



# Living well with dementia: A National Dementia Strategy

## Good Practice Compendium – an assets approach

**DH INFORMATION READER BOX**

Policy	Estates
HR / Workforce	Commissioning
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Clinical	<b>Social Care / Partnership Working</b>

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<b>For Recipient's Use</b>	

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### **Introduction to the good practice compendium**

This Good Practice Compendium has been brought together from across the regions to support local delivery of the National Dementia Strategy (Strategy) and improve outcomes for people with dementia and their carers. It is a local enabler for change, as described in the Department of Health's revised, outcomes focused implementation plan: *'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy'*<sup>1</sup>.

The good practice examples are listed by region. As a guide, each example is mapped to the relevant Strategy objective (see Appendix 2/page 152 for a full listing) and to the illustrative example of quality outcomes for people with dementia (as described in the revised implementation plan) – see Appendix 1/page 150.

Contact details are provided at the end of each good practice example if you are interested in finding out further information.

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<sup>1</sup> 'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy' (8 September 2010)  
<http://www.dh.gov.uk/en/index.htm>

**EAST MIDLANDS**

**1. Community Care Centre, Staveley, Derbyshire**

This Centre is the first of a full network of a number of high quality Community Care Centres across Derbyshire that will become the focal point for delivering services to older people with more complex levels of need, and that promote individual requirements for independence, well being and dignity.

**Aims**

The Staveley Community Care Centre provides centre based, residential and outreach services as part of the integrated network of support to the locality. The building and services are designed to work in harmony with public, specialist therapeutic and private living areas, all of which have been designed to be dementia friendly.

The main features of the service model are that it supports:

- Adults living with dementia and their carers
- Local people – the centre will be a hub for the local community with integrated services tailored to the needs of the communities it serves.

The Centre has open public areas, centre based services tailored to meet assessed need, as well as short and long term residential care, all promoting individual requirements for independence, well being and dignity.

Focusing on dementia the Community Care Centre provides:

- A range of flexible day opportunities for people in the community which include day respite, advice and information services, rehabilitation and health and support services
- Short term intermediate and respite care for older people; and
- Long term care for older people with dementia and more complex needs.

The aim of the Centre is to:

- act as a hub of services for older people with chronic ill health and other long term conditions, particularly dementia, who require intensive care management;
- support carers; offering respite care, information and advice in a local setting;
- provide more integrated services tailored to the needs of the communities they serve;
- help older people, particularly those with dementia , to regain lost skills and abilities, maximising their potential to live in their own homes as long as possible, promoting independence and dignity
- provide better access to assistive technology including tele-health and tele-care.

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	<ul style="list-style-type: none"> <li>• promote and sustain inclusion and well being;</li> <li>• provide a “one stop shop” with a range of facilities; including a Health and Wellbeing Zone supported by Health Trainers</li> <li>• bring in voluntary and statutory bodies to provide information and advice on a host of topics including helping to maximise income; and,</li> <li>• provide accessible services in high quality, energy efficient, future proof dementia friendly buildings.</li> </ul>
<b>Local Context for Initiative</b>	<p>National projections applied to Derbyshire are that there will be a 70% increase by 2028 in the number of people over 65 who will develop some form of dementia. This represents an additional 6,600 older people living with dementia in the County by 2028, with over 16,000 in total. It is anticipated that 87% will have mild to moderate dementia, with 13% having severe dementia.</p> <p>Derbyshire County Council has identified the need for better services and support for people with dementia, working with Stirling University to focus on dementia friendly design and service provision with prevention and early intervention at the heart of the ethos and philosophy.</p> <p>The Community Care Centres play a pivotal role in the Authority’s plans to modernise services to meet changing needs and expectations as described in Derbyshire’s ‘Services for Older People – Joint Commissioning Strategy 2009-2014’ and in responding to the recently published “Living well with dementia – the National Dementia Strategy 2009”</p> <p>Work was undertaken locally to determine how it would be best to meet this growing need. It was agreed that the Council would need to develop:</p> <ul style="list-style-type: none"> <li>• Specialist services which will address the growing numbers of people with complex needs, with a particular focus on dementia</li> <li>• More efficiently co-ordinated and personalised services which are consistent with the aspirations and needs of service users and their carers</li> <li>• Service models which help to prevent ill health and promote well being in the older population</li> <li>• Services which help people to regain lost skills and maximise their independence and self care</li> <li>• Services which link more effectively with health service provision, facilitating an enhanced care journey for service users with improved health and social care outcomes</li> <li>• Support for Carers</li> </ul> <p>The Community Care Centre model is starting to address these needs initially in Staveley. The plan is to develop a network of Centres across the County over the next 5 to 10 years and this first development is a template for future schemes.</p>

