.

- Population estimates also indicate an overall increase in the age of the population moving forward. Demographic projections indicate that the highest growth will be in the age group 50+, increasing from 57,900 (26%) as of 2009 to (37%) 79,100 by 2031. With a prevalence of 1.4% for early onset dementia among 50+ we can estimate 1,107 people with dementia by 2031 from this age alone.

- Information taken from projections of POPPI and PANSI indicates that there were 1,680 people 65+ with dementia in the Borough in 2009 and by 2030 this figure will rise to 2,135.

- The prevalence of early onset dementia was judged to be higher in men than in women for those aged 50–65. Early onset dementia is comparatively rare, accounting for 2.2% of all people with dementia in the UK i.e. an estimated 55 people in Waltham Forest in 2010.

- The prevalence of dementia is higher amongst older adults with learning disabilities compared to the general population (22% compared to 6% in aged 65+), and is associated with a range of potentially challenging behaviours and health problems. People with Down's Syndrome are at particularly high risk of developing dementia, with the age of onset being 30-40years younger than that for the general population. Amongst people with moderate to profound learning disabilities, deaths from dementia are more common in men than women (Emerson and Baines, 2010).

- Waltham Forest has 92 people with Down's syndrome, 29 of those are between the ages of 45-64 (ONS, 2008) which put them at risk of developing early dementia.

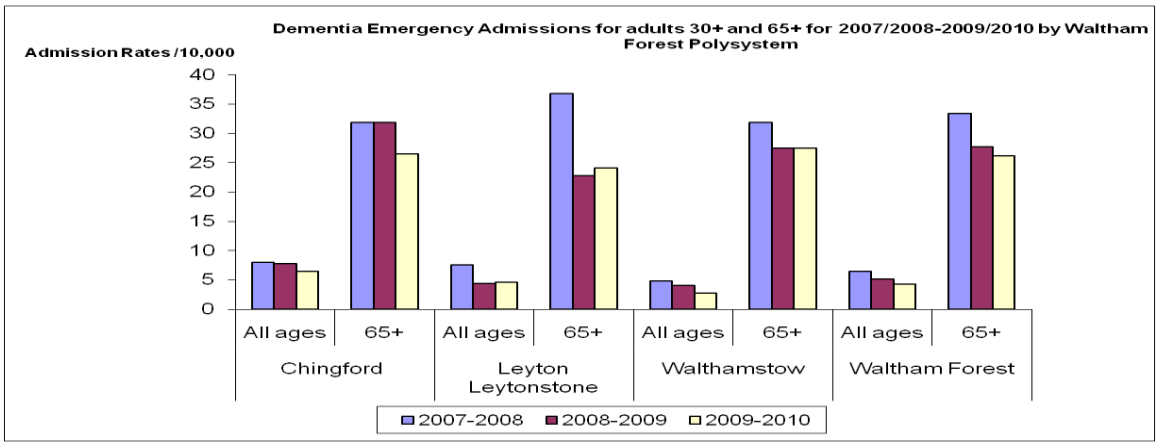
- Diagnosis of people with learning disabilities may be problematic because of the co-morbidities and challenging behaviour among people with learning disabilities, as such diagnostic overshadowing may occur. It is advisable to assess every adult with Down's syndrome at the age of 30 to establish a baseline against which to compare future

suspected changes in functioning. Consideration should also be given to screening all adults with Down's Syndrome over the age of 40 regularly because of the increased risk of dementia and the prevalence of undetected treatable illnesses. The role of the Learning Disabilities psychiatrist is crucial to making the differential diagnosis once all the assessment data have been collected (The Royal College of Psychologist, 2009).

- The number of very elderly with complex needs is increasing; after 2010, the 65-74 years age group will increase. As the population ages, there is a higher prevalence of physical conditions which may contribute to dementia, therefore the rate of dementia is expected to increase.

- The highest rate of emergency admissions comes from the age group 65+ for all three Polysystems and throughout the Borough as a whole (Figure 4)

Figure 4



- Dementia emergency admission rates are higher in Walthamstow and in Chingford compared to Leyton/ Leytonstone (Figure 4 above)

- It is of concern that only 46% of the estimated total figure for people with dementia has been diagnosed by GPs, with over 50% of people with dementia undiagnosed. This indicates the need for more proactive case finding.

- 527 people with dementia were reviewed in the previous 15 months. The total number actually eligible to be reviewed on GP registers is 679 (QOF, 2007/8).