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<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The Centre covers both accommodation based and visitor based services, providing in reach and out reach services as part of the integrated network of support in each area. It will do this through:</p> <ul style="list-style-type: none"> <li>i) <b>Accommodation-based services:</b> 16 long stay residential beds; 8 overnight short breaks beds and 8 Intermediate care beds</li> <li>ii) <b>Visitor based services:</b> Intensive day care: 15-20 places per day; 7 days per week; and day opportunities: a range of multi-purpose rooms and facilities which can provide opportunities for assessment, therapy, treatment, social activities and bistro computer suite</li> </ul> <p>Benefits of the Community Care Centre includes:-</p> <ul style="list-style-type: none"> <li>• Improved opportunities to live independently, through specialised care for people with dementia and care, advice and support to older people and carers within the surrounding community;</li> <li>• Easier access to a broad range of services and information;</li> <li>• Increased social inclusion for older people;</li> <li>• Improved choice and control;</li> <li>• Improved dignity and safety;</li> <li>• Improved preventative, early intervention and re-ablement services;</li> <li>• Community based peer support for carers;</li> <li>• Increased direction and leadership in the efficient use of resources;</li> <li>• Sustainable and energy efficient buildings; and</li> <li>• Buildings that promote good, dementia friendly design and facilities of which present and future generations can be proud.</li> </ul>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>The main challenges faced in developing the Centre were:</p> <ul style="list-style-type: none"> <li>• Developing a coherent model that engaged the local community as well as supported those with specialist and complex needs <ul style="list-style-type: none"> <li>○ This was achieved through ongoing local consultation; work with local community groups etc. There is now a range of involvement in the Centre from the local Staveley Seniors Group to the neighbouring school whose students have painted a mural for the centre and are seeking to support the Internet café.</li> </ul> </li> <li>• Designing a building that in addition to being accessible to those with disabilities, is also accessible to those with dementia <ul style="list-style-type: none"> <li>○ This was achieved by working closely with Stirling University to integrate dementia friendly design into the building from the earliest opportunity at planning stage, ensuring compliance through the building contractor through a detailed output specification, and through ongoing consultation with those with specialist dementia knowledge as the building developed</li> </ul> </li> <li>• Developing a service model that provided support along the whole spectrum of an individual's care pathway <ul style="list-style-type: none"> <li>○ This was achieved by following the model set out for older person's services in Derbyshire's Joint Commissioning Strategy, including information and advice, general prevention and targeted early intervention services for those with dementia, and services targeted to provide care,</li> </ul> </li> </ul>



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	<p>treatment and support, and care in a registered care setting. Work is ongoing to support early diagnosis and assessment of dementia and provide continuity of care.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>The Staveley Community Care Centre has been funded as part of Derbyshire County Council's capital investment programme. It cost £7.5m to develop, with ongoing revenue requirements to support the service model. The revenue requirements have been secured through a reconfiguration of local services within the new service model for older people, of which the Community Care Centre is one element. Other complementary aspects of the service model include supported independent living in a person's own home, extra care housing, direct payments, and traditional residential and nursing accommodation.</p> <p>The success of the development was dependant on the active support of local elected members. Partnership working was vital to the delivery of the objectives, a jointly agreed vision and dementia strategy with NHS Derbyshire County set the direction for both organisations to work together.</p>
<p><b>Transferable Learning</b></p>	<p>A full lessons learned log has been kept for the project, and a post service development project closure report has been completed. Whilst a full evaluation is planned for when the Centre has been fully operational in six months time, early lessons include:</p> <ul style="list-style-type: none"> <li>○ Models of service delivery for the new Centre need different culture and philosophy from existing services that transfer to the new facility <ul style="list-style-type: none"> <li>○ e.g. catering model requires change from traditional / day care model to bistro and restaurant model</li> </ul> </li> <li>○ Whole staff team approach is crucial in delivering a person-centred response <ul style="list-style-type: none"> <li>○ e.g. cleaning staff and care staff employed by the same organisation, working to same aims and policies, supporting residents and other service users</li> </ul> </li> <li>○ Reception staff need to be skilled up to become information advisors as well as traditional receptionists</li> <li>○ Informal community activities and information sessions need an infrastructure to support them to develop and be effectively co-ordinated to provide a full programme for the Centre</li> <li>○ Local stakeholder engagement in the use of the building and activities that go on in them is crucial to support appropriate building design and service commissioning <ul style="list-style-type: none"> <li>○ This lesson has been learned and the second scheme in Swadlincote has just held a successful community reference group meeting to identify and take forward activities and design issues.</li> </ul> </li> </ul>
<p><b>Validation/ Evaluation</b></p>	<p>A full evaluation is planned to include: the effectiveness of service model as a whole and key elements, staff skills and training. The recommendations from the evaluation will be used to amend the future service delivery.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The Centre has been designed to be flexible to the future needs of people with dementia and their carers and it is anticipated that the type of services will</p>

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	<p>change over the forthcoming years.</p> <p>Additional investment in staffing at the Centre will be required on an incremental basis as the level of need rises and new service aspects are developed. Future investment will be arranged via the established joint commissioning process in partnership with NHS Derbyshire County</p> <p>A further Centre is currently under development in Swadlincote. It is hoped that a further 6 Specialist Community Care Centres will be funded which would provide a Centre in each of the County localities.</p>
<p><b>Key contact/ Locality</b></p>	<p>Alice Sanghera  <a href="mailto:Alice.sanghera@derbyshire.gov.uk">Alice.sanghera@derbyshire.gov.uk</a>            01629 49932077</p>
<p><b>Dementia Strategy Objectives</b></p>	<ul style="list-style-type: none"> <li>• <b>Objective 2: Early diagnosis:</b> The Centre will provide a locally based accessible location for Memory Assessment Services</li> <li>• <b>Objective 3: Good quality information:</b> the general public, people with dementia and their carers will be able to access specific information and advice – from staff at the centre, professional social care staff, health staff and from a dementia support worker. Appointments will be provided either at the Centre or in someone’s own home if they cannot access the centre. An Alzheimer’s Dementia Café will also operate from the centre offering people advice and information.</li> <li>• <b>Objective 5: Develop structured peer support and learning networks:</b> A peer support group will be available for carers and they will also have the opportunity to access Caring with Confidence courses at the Centre</li> <li>• <b>Objective 7 : Implement the New Deal for Carers:</b> The Centre will provide support for carers through: peer training support groups, short breaks, stress and buster sessions, information and advice;</li> <li>• <b>Objective 9: Improved intermediate care for people with dementia:</b> The Centre provides 8 intermediate care beds. Intermediate care services will provide a range of services that are person centred and provide needs based care that manages both the physical and mental health needs of older people.</li> <li>• <b>Objective 10: Considering the potential for housing support, housing-related services and tele-care to support people with dementia and their carers:</b> The Centre will improve access to assistive technology and will include a tele-care information suite whereby local people can find out more about how technology can support them.</li> <li>• <b>Objective 11: Living well with dementia in care homes:</b> The Centre provides 16 long stay beds for people with dementia including those with long term care needs. Care will be based on individual Person Centred Plans and residents will be provided with positive and regular interventions aimed</li> </ul>

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	<p>at: strengthening existing skills and focussing on empowering individuals; providing opportunities for activities and engagement, including access to outside space. There will also be end of life specialist support.</p> <ul style="list-style-type: none"><li>• <b>Objective 13: An informed and effective workforce for people with dementia:</b> A training pathway has been developed for all staff working in the Staveley Centre. The dementia training reflects and is based on Government guidance from the National Dementia Strategy, and so will influence the services and support that people receive.</li></ul>
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2. Improving Dementia Care in the Acute Hospital, Leicestershire	
<b>Aims</b>	To improve the quality of care and patient experience of people with dementia who are admitted to the acute hospital.
<b>Local Context for Initiative</b>	<ul style="list-style-type: none"> <li>▪ Completed a dementia audit across 3 hospital sites in 2007/8 which included a review of the; environment, patient assessment, communication, continence, nutrition, patient safety and education.</li> <li>▪ Organisational drive to improve services for people with dementia and their carers.</li> <li>▪ LLR National Dementia Strategy Local Implementation Network.</li> </ul>
<b>Achievements/ Benefits</b>  <b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> <b>User/Carer Involvement</b>	<p>Achievements include;</p> <ul style="list-style-type: none"> <li>▪ Raising awareness and changing staff attitudes through Person Centred Dementia Care training to date over 600 staff have completed the training</li> <li>▪ Held a dementia conference attended by 100 staff</li> <li>▪ Developed a 10 point guide for staff in conjunction with Trent Dementia Services – Caring for people with dementia in the acute hospital</li> <li>▪ Introduced a ‘Patient Profile’ for people with dementia, to promote better communication and understanding</li> <li>▪ Improving and changing our signage to new pictorial signage</li> <li>▪ Recruited mealtime Assistant Volunteers</li> <li>▪ Put in a bid to train 30 staff in Dementia Care Mapping with the University of Bradford and Bradford Dementia Group to assess the patient experience of people with dementia.</li> </ul>
<b>Challenges</b>  - <b>How these were addressed</b>	Competing with many different priorities, this was addressed by ensuring that the right people are involved with the different projects. It has been easier to promote with the national and local drivers.
<b>Resources/ Capability/ Capacity</b>  - <b>What does it take to make this happen?</b>	<ul style="list-style-type: none"> <li>▪ Nominated lead/champions</li> <li>▪ Partnership working – multi –agency and within the organisation i.e. facilities</li> </ul>
<b>Transferable Learning</b>	<ul style="list-style-type: none"> <li>▪ Audit tool</li> <li>▪ Staff handbook</li> <li>▪ Patient Profile</li> <li>▪ Person centred dementia care</li> </ul>
<b>Validation/ Evaluation</b>	<ul style="list-style-type: none"> <li>▪ Patient satisfaction/improved experience</li> <li>▪ Audit of the use of the patient profile</li> </ul>

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<b>Sustainability/ Next Steps</b>	<ul style="list-style-type: none"><li>▪ Set up a trust wide Dementia care Group to develop a clinical pathway</li><li>▪ Continue to roll out staff training programme</li></ul>
<b>Key contact/Locality</b>	Emma Spencer, Service Development Manager 0116 258 5608 <a href="mailto:emma.spencer@uhl-tr.nhs.uk">emma.spencer@uhl-tr.nhs.uk</a>  Dr Nainal Shah, Consultant 0116 258 5057 <a href="mailto:nainal.shah@uhl-tr.nhs.uk">nainal.shah@uhl-tr.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	8, 13.