- The table below shows a breakdown of the no of people with mild, moderate and severe, late onset dementia by age group (2010)

Age group	Mild	Moderate	Severe
65-69	29	15	3
70-74	41	20	5
75-79	40	22	8
80-84	46	26	9
85+	67	48	25
all above	223	131	50

- In 2007 it was estimated that the number of people from BME Groups with late onset dementia will increase to 545 in 2021 compared with 226 2001.
- Forecasts show that in Waltham Forest there will be a 4% increase in the numbers of people with Dementia in 2010 compared to 2005

2.4 Key challenges for health and social care

i. Demographic changes, i.e. an increased and ageing population will increase the prevalence of dementia. We already know from local data that the age group most likely to go into residential care are the 65+ with dementia. The challenge for NHS WF and LBWF, is how it will reduce or delay the use of institutional care. Our joint Draft Prevention and Early Intervention strategy recognises early intervention as being both cost and socially advantageous. In the early stages people with dementia require limited care and assistance compared to the expensive full-time care required by many people in the moderate to late stages. Similarly, delaying or slowing the progression of these diseases will reduce the potential negative consequences for carers and facilitate the individual to stay in their own home for as long as possible.

Moreover, a number of (low-level) preventative factors have been associated with Alzheimer's disease such as a healthy diet, promotion of physical and cognitive activity and controlling cardiovascular risk factors such as diabetes, high cholesterol and hypertension. The importance of public campaigns and public health promotions to raise awareness and education on risk reduction cannot be underestimated. These initiatives are significant because if we could delay the onset of dementia for two years, this would reduce the prevalence by 20% and if we could delay it by five years it would halve the prevalence [source: A problem shared is a problem halved? Dementia: Learning opportunities from Europe, Feb 2010].

ii. There is a significant level of unmet need with only 41% of the estimated number of people with dementia, having been diagnosed by a GP. It makes economic sense to invest in local research and pro-active case finding, if we are to target early intervention and preventative services effectively. This also requires working collaboratively with GP practices and the development of a dementia care pathway.

iii. Carers play a vital role in providing largely unpaid care and many need help and support to continue to their caring role; the demands of caring can cause both emotional and financial difficulties. All carers have the right to an assessment and the joint Carers strategy provides respite and short breaks for carers. The dementia strategy recognises that carers of people with dementia need specialist advice, support and information about the disease so that they can plan ahead.

iv. A growing number of elderly people have complex needs; therefore providing effective care for people with co-morbidities is crucial.

v. The growth in the number of people from BME Groups with late onset dementia is significant; engagement and development of culturally sensitive services will need to be considered to promote access.

SECTION 3: CURRENT SERVICE PROVISION

3.1 Health

The majority of Dementia patients are managed by their GP in primary care. The diagnosis of Dementia is a Quality Outcomes Framework (QOF) indicator. The Clinical Director and Clinical Lead for Older People are involved in work to review Dementia care with other clinicians and stakeholders. It is generally thought that the QOF data does not adequately reflect the actual prevalence of Dementia in primary care.

GPs play a key role in the prevention of Dementia, minimising health related risk factors, such as high blood pressure, smoking and cholesterol, and providing lifestyle advice in areas such as diabetes, diet and exercise.

North East London NHS Foundation Trust (NELFT)

NELFT is commissioned to provide services for older persons who have both dementia related illnesses and/or functional mental health problems. They offer services to people who require assessment, diagnosis and, where required treatment options, for people with complex and significant mental health problems.

Support is provided through a Multi Disciplinary approach and the current service provision consists of:

- Acute Mental Health Services
- Older Persons Liaison service
- Community Mental Health team
- Older Persons Day Hospital (currently under review)
- Memory Service (newly developing)

NELFT does not provide long term nursing care for Older Persons.

Acute Mental Health Services

For those persons who experience a significant mental health crisis the person may be admitted to a psychiatric In-Patient ward if they are considered a risk to themselves or others. The acute In-Patient unit, based at Whipps Cross Hospital site, offers a multidisciplinary team approach to care and is considered short-term support to help the person recover from significant mental health problems.

In adult mental health services people are offered an alternative to hospital admission to support them with the crisis through the Home Treatment Team. In Waltham Forest this is currently not provided for older persons, further development/consideration is therefore required to ensure equality of access for Older People.

Older Persons Psychiatric Liaison

There is 1 Band 6 nurse for Older Persons working with the adult Psychiatric Liaison service based at Whipps Cross University Hospital Trust (WXUHT). This person offers assessment

following referrals made from the wards and suggestions on treatment options. The Older Persons psychiatrists also offer some limited input into WXUHT.

Community Mental Health Team (CMHT)

The CMHT is a multidisciplinary service, which currently provides the Single Point of Access for older people to mental health services. The service works to support people with Dementia as well as those with functional illnesses such as psychosis, depression etc. It works in partnership with Social Services, Third Sector and community based providers to deliver a holistic, complete package of support and care. In line with recovery models of practice, it is expected that most people referred will, at some point, be discharged from the service.

The CMHT, based at Red Oak Lodge, services Waltham Forest residents aged 65 years or over with functional or organic mental health problems. Service users under 65, who have been assessed by the adult mental health service and have a diagnosis of early on set Dementia, may also be supported by the service.

All referrals are made to the duty system at Red Oak Lodge (Monday to Friday 9-5). The service accepts referrals from professionals and members of the public however most referrals are via GPs who rule out physical health problems prior to referral.