3. Mental Health Intermediate Care Service, Nottinghamshire Community Health	
<b>Aims</b>	<p>The Specialist Mental Health Intermediate Care Service works within <i>Level 3 Moderate to Complex &amp; 4: Specialist mental health</i> within the Nottinghamshire 5 step care model for older people’s mental health services. The team provides an accessible, equitable and quality service, based on evidence-based practice for older people presenting with higher risk, complex mental health problems requiring more frequent intervention and management and co-morbid physical problems.</p> <p>The main aims are to:</p> <ul style="list-style-type: none"> <li>➤ To provide rapid assessment to people in the community at risk of losing their independence and to provide support to avoid unnecessary admission to hospital or care</li> <li>➤ To work with individuals and their families to facilitate timely and safe discharge from acute and specialist mental health beds</li> <li>➤ To support people in residential care who wish to return to the community</li> <li>➤ To work with other “end of life” services to support people to die at home if this is their wish and that of their carers.</li> </ul>
<b>Dementia Strategy Outcomes</b>	<p>Objective 6: Improved community personal support services – the team provides specialist advice and training on an individual case by case basis to improve capability in mainstream home care services.</p> <p>Objective 7: Implementing the Carers’ Strategy – the team provides advice and training to carers on an individual case by case basis.</p> <p>Objective 9: improved intermediate care for people with dementia – the team provides specialist intermediate care for people with moderate dementia.</p>
<b>Local Context for Initiative</b>	<p>NHS East Midlands’ strategy <i>From Evidence to Excellence</i> June 2008 prioritised equal access to physical health services for older people with mental health problems.</p> <p>Improved intermediate care services and reablement services were also prioritised in Nottinghamshire’s <i>Joint Commissioning Strategy</i> 2009. This is a jointly commissioned service with financial investment from both the PCT and Local Authority.</p> <p>The service is currently available in one cluster, Principia. The service commenced September 2008.</p>
<b>Achievements/ Benefits</b> <b>To Include:</b> - <b>Quality Improvements</b>	<ol style="list-style-type: none"> <li>1. Improved patient satisfaction</li> <li>2. Improved carer satisfaction</li> <li>3. Improved quality of life for people with dementia</li> <li>4. Enable people to be supported at home/ in the community for longer</li> <li>5. Improve capability and quality in mainstream home care or day care services through the provision of a specialist outreach liaison service offering advice,</li> </ol>

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<ul style="list-style-type: none"> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>support, training and education</p> <p>6. Improve links with primary and secondary care and mainstream intermediate care</p> <p>7. The Team is a resource for other services</p> <p>The Team has contributed to significant reductions in use of mental health inpatient beds compared to other clusters in the PCT.</p>
<p><b>Challenges</b></p> <p>- <b>How these were addressed</b></p>	<p>The main challenge has been implementing this as an alternative pathway for avoidable admissions to general hospital since it is only available in one PBC cluster. There are some good case studies around individual patients but this has not had an impact on contract activity yet.</p> <p>This model is being explored as part of the QIPP agenda to determine if it can be rolled out to the wider health community.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- <b>What does it take to make this happen?</b></p>	<p>The Team is a multidisciplinary NHS team. Adult Social Care &amp; Health also fund a dedicated social worker.</p> <p>The team operates as a virtual ward with a caseload of about 25 people who receive care for 9-12 weeks – about 130 people p.a.</p> <p>The Team are also able to commission ongoing Home Support via the ASCH Framework system and provide relevant training/handover for generic home care staff.</p>
<p><b>Transferable Learning</b></p>	<ul style="list-style-type: none"> <li>• The service is located in a primary care centre which has facilitated closer working with primary care staff. The Community matron is located in the same building and close working relationships have been established.</li> <li>• The team use the Nottinghamshire single assessment process (SNAP) which facilitates the sharing of information and there is agreement that health professionals can access the local authority data base.</li> <li>• The open referral system means that the team are more accessible to families and informal carers, although this may increase their level of referrals which result in signposting to other services.</li> <li>• The contribution of the team in working with individuals and families to gain their trust and provide tailored individual short term packages has been particularly helpful in supporting people to engage with community services who have otherwise been resistant to doing so and therefore more likely to have to move to hospital or residential care.</li> <li>• The team works alongside domiciliary care providers to help increase their skills in supporting people with challenging behaviour when the ongoing community package is being arranged.</li> <li>• For some individuals, a residential placement will be the placement of choice; the team has supported individuals moving from long stays in</li> </ul>

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	hospitals in to residential care and has helped to sustain the placement which might otherwise have broken down.
<b>Validation/ Evaluation</b>	<ol style="list-style-type: none"> <li>1. Evaluation reports produced by the service, January 2009 and January 2010.</li> <li>2. CSED report Crisis response and older people with mental health needs, May 2010.</li> </ol>
<b>Sustainability/ Next Steps</b>	<p>A key challenge has been getting sign up to roll this model out across all 5 clusters.</p> <p>NHS Nottinghamshire County agreed at its June 2010 Board to implement the model in one further cluster as part of the Newark Healthcare Review. This is being funded via a ward closure and new investment from ASCH.</p>
<b>Key contact/Locality</b>	<p>Gill Oliver, Mental Health Programme Lead NHS Nottinghamshire County <a href="mailto:gill.oliver@nottspct.nhs.uk">gill.oliver@nottspct.nhs.uk</a></p> <p>Jane Cashmore, Inter-agency Planning and Commissioning Manager Adult Social Care &amp; Health Department Nottinghamshire County Council <a href="mailto:jane.cashmore@nottsc.gov.uk">jane.cashmore@nottsc.gov.uk</a></p>
<b>Dementia Strategy Objectives</b>	9



#### 4. Northamptonshire Dementia Care Advisors Demonstration Site programme

<p><b>Aims</b></p>	<p>The service facilitates access to appropriate care, support and advice to people with dementia and their carers; it supports navigation of the care pathway from referral through specialist services and onto longer term support to enables people to maintain their independence, health, social inclusion and quality of life.</p>
<p><b>Local Context for Initiative</b></p>	<p>The service links a range of strategic developments: most importantly the local response to the National Dementia Strategy, but also the Northamptonshire Carers and Prevention Strategies.</p> <p>Northamptonshire has had some excellent services provided by the County Council NHS and Third Sector for many years, but access has tended to be difficult, capacity insufficient and most importantly, there has been considerable local variation in what is available, a legacy of different PCTs' commissioning and localised development of VCS services.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>For the purposes of the programme, the county has been divided into four areas with one DCA working in each area (the grant funds three FTE posts, but three staff have been appointed on a part-time basis). By June 15<sup>th</sup> 2010, 105 individuals had been referred to the services, of whom 47 were people with dementia and 58 carers. Referrals had been received from Community Mental Health teams, NCC Adult Care Team, Third Sector partners (particularly The Alzheimer's society), carers and customers, and various NHS teams.</p> <p>The DCAs have undertaken extensive promotion of the service and raised awareness across the health and social care system, the wider statutory and voluntary sectors and the general public; they have worked with the NHFT Community Development team to develop links with the BME communities, and have met with a range of groups serving and representing these communities. To develop awareness of the service in rural communities, the DCAs have worked with NCC Libraries Service, visiting villages with a mobile library, and liaised with community transport services, Northants ACRE and care agencies that cover rural areas.</p> <p>The DCAs are also developing a Northamptonshire directory of services aimed at people living with dementia and their carers; this will be completed by August 2010.</p>

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<p><b>Challenges</b></p> <p>- How these were addressed</p>	<p>We were required to use a competitive tendering process to identify a provider, which led to some delays; however, it proved to be an effective and efficient method of identifying a service provider and has resulted in savings against the original budget allowing an additional 50% service capacity to be delivered.</p> <p>Reaching people from BME communities is a challenge, but we are addressing it through hard work and tireless networking by a very committed staff team.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- What does it take to make this happen?</p>	<p>I don't think we could have delivered the service without dedicated Dept. of Health funding.</p> <p>A strong local partnership and 'champions' for dementia services have been essential.</p>
<p><b>Transferable Learning</b></p>	<p>Locating the DCA service within the local mental health provider trust has worked well; whilst demonstration programmes in some parts of the country have struggled to identify appropriate cases, the rate of referral to the Northamptonshire service has been sufficient to meet performance indicators without overstressing capacity. This suggests that the position of the service within the care pathway is optimal.</p> <p>There has been some controversy nationally about whether the DCA service should address the needs primarily of people with dementia, or whether it should also offer support and advice to carers. The evidence from the Northamptonshire programme so far suggests that the two are inseparable and that by addressing the needs of 'family units' the service is proving more effective than would be the case if it focussed exclusively on the needs of people with dementia.</p> <p>It is clear that advice about legal and financial issues, medical prognosis and treatment and social care and support have featured significantly in the advisors' work; referral to services that can help people 'live well with dementia' are also important, as is emotional support from a professional with a good understanding of the condition.</p>
<p><b>Validation/ Evaluation</b></p>	<p>It would be premature to try to draw conclusions about the outcomes for customers that the programme is delivering at such an early stage; the national evaluation will assess outcomes systematically and independently. However, the evidence suggests that people with dementia and their carers are better able to access appropriate advice and support through the project, and that they are being signposted to services that enable them to maintain their health, quality of life and independence. This is a priority for both the National Dementia Strategy and Northamptonshire's local response, and it would be reasonable to infer that customers and carers are better supported and better able to 'live well with dementia' as a result. There is also evidence that the service is reaching groups that have not in the past accessed dementia services. Without prejudging formal evaluation, therefore, there are grounds for considerable optimism and satisfaction at this stage.</p>

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<b>Sustainability/ Next Steps</b>	We will need to convince potential funders of the value of the service this year; unfortunately, the slippage of the national evaluation's timescales means we will rely on local evidence that is not independently validated.
<b>Key contact/Locality</b>	Jonathan Ward-Langman Northamptonshire County Council <a href="mailto:JWardLangman@northamptonshire.gov.uk">JWardLangman@northamptonshire.gov.uk</a>
<b>Dementia Strategy Objectives</b>	1, 2, 3, 4, 6, 10

**EAST OF ENGLAND**

5. Increasing awareness and uptake of Direct Payments and Personal Budgets by people with dementia and their carers in the East of England	
<b>Aims</b>	<p>The social care Joint Improvement Partnership (JIP) in the East of England funded a project manager to facilitate the development and enhancement of the processes that enable people with dementia to receive and manage a personal budget or direct payment.</p> <p>The outcomes of the project will be:</p> <ul style="list-style-type: none"> <li>• To increase the number of people with dementia who are aware of personal budgets and direct payments.</li> <li>• To increase the number of people with dementia receiving a personal budget or direct payment.</li> </ul>
<b>Local Context for Initiative</b>	<p>The East of England JIP prioritized dementia in its work in 2009/10. This role was created in order to drive the personalisation agenda forward for people with dementia and to ensure a positive change towards this in the service support given to people with dementia and families.</p> <p>Currently, many services for people with dementia are pre-purchased by local authorities and people are often “slotted into” large scale services or offered short periods of support, sometimes as little as 15 minutes and in many cases with a different carers visiting on a daily basis. This type of support can be detrimental to people with dementia who rely on routine and consistency of care in a familiar environment. Cash payments can provide the type of personalised support which will enable people to remain in their own homes, stay in control of the type of support they receive and have the flexibility of care that meets the fluctuating needs of the illness. Individualised care would also help people with dementia remain active and healthy longer with resources becoming available at any given point along the ‘dementia journey’.</p> <p>There are challenges to providing this type of support to people with dementia, in particular ‘risks’. However, these risks are often ‘perceived potential’ risks that can be managed and minimised by a comprehensive risk assessment, while still promoting independence, dignity and choice</p>
<b>Achievements/ Benefits</b>	<p>The project manager has linked in with key partners and organisations working in personalisation and dementia to create a shared agenda. These have included Dementia Choices, regional groups working on workforce development and training, and work on personal health budgets.</p>
<b>To Include:</b>	<p>The project manager has worked with the local authorities and other organisations to establish a monitoring system to evaluate the numbers of people with dementia accessing and using an individual budget or direct payment. Baseline data has been collected from manual team records</p>
- <b>Quality Improvements</b>	<p>The project manager has facilitated positive risk taking through</p> <ul style="list-style-type: none"> <li>• the adaptation of a person centred risk assessment</li> </ul>
- <b>Innovation</b>	
- <b>Productivity (cost efficiencies)</b>	
- <b>Prevention</b>	