When fully staffed the CMHT has the capacity to support around 200 service users and approximately 150 carers. The Multidisciplinary team is made up of social workers, nurses, doctors, occupational therapists etc.

The service is dependant on throughput via partnership working to ensure people receive the service they need when they need it.

Services Provided:

A range of interventions are provided via the CMHT and in partnership with other Older Persons resources. Some of the interventions are:

- Diagnosis and treatment
- Domiciliary visit for comprehensive assessment and ongoing support
- Advice and education to both Service Users and other organisations around mental health issues
- Mental Health Act co-ordination
- Monitoring and support (care coordination) of mental and physical health
- Administration and monitoring of psychiatric medication
- Application and administration of social care packages; day care , personal care and residential placement etc
- Continuing Care assessments
- Activity of Daily Living assessment and care planning
- Psychology input / Neuropsychological assessment
- Carer assessment, support and information
- Safeguarding
- Carer support group.

The performance of the service is reviewed monthly via the local and Trust Wide Performance and Integrated Governance meetings. The PCT contract meeting also on a monthly basis

reviews the service in terms of both contracted activity and performance targets and development objectives.

From a Service user and carer perspective a service user and carer forum for older person's services takes place twice a year. The NELFT wide service user and carer audits are also in place and the Trust action plans the national Patient Survey audit results.

The CMHT is not a service specific to Dementia; they work across the mental health spectrum. The Dementia Strategy outlines the need for a clear Single Point of Access for assessment, diagnosis and treatment options for Dementia and states this sits within Memory Services. Work is currently underway to re-model and align services to this requirement.

Admiral Nurse Service

There is a limited Admiral Nurse Service in Waltham Forest of one Band 6 nurse. This service will form part of the Memory Service which is currently developing to full functioning. The Admiral Nurse Service was developed through successful reconfiguration of existing resources and funding streams.

The role of the Admiral Nurse is to work with families and carers of people with complex and difficult presentations of dementia as well as to provide training and consultancy to other professionals working in dementia care settings.

The Admiral Nurse offers one to one support to carers supports educational groups facilitated by the voluntary sector and contributes to the following National Dementia Strategy objectives:

Objective 1: Improving public and professional awareness (training, organising events during carers' week etc)

Objective 2: Good quality early diagnosis and intervention for all (working with GPs)

Objective 8: Improved quality of care in general hospitals (collaborative working with staff in acute care hospitals).

Feedback from the Dementia Workshop suggests this is a pivotal and valued service. Analysis indicates that local need outweighs current service capacity.

Memory Services

Memory Services are recommended in the NICE Dementia Guidance (2006) and the National Dementia Strategy (2009) as the most appropriate means of bringing together a multi-disciplinary team for the purpose of achieving early assessment, diagnosis and treatment of people with dementia and certain other related disorders. Memory Services are usually located within existing Older Persons services.

Currently, NHS WF is working with NELFT to redesign within existing resources, the NELFT Older Persons day hospital service provision into a Memory Service to begin to meet the requirements as set out in the National Dementia Strategy. As this service develops key partners such as Social Services, Primary Care, Third Sector and Community Health Services

will be integral to the operational functioning of this service. Throughput is essential to ensure people will receive timely assessment, diagnosis and treatment recommendation.

Once the service is fully functioning it will reduce the long waiting times for assessment of both general assessment of dementia and more complex neuropsychological assessments.

Services Provided:

The new service aims to provide a Single Point of Access for the assessment, diagnosis and to offer treatment options to people with a possible Dementia. Once fully functioning the expectation is the multi-disciplinary team will agree on the diagnosis, available treatment options which will include medical, psychological and social care interventions.

Current numbers accessing the service with Dementia

The current memory service commenced on 07.07.10 and currently is able to review around 30 clients a week in 1 hour time slots. To date 30 clients have attended and been assessed.

Performance/patient satisfaction

Currently a service user satisfaction questionnaire is distributed at each appointment. The team also work to the NELFT wide Service User and Carer audits.

This service is in early stages of development in Waltham Forest. It is recognised that further review and reconfiguration will be required as this development is progressed in order to ensure delivery of a quality and fully functioning service.

Whipps Cross University Hospital NHS Trust

Whipps Cross University Hospital NHS Trust (WXUHT) is the provider of acute healthcare and universal hospital services in Waltham Forest. In 2009/10, WXUHT admitted 1308 patients with a co morbidity of dementia. Of these 1182 were admitted via A&E as emergencies, 18 'other' emergency route, 7 were provider transfer and 101 were elective admissions.

In 2010/2011, WXUHT aim to implement a new dementia care pathway that will inform and improve the patients' journey through the Trust. This pathway will be applicable to all patients admitted with co-morbidity of dementia, as well as impacting on the diagnosis of patients presenting on emergency or elective pathways.

This initiative includes proposals for the following developments[4]:

- All over 65's admitted should have a mini cognitive assessment – a low score will trigger a full Mini Mental State Examination (MMSE). The MMSE is not suitable for making a diagnosis, but can be used to indicate the presence of cognitive impairment such as in a person with suspected Dementia which warrants further assessment. This is being introduced first for A&E admissions before being rolled out to elective admissions.