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<p>- <b>User/Carer Involvement</b></p>	<ul style="list-style-type: none"> <li>designing and producing a process chart in relation to the new Direct Payment regulation for practitioner use – this clarifies issues in relation to capacity</li> </ul> <p>This work has been undertaken in collaboration with the Social Care Institute for Excellence (SCIE).</p> <p>The project manager has increased knowledge and understanding of opportunities created by individual budgets for people with dementia and their carers. This has been achieved through linking with regional and local Alzheimer’s workers, including the newly appointed Dementia Advisers; with regional leads and carers groups across the region; with carers training. Some of this work has been with a carer who supported her husband at home with the support of Direct Payments, Independent Living Fund and carer’s Direct Payments, and who is willing to share her experience with groups of carers and professionals. Carers have been very keen to learn about what support is available and how to access this and this has highlighted the need for information for carers on what is available.</p> <p>The project manager has worked directly with local authorities and Mental Health trusts to review and enhance their current processes by which people with dementia access an individual budget. This has included reviewing and establishing ‘care pathways’.</p>
<p><b>Challenges</b></p> <p>- <b>How these were addressed</b></p>	<p>There were difficulties in getting response at team level in local authorities once the initial contact was made with councils. The project manager contacted councils again asking for nominated ‘champions amongst frontline staff to support the implementation of the new tools and culture change.</p> <p>A lack of awareness and understanding of direct payments among front line professionals and also a lack of leadership and commitment to implementing Direct Payments /Personal Budgets from middle management. This is the area of least knowledge and in some cases is blocking progress and creativity. Mental health teams need concentrated support to recognise the benefits of Direct Payments /Personal Budgets for people with Dementia and mental health in general. The project manager has set up 4 workshops to action change, targeted at 80 team leaders and senior practitioners. The learning from the workshops will be shared across health and social care. The workshops will be followed up by the Project Manager to ensure change is happening.</p> <p>Inability to obtain quantitative data from local authorities regarding the numbers of people with dementia receiving a Direct Payment (they are only being asked to collect data according to main client groups and data specific to dementia is not being collated). Individuals and teams have been able to provide some accurate manual data that can be used as a baseline.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- <b>What does it take to make this happen?</b></p>	<p>The project has needed dedicated staff time and senior manager support, plus partners such as the voluntary sector who are willing to engage. This has had to be coupled with an ability to assess what the obstacles to improvement are and to devise appropriate responses such as tools and training.</p>

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<b>Transferable Learning</b>	<p>To make the take up personal budgets and direct payments a reality for people with dementia and their carers there needs to be a culture change amongst middle managers to personal budgets and direct payments in general, not only for people with dementia.</p> <p>Personal experience e.g. from a carer who has used personal budgets/direct payments has resonated strongly with carers, similarly the first hand experience of the project manager in working with people with dementia in a personalised way has resonated with staff.</p>
<b>Validation/ Evaluation</b>	<p>The project has been evaluated by the project worker against the agreed work plan. The JIP has agreed to fund the post to September 2010, a year in total.</p> <p>The project manager has been invited onto the reference group of the national Dementia Choices project and is working with them to produce written information for people with dementia regarding Personal Budgets and Direct Payments.</p>
<b>Sustainability/ Next Steps</b>	<p>To date objectives have are been met, especially around increasing awareness amongst individuals and in embedding this is e.g. in workforce development plans, carers work.</p> <p>It is too early to determine what impact the project has had on increasing the numbers of people with dementia that are receiving a PB or DP. Further work on monitoring systems, the implementation of the tools, further concentrated effort to engage at team level and middle manager training are designed to drive the culture change forward. This is the focus of the work for 2010/11.</p>
<b>Key contact/Locality</b>	<p>Tina Lightfoot, Project Manager            Tel: 01473 709298            E-mail: <a href="mailto:Tina.Lightfoot@essex.gov.uk">Tina.Lightfoot@essex.gov.uk</a></p> <p>Documents and reports can be found on <a href="http://www.jipeast.org">www.jipeast.org</a> under workstreams – dementia.</p>
<b>Dementia Strategy Objectives</b>	<p>Objective 6 - community services            Objective 7 - carers</p>

## 6. Memory assessment and support service (MASS) piloted by North Essex Partnership NHS Foundation Trust (NEPT)

<p><b>Aims</b></p>	<p>North Essex Partnership NHS Foundation Trust (NEPT) set up a memory assessment and support service (MASS) in collaboration with Alzheimer's society in January 2009. It aimed to provide a single point of entry for all new referrals with dementia/possible cognitive impairment, irrespective of age. MASS provides a full diagnostic, treatment and support facility for adults experiencing cognitive impairment. The aim is to provide a seamless service for those members of the population who are suffering from cognitive impairment in the mid Essex area, with a very strong emphasis on supporting carers and families of the person diagnosed with dementia. This requires a clear referral pathway to ensure the process, including a structured disclosure meeting, is conducted smoothly and efficiently, whilst ensuring it is understandable to people with dementia and their carers.</p>
<p><b>Local Context for Initiative</b></p>	<p>Prior to 2009 there were a range of processes, approaches and systems for diagnosis, prescribing and monitoring anti-dementia medication, depending on age, the area in which people lived, their consultant, and route of referral through pathway. In total there were 19 potential points of access in NEPT to memory services. Piloting a memory assessment and support service (MASS) for an 18-month period would enable better understanding of the demand for such a service and obtain better quality data on dementia prevalence in Mid Essex.</p> <p>Services to younger people with young onset dementia were not consistent and often patients and their families were having to go out of area to access good quality services.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The MASS service has shown some distinct benefits over the previous pathway arrangements. A simplified care pathway includes:</p> <ul style="list-style-type: none"> <li>• GPs performing dementia screening and eliminating inappropriate referrals.</li> <li>• Single point of entry, seamless service which includes younger adults with cognitive impairment.</li> <li>• Single uniform comprehensive assessment with the first appointment always taking place at the patient's home.</li> <li>• Structured diagnosis and disclosure appointment with support and aftercare.</li> <li>• Every carer is offered carers assessment, support and signposting</li> <li>• Improved access to Neuro psychological testing.</li> <li>• Coordinated, comprehensive MDT discussion for every service user's assessment and plan.</li> <li>• Uniform approach to prescribing of anti-dementia medications and subsequent monitoring, ensuring consistency of service and fair access to treatment.</li> </ul> <p>The service works collaboratively with voluntary services to ensure there is no duplication, pulling resources together to maximise patient outcomes.</p>

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	<p>Service activity has increased with a speedier response to referrals, assessment, diagnosis and treatment. There were 642 referrals made over the year (2009), with an average 53.5 referrals being made per month. The majority of referrals (84%) were made from GP practices and 99.5% of referrals were allocated an appointment within 7 days of referral. For 58% of those referred, a home assessment was carried out within 14 days of allocation (or within 21 days of the original referral).</p> <p>Of the original 642 cases referred, 74.5% were diagnosed with dementia in the 2009/2010 period. Within the MASS pathway, 22.4% were diagnosed after the first appointment, 55.4% after the 2nd appointment and 22.2% after the third.</p> <p>The patients and their carers believe that MASS provides personal care, that it is easily accessible by service users, that it covers the wide range of service user needs, shows high levels of coordination and continuity, and that it provided good medical treatment for users and imparted good coping strategies to carers and service.</p> <p>Because there are better ways of monitoring, clinicians are able to take a greater chance in prescribing to high risk patients where in the past they would not have done so. Thus some people with dementia have improved access to anti-dementia drugs.</p> <p>There were 50 GP practices covered by the service. Comparing their dementia registers for March 2008 and March 2009 found an overall increase of 88 new patients on the registers (22 practices showed a reduction in the number of cases and 25 showed an increase in patients). The evaluation report looked at two GP surgeries in more detail - one had 36 patients on their register in December 08 compared to 52 in December 09 and the other had 82 on their register in December 08 compared to 108 in December 09. Comments from both of these surgeries is that GPs feel it is a good service and the pathway works well.</p> <p><i>My 85 year old mother was diagnosed with dementia through the memory clinic in September 2009. Our family have found this service to be first class. The co-ordinated aspects are valued by my parents. We have enjoyed seeing the same person throughout the treatment. My father (also 85) has benefited greatly from the referral to the Alzheimer's staff who are part of the unit. As a result my mother is receiving excellent medical treatment and, as a couple, my parents are managing to cope with the aid of practical aids and benefits. Congratulations on this initiative (family member).</i></p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>One of the main issues was to agree a care pathway that helps to ensure that certain screening is done to eliminate other possible causes for memory difficulties prior to referral to MASS. Through consultation with primary care and GPs, the service was able to devise a pathway that is simple and quick to follow. This process also gained commitment from other health colleagues to the pathway in order to change the traditional route for referral to a single point of access. It has worked very well although initially there were teething problems.</p> <p>The team carried out a big launch of the pathway prior to the pilot starting by distributing leaflets etc about the service and visited many GP surgeries to reinforce the message.</p> <p>People with memory problems/dementia and their carers receive a service that is</p>