[4] Please note that the Dementia Care Pathway proposals are working documents and therefore subject to change.

- In line with the Healthcare for London Strategy which recommends a Dementia Adviser in each clinical area, a Dementia Adviser role to be piloted within Accident & Emergency. This role will be taken on by an existing member of staff.

- Basic Dementia awareness will be included as a component of all new staff induction. In addition, all nursing staff across the Trust will be required to complete Dementia refresher training once every 12 months.

- Whipps Cross is intending to approve recruitment for a Consultant Nurse for Dementia and Delirium. In summary this post will provide expert clinical practice and nursing leadership care and management of patients with complex care needs, particularly those with a diagnosis of dementia and those affected by delirium on admission.

- Development of care pathway including dementia specific care and discharge planning in line with NICE Guidance and National Dementia Standards

- Improve physical health of patients with dementia co-morbidity through weight assessments on admission and discharge, and additional nutritional support under the supervision of the nurse in charge of the ward, as appropriate.

Performance/productivity indicators have been identified in order to assess the dementia care pathway throughout 2010/11. This will include a focus on patient and carer information to be audited Feb 2011.

Outer North East London Community Services

This is the main community services provider. However it is not commissioned to provide specialist dementia services since these are provided through NELFT though ONEL CS generic nursing services such as District Nursing will provide nursing services to those with dementia that have appropriate nursing needs. There is a small unit of seven beds providing NHS continuing care to older people with dementia at Highams Court in Chingford.

Heathlands Care Centre

In May 2009 the provision of services for continuing care for older people with dementia commenced from a newly commissioned service at Heathlands Nursing Home. This provides a 50 bed service for these patients. It is rated as 'Good' by the Care Quality Commission (CQC) and replaced older and less appropriate in-patient wards on the Thorpe Coombe Hospital site.

3.2 Adult Social Care – current service provision

The Moreley Centre

The Morley Centre works in collaboration with NELFT and the PCT (Primary Care Trust) to provide specialist day care services for people with dementia to enable them to maintain independence at home. The centre offers a range of activities including music and relaxation, group discussions, aromatherapy, reminiscences, shopping trips and outings.

This service appears effective but there is the need for better collaboration with GP practices for case finding, cross-referrals and monitoring of patients.

Local Authority Dementia Support Services

This is an outreach service proving support for people with a diagnosis of dementia that are living at home. Support is person-centred and includes skills maintaining, occupation and activity, life history work, validation of their being, empowerment, and respite for carers. The day club provides a social environment to encourage peer support and social interaction. Referrals can be made by NHS WF, WF Adult Social Care and the voluntary and third sectors via the Access and Assessment team.

The service outcomes include carer respite, promotion of independence and empowerment .Maintain existing skills, peer support, gateway to other services, enable the person to live at home as long as possible

Currently 75 people with dementia that are 65 and over, are accessing services as well as 4 service users under 65. 112 Carers are also receiving services.

There are 767 people with dementia registered with GPs and 79 people diagnosed with dementia accessing the in-house dementia support service. It is not clear what proportion, if any referrals come through GPs. There is potential to develop this service to improve collaborative working with GP practices.

Extra Care Housing

Extra Care Housing is a type of specialized housing that provides independence and choice to older adults with varying care needs, including dementia. This type of housing enables people to remain in their own home, preventing the need for costly institutional care, with support available as and when they need it and to suit their individual needs. There are eight extra care sheltered housing schemes in the Borough offering a total of 252 flats funded through £502,977 Supporting People Commissioning and £222,189 care. The schemes provide 24-hour support and care, including meals, domestic help, leisure and recreation facilities and a genuinely safe environment to its residents.

Extra care Support Workers work collaboratively with Adult Social Care and the PCT to establish service user's needs and make referrals to the Dementia Team, where appropriate.

The dementia outreach service is running very successfully within Extra Care services for scheme tenants and the wider community. Activities within the schemes include, dominoes, bingo, quizzes, singing, hot meals, tea and cakes.

Extra Care Housing has been shown to prevent the need for costly institutional care; therefore, there is a very strong case for increasing the capacity of Extra Care housing schemes to meet the needs of the growing number of people with dementia.

The Rainbow Project

Through the Rainbow Project, Dementia Support Groups operate in Baytree House, Albany and Gainsfield Courts. Activities have included a mobile film club, a gardening club, regular arts and crafts sessions and ASWA (Arabic Speaking Women's Association) activities.

Lea Valley Crossroads

Lea Valley Crossroads is funded by McMillan to provide palliative care to people in their own home when death is near, including people with dementia. According to local data, approximately 15% of users are people with Dementia.

New Testament Assembly Community Project

This is a drop-in/ day care centre that offers leisure, health and educational activities with the aim of enabling to people to stay lead healthier lives and stay active. On average nine people per day with mild dementia attend the day centre.