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	<p>person-centred This is particularly challenging because it means that the team needed to pay attention to details, as well as coordinating all appointments to ensure patients and their carers are seen by the same person who carried out the initial and subsequent (if any) assessments. There is a formal part of the disclosure meeting and an informal supportive chat by the support worker, where carers and patient are given additional support or to further clarify anything that they did not understand. This has placed particular pressure on the administrative staff to develop and improve processes.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>The service is staffed by doctors, nurses (3 band 6 and one band 5 nurse and 3 support workers one of whom is from the Alzheimer's Society), a band 3 whole time equivalent administrative support and psychology staff (recently recruited). It utilises existing medical staff to feed into the memory assessment on a sessional basis and one of the consultant psychiatrists has taken the clinical lead for the service. An occupational therapist is brought into the service as and when needed. The team leader at the local day hospital also oversees the day to day management of the service.</p> <p>The base for the service is The Crystal Centre, Broomfield Hospital in Chelmsford. Appointments may be carried out in a clinic or people's own homes - the first assessment is almost always carried out in the patient's own home with their carers and relatives.</p> <p>Physical examinations and blood tests are currently being undertaken in primary care settings, if a brain scan is required this is arranged at another time at the local acute hospital which is on the same site.</p> <p>Treatments may include memory enhancing medication, attendance at day centres and attendance at therapy groups. Support for carers is an integral part of the service.</p>
<p><b>Transferable Learning</b></p>	<p>Successfully developing an integrated service requires significant negotiation with all providers involved in the service to redesign pathways and maximise the use of existing resources. Key stakeholders in this model have been GPs and the voluntary sector.</p> <p>A person centred approach depends on excellent administrative staff to co-ordinate the process.</p> <p>Evaluation is of greater benefit if started before the pilot to establish baselines.</p>
<p><b>Validation/ Evaluation</b></p>	<p>The service was externally evaluated by Bournemouth University. The evaluation commenced after the service began to operate so it was not simple to make comparisons with the previous service or to establish cost effectiveness fully. The evaluation found that the MASS service has shown some distinct benefits over the previous pathway arrangements. Service activity has increased with a speedier response to referrals, assessment, diagnosis and treatment. There has been a consequent increase in the number of people being diagnosed with dementia (at an earlier stage) and revealed in the numbers on the Dementia register. The integrated service, within a purpose-built unit, has distinct advantages and this was emphasised by the positive comments from service-users, carers, family and staff. There are increased costs associated with the service, not least because of initiating and monitoring treatment, especially anti-</p>

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	dementia drugs to a larger population, based on earlier diagnosis.
<b>Sustainability/ Next Steps</b>	<p>The team are reviewing service redesign to ensure they are to maximising the use of resources to improve patient outcomes. Overall the level of referrals were higher than expected which creates issues for the long term sustainability of the service.</p> <p>The formal evaluation of the pilot, carried out by Bournemouth University, coupled with service redesign, is supporting dialogue with commissioners to ensure that the service can continue. The evaluation recommended that a dedicated medical service rather than sessional input would improve consistency and continuity of care.</p>
<b>Key contact/Locality</b>	Michelle Thompson North Essex Partnership NHS Foundation Trust <a href="mailto:Michelle.thompson@nepft.nhs.uk">Michelle.thompson@nepft.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	2, 3, 4.

## 7. The Peterborough Palliative Care In Dementia Group

<p><b>Aims</b></p>	<p>The group exists to provide a peer support network for a wide range of professionals in primary and secondary care and the care home sector.</p> <p>It</p> <ul style="list-style-type: none"> <li>• provides a local focus for leading on and supporting the implementation of national strategies in relation to palliative care in dementia.</li> <li>• develops and disseminates expertise on working with people with dementia at the end of life in particular in nursing and residential homes, also in hospital wards and community settings.</li> <li>• sets and improves standards in relation to this.</li> <li>• provides an education and training function through a series of symposia, presentations at conferences, publications and websites.</li> </ul>
<p><b>Local Context for Initiative</b></p>	<p>The group was prompted by recognition of lack of knowledge and skills in end of life care for people with dementia and examples of poor practice. Emergency hospital admissions, especially at the end of life and a perceived lack of support for care home staff during Out of Hours, were a particular concern. (An audit of emergency hospital admissions from 6 care homes was carried out for 2005/06 and repeated for 2008/09).</p> <p>The group reports to the Peterborough End of Life Steering Group and brings together a wide range of expertise: Palliative Care Consultant, GP lead, local GPs, Care home managers and staff, Consultant Psychiatrist, Consultant Psychologist, Community Dietician, Speech and Language Therapist, Community Macmillan Nurse, Community Psychiatric Nurse, Memory Clinic Staff, Modern Matrons – Community and In Patient.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p><b>Achievements</b></p> <p>Key activities of the group include:</p> <ul style="list-style-type: none"> <li>• Provided 3 training days for over 60 people from a variety of professions.</li> <li>• Modified Liverpool care pathway for use in dementia.</li> <li>• Training in and use of the Doloplus 2 Pain scale for older people with communication difficulties.</li> <li>• Developed acute agitation guidelines for use in care homes and wards.</li> <li>• Adopted the BMA/RGN guidance on DNAR using the “Allow a Natural Death” documentation.</li> <li>• Contributed to journal articles on feeding and end of life care.</li> <li>• Carried out an audit of place of death of older peoples in care homes in Whittlesey.</li> <li>• Liaised with Commissioners, GPs and care Homes re GP alignment to care homes. (Peterborough PCT has created a Locally Enhanced Services (LES) for GP practice: care home alignment. The PCDG was responsible for drawing up the GP service specification incorporated into the LES).</li> </ul>

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	<p>A conference early in 2010 attracted over 100 people including care home staff, mental health staff and GPs. The conference covered</p> <ul style="list-style-type: none"> <li>• Medical and Nursing Aspects of the Hospice Approach for Care Home Patients</li> <li>• Anticipating