William Morris Day Centre

The centre offers drop-in and day care, leisure activities and lunch. Not dementia specific, but is open to dementia users.

Telecare

In Waltham Forest Telecare and Community Alarms are used to enable vulnerable people to maintain independence and security within the home. This is a service jointly funded by LBWF and NHS WF. Telecare builds on community alarm system, which allows people to call for help in an emergency by pulling a cord or a pendant worn around the neck. It gives service users a sense of security in the knowledge that if a problem occurs they are able to raise a call for assistance. It also gives peace of mind to carers and relatives who are able to have a better quality of life in the knowledge that the Telecare equipment will trigger a response in the event the service users raise a call.

Research has shown that the use of Telecare has a positive impact for both users and their carers, including:-

- Improvements in their sleeping patterns, which reduce exhaustion and help them, sustain their caring role.
- Reduced anxiety and stress, as there is less need to worry about the safety of the person cared for – in Scotland, 75% of carers reported reduced stress (Beale, S, Sanderson, D and Kruger, J (2009) Evaluation of the Telecare Development Programme: Final Report, Glasgow, The Scottish Government (p47)

> Telecare has been shown to greatly assist with keeping people safe and enabling them to continue to live independently. There is a need to explore more advanced technologies, e.g. telemedicine which will remind people with dementia to when medicines should be taken.

Home Care

LBWF is committed to ensuring that people with dementia are supported to live in their own homes and to prevent or delay the need for more acute settings. The recent homecare tender included an enhanced specification for the specialist homecare for people with dementia.

Re-ablement service

The re-ablement service provided through the in-house Home Care Team to enable people to leave hospital appropriately, safely and efficiently. People who have lost their skills for daily living are encouraged to re-learn them to build their confidence and to enable them to be as independent as possible in their homes. The overall aim is to help people remain at home, to prevent hospital admissions and when appropriate to reduce the level of needs. The service is for up to six weeks.

Residential placements for people with dementia

The group most at risk of entering residential care people over 65, with dementia. The Borough has secured 144 residential placements for people with dementia at a total cost of £560.71 per week.

3.3 What we've been told about dementia care in the Borough?

Feedback from the dementia workshop (Appendix 2) facilitated by NHS WF and LBWF, and attended by carers and people with dementia, revealed the following common concerns to the themes put forward:

a) What Health input do we need for people with dementia?

- GPs and other professionals need specialist training in dementia care
- GPs to be proactive in early diagnosis
- Specialist day centres for people with dementia
- Need for a memory clinic
- Improved intermediate care
- Need for joined-up working

b) Models of good practice / areas of improvement in service provision

- Day care facilities closer to home
- Training for Home care staff
- Training for carers
- Monitoring patients that have not contacted patients for over a year
- Develop awareness amongst staff and public
- Forums for carers/ peer support
- Improve knowledge and use of Telecare
- Awareness of spiritual, cultural and emotional needs of people with dementia from different ethnic backgrounds

c) The next step forward for dementia care in WF

- Develop a local dementia strategy with clear actions and timescales
- Identify dementia champions
- Make better use of existing resources
- Develop a dementia register in the Borough
- On-going communications and campaigns
- Dementia advisors that are accessible by GPs
- More Extra Care housing
- One-stop-shop for dementia
- Improved services for people with learning disabilities that have a diagnosis of dementia
- People with dementia and their carers to have ‘Key Workers’ or ‘Day-care Co-ordinators’
- People with dementia and their carers to be given key contact numbers

SECTION 4: STRATEGIC PRIORITIES IDENTIFIED FOR WIDER CONSULTATION

4.1 Strategic considerations

LBWF and NHS WF have considered how it will respond to the National Dementia Strategy, meet local challenges, including demographic changes and also deliver services within current financial climate, with reduced financial resources. We have also taken on board what people have told us.

This section addresses the priorities for implementation that have been jointly agreed in recognition that some existing services are working really well, with others requiring re-configuration to deliver improved services for people with dementia and their carers:

4.2 Priority One: Improving public and staff awareness

Outcomes	○ Improved awareness of, and understanding of consequences of dementia ○ Reduce stigma attached to dementia ○ Promotion of dignity and social inclusion ○ Self-identification ○ Early identification and support

4.2.1 How will we achieve these outcomes?

- Develop a joint communications plan to raise awareness and understanding of dementia, audience to include people aged 50+, carers, and BME groups
- Consider health promotion and awareness raising campaign through the voluntary sector, GPs and community organisations to build on national awareness campaign
- Integrate the wider health promotions campaign, e.g. advice to identify and address risk factors for stroke (one of the main causes for vascular dementia)
- Improved training for staff working with older people, mental health and learning disability services.
- Include basic dementia awareness will be included as a component of all new staff induction. In addition, all nursing staff across the Trust will be required to complete Dementia refresher training once every 12 months.

4.3 Priority Two: Good quality early diagnosis and intervention for all

Outcomes	○ Access to a care pathway that delivers a rapid and competent assessment ○ An accurate diagnosis that is sensitively communicated to the person with dementia and their carers ○ Treatment care and support, as needed, following diagnosis ○ Increased numbers of people with dementia registered on GPs registers

4.3.1 How will we achieve these outcomes?

- Work in partnership to complete a comprehensive and thorough needs analysis to assess and plan for the unmet need in the Borough
- Map the current care pathway and review the current service against the national strategy and the London model to identify gaps
- Develop a whole system integrated care pathway which includes: enhanced prevention of dementia through linking with health programmes aimed at reduction of the risk factors such as smoking, cholesterol control, diet & exercise; early intervention through to specialist provision; and end of life care
- Mainstream screening for Dementia for all over 65s within Primary Care. This will require identification of an appropriate screening tool for primary care to support case finding and the facilitation of appropriate awareness raising workshops in order to ensure all GPs are knowledgeable regarding risk factors, common indicator co-morbidities (such as Urinary Tract Infections, falls), screening and care pathways.
- Consider the development of the Dementia Adviser role based within appropriate services within the care pathway[5].
- Develop good quality services for early diagnosis and intervention via continued development and reconfiguration of the Memory Service (established July 10) to provide a Single Point of Access for Dementia
- Consider Telecare as a solution to managing the projected increase in people with dementia to reduce pressures on residential budgets, support carers and reduce hospital admissions.

4.3.2 Business case for Telecare

One way of avoiding institutional care is through the use of Telecare, which has been shown to:

- Reduce risks in the home for vulnerable people

[5] The Dementia Adviser role will be piloted with Whipps Cross University Hospital NHS Trust in 2010/11

- Support service users and their carers by distinguishing situations that may require rapid emergency support, reassuring family members and carers
- Assist in the management of specific conditions through monitoring, for example, movement within the home and falls
- Enable timely hospital discharges and ensuring people remain safely at home – achieving significant cost savings but also enabling people to be at home where majority of people prefer to be
- Reduce health and social care costs for example for overnight services and certain types of home visits. A review of 20 cases [source: Use of Resources in Adult Social Care: A guide for Local Authorities, Oct 2009) has found that the 'Just Checking System, for example will deliver cashable efficiencies across the wider health and social care system arising from:
    - more accurate assessments leading to targeted timing and sizing of care packages and support
    - delaying or preventing residential placements; and
    - improved independence, choice and control for all client groups

The sample of 20 cases demonstrated net savings of £120,000 (£6,000 per person).

4.4 Priority Three: Improved Community Personal Support

It is estimated nationally, that two-thirds of people with dementia live in their own homes, giving rise to a need to commission services that support people to maintain their skills and abilities, to maintain their social networks to remain living in their own homes.

Outcomes	○ Promotion of Individual Budgets for person-centred services ○ Maximising skills and abilities ○ Social inclusion ○ Living independently

4.4.1 How will we achieve these outcomes?

We will:

- Maintain accurate records of people with dementia living at home and receiving individual budgets when LBWF's Resource Allocation System has been rolled out
- Monitor services being purchased by people with dementia, identifying trends and reviewing support planning and brokerage services
- Ensure safeguarding procedures and protocols are effective and kept under review

- Develop flexible, person centred packages of support through individual budgets. This will require a focus on market stimulation in order to ensure availability and access to a varied menu of services and resources.
- Consider how peer support and learning networks can be developed/integrated within mainstream services
- Work collaboratively to ensure safe and timely hospital discharges, and support at home to re-adjust, through re-ablement or inter-mediate care (whichever is more appropriate)
- Carry out comprehensive assessments of people with dementia and their carers to identify future needs, respite care needs

4.5 Priority Four: Improved quality of care for people with Dementia in general hospitals

Living Well with Dementia suggests improving care for people with dementia in general hospitals by providing leadership through a nominated senior clinician, and developing a care pathway for people with dementia that is supported by a specialist liaison service.

Outcomes	○ Dementia is recognised when people are admitted to hospital ○ People receive treatment and care that takes account of their dementia ○ Treatment outcomes not compromised by their dementia ○ Their dementia is not made worse by the disorientating effects of admission to a general hospital

4.5.1 How will we achieve these outcomes?

We will:

- Identify a senior Whipps Cross University Hospital NHS Trust Clinician to champion and lead improvements in treatment and care of people with dementia and training
- Develop a care pathway and best practice models of care for people with Dementia in general hospitals including dementia specific care and discharge planning in line with NICE Guidance and National Dementia Standards
- All over 65's admitted should have a mini cognitive assessment – a low score will trigger a full Mini Mental State Examination (MMSE). The MMSE is not suitable for making a diagnosis, but can be used to indicate the presence of cognitive impairment such as in a person with suspected Dementia, which warrants further assessment. This is being introduced first for A&E admissions before being rolled out to elective admissions.
- Pilot a Dementia Adviser role within A&E

- Recruit a new Consultant Nurse for Dementia & Delirium
- Improve physical health of patients with dementia co-morbidity through weight assessments on admission and discharge, and additional nutritional support under the supervision of the nurse on charge of the ward, as appropriate.

4.6 Priority Five: Living well with dementia in care homes

Outcomes	○ People with dementia that are living in residential or nursing homes have improved quality of care ○ People with dementia will be supported to remain safe and continue to use their skills

4.6.1 How will we achieve these outcomes?

We will:

- Ensure that staff working in care homes receive relevant training in dementia care
- Monitor care homes performance and quality of dementia care, through contract monitoring arrangements
- Specialist mental health services to provide in-put into care homes
- Community and mental health commissioners to support care homes through community responses to medical and mental health crises, and by reducing referrals to hospital care
- Ensure local nursing homes explicitly address the needs of people with dementia including best practice models such as the Liverpool Care Pathway
- Ensure adequate independent Mental Capacity Act advocacy is available for people with dementia
- Ensure clear protocols on, and monitoring of, the use of anti-psychotic medication for people with dementia to be in place.

4.5 Priority Six: an informed an effective workforce for people with dementia

Training and education around dementia, raising awareness, skills, attitudes and dignity, should be an integral part of foundation training of health, social care and third sector staff .

Outcomes	○ Everyone who works with people with dementia, whether in a specialist or mainstream setting, has the necessary knowledge and skills to deliver a service to the highest standard

4.5.1 How will we achieve this outcome?

We will:

- Carry out an audit across health and social care to understand capacity and capability
- Develop a Dementia Training and Development plan for health and social care staff
- All services, whether specialist or non specialist to be required to demonstrate that they have training plans in place, for their staff to ensure that they can deliver their service taking into account the particular needs of people with dementia
- Integrate voluntary sector providers into training wherever possible
- Set up a Dementia Forum for service users, carers, GPs, WXUHT, NELFT, and the voluntary and third sector to facilitate discussions and opportunities in dementia care services.

4.6 Priority seven: develop a joint commissioning strategy

Outcomes	○ The Dementia Strategy is implemented successfully; all stakeholders have been consulted on it ○ De-Commissioning and re- commissioning of services is on the basis of value for money, better productivity and improved quality

4.6.1 How will these outcomes be achieved?

We will:

- Ensure the commissioning model complies with Quality, Innovation, Productivity and Prevention (QIPP)
- Identify the potential for joint commissioning arrangements
- Agree an implementation plan and mechanisms for monitoring
- Adopt a whole system approach that includes service users and carers at the heart of decision-making.

4.7 Priority eight: implement the joint Carers Strategy

Outcomes	○ Carers will have an assessment of their needs ○ Carers will report that they feel supported to carry on their caring role ○ Carers will be receive short respite breaks from their caring role ○ People with dementia will be able to continue living at

	home, independently, avoiding the need for residential care

4.7.1 How will these outcomes be achieved?

- The draft joint Carers Strategy currently out to consultation will be implemented, following consultation and engagement with Service users and their carers
- The draft joint Carers Strategy will promote support and short breaks for Carers of people with dementia
- Through collaborative working with the mental health teams and GP practices carers will be identified and referred on for support and breaks from their caring roles

Dementia Strategy Action Plan

Actions	Lead role	Yr1			Yr2	Yr3	RAG
		Qtr2	Qtr3	Qtr4			
Strategic priority one: improving public and staff awareness							
Develop and agree a joint communication plan to raise awareness and understanding of dementia, audience to include people aged 50+, Carers, and BME groups	NHS WF AD for Communications & Engagement Adult Social Care Public Health			*			
Consider the development of a health promotion awareness campaign through GPs, the voluntary sector and community organisations to build on the national dementia campaign	NHS WF Consultant in Public Health Medicine Adult Social Care				*		
Provide ongoing and enhanced training for staff working with older people, mental health and learning disability services to include safeguarding arrangements for people with dementia	Health Adult social care Service Providers						
Provide basic dementia awareness as a component of induction for all new staff at Whipps Cross	Whipps Cross Consultant Physician - Medicine for Elderly People Whipps Cross Service Manager (Specialist Medicine)	*					

Actions	Lead role	Yr1			Yr2	Yr3	RAG
		Qtr2	Qtr3	Qtr4			
Strategic priority two: Good quality early diagnosis and intervention for all							
Health and Social Care to work in partnership to complete a comprehensive needs analysis to assess and plan for the unmet need in the Borough	NHS WF Consultant in Public Health Medicine & Adult Social Care		*				
Map the current care pathway and review the current service against the national strategy and the London model to identify gaps	Dementia Strategy Working Group			*			
Develop a whole System integrated dementia care pathway, which includes enhanced prevention of dementia and links with health programmes aimed at reduction of the risk factors such as smoking, cholesterol control, diet and exercise, early intervention through to specialist provision and end of life care.	Dementia Strategy Working Group				*		
Identification of an appropriate screening tool for primary care to support case finding and mainstream screening for all over 65s	GP Clinical Director GP Clinical Lead/ NELFT			*			
Facilitation of appropriate awareness raising workshops in order to ensure all GPs are knowledgeable regarding risk factors, common indicator co-morbidities (such as urinary tract Infections, falls) and appropriate screening	GP Clinical Director / Lead Public Health			*			
Dementia Adviser role to be piloted with Whipps Cross University Hospital NHS Trust in 2010/11	Whipps Cross Consultant Physician - Medicine for Elderly People / Whipps Service Manager			*			

Actions	Lead role	Yr1	Yr2	Yr3	RAG

		Qtr2	Qtr3	Qtr4			
Strategic priority two: Good quality early diagnosis and intervention for all (cont…)							
Re-configuration of memory service to provide a single point of access for people with dementia	Commissioning Manager Mental Health & Substance Misuse NELFT Operational Director				*		
Pilot the "Just Checking" (Telecare) system to evaluate impact and outcomes for people with Dementia	ASC- Head of Strategic Commissioning		*				
Strategic priority three improved community personal support							
Maintain a database to collect information about people with dementia living at home and receiving individual budgets	ASC- Head of Strategic Commissioning		*				
Monitor and review trends and support planning for people with Dementia receiving Individual Budgets	ASC- Head of Strategic Commissioning			*			
Work in collaboration with providers to ensure availability and access to a varied menu of services for people and resources for people with dementia receiving individual budgets	ASC- Head of Strategic Commissioning			*			
Health and Social care to work collaboratively to ensure safe and timely hospital discharges and for provision of support at home to re-adjust through intermediate care	Health & Social Care Provider						
Carry out comprehensive assessments of people with dementia and their carers, to identify respite and future needs	Health & ASC- Head of Strategic Commissioning						
Actions	**Lead role**	**Yr1**			**Yr2**	**Yr3**	**RAG**

		Qtr2	Qtr3	Qtr4			
Strategic priority four: Improved quality of care for people with dementia in general hospitals							
Identify a senior Whipps Cross University Hospital NHS Trust Clinician to champion and lead improvements in treatment and care of people with dementia and training	Whipps Cross Consultant Physician - Medicine for Elderly People	*					
Develop a care pathway and best practice models of care for people with dementia in general hospitals including dementia specific care and discharge planning in line with NICE guidance and national dementia standards	Whipps Cross Consultant Physician - Medicine for Elderly People Whipps Cross Service Manager (Specialist Medicine) GP clinical leads, Quality team NHS WF			*			
Carry out mini cognitive assessments on all over 65's admitted in hospital – a low score will trigger a full Mini Mental State Examination (MMSE)	Whipps Cross Consultant Physician - Medicine for Elderly People Whipps Cross Service Manager (Specialist Medicine)			*			
Pilot a dementia Adviser role within A & E	Whipps Cross Consultant Physician - Medicine for Elderly People Whipps Cross Service Manager (Specialist Medicine)			*			
Recruit a new Consultant Nurse for dementia and delirium	Consultant Physician - Medicine for Elderly People/ Whipps Cross Service Manager			*			
Actions	**Lead role**	**Yr1**			**Yr2**	**Yr3**	**RAG**

		Qtr2	Qtr3	Qtr4			
Strategic priority five: Living well in dementia in care homes							
Provide training in dementia care to care home staff	Adult Social Care						
Monitor care homes performance and quality of dementia care, through contract monitoring arrangements	Adult Social Care						
Community and mental health commissioners to support care homes through community responses to medical and mental health crises	Adult Social Care Service Providers						
Provide adequate Mental Capacity Act advocacy for people with dementia	Health and Adult Social Care						
Develop clear protocols on the use of anti-psychotic medication for people with dementia, including monitoring	NELFT / Head of pharmacy team		*				
Strategic priority six: An informed and effective workforce for people with dementia							
Carry out an audit across health and social care to understand capacity and capability	Health & ASC Providers				*		
Develop a dementia training and development plan for health and social care staff	Health & social care providers		*				
Service providers to be required to demonstrate that they have training plans in place for staff working older people and people dementia; mandatory requirement	Health & Social care Providers	*					

Actions	Lead role	Yr1			Yr2	Yr3	RAG
		Qtr2	Qtr3	Qtr4			
Strategic priority six: An informed and effective workforce for people with dementia							
Set up a Dementia Forum for service users, carers, GPS, WXUHT, NELFT, and the voluntary and third sector to facilitate discussions and opportunities in dementia care services and for effective engagement	NHS WF Director of Commissioning LBWF Head of Strategic Commissioning	*					
Strategic priority seven: Develop a joint commissioning strategy							
Identify and explore opportunities for joint commissioning	NHS WF Director of Commissioning LBWF Head of Strategic Commissioning						
Adopt a commissioning model that complies with Quality, Productivity and Prevention (QIPP)	Health & Adult Social Care		*				
Agree an implementation plan and mechanism for monitoring	Health & Adult Social Care			*			
Develop an engagement strategy to include the whole-system			*				
Through collaborative working, mental health teams, WXUHT and GP practice's will refer Carers for assessment for support to help them to continue their caring role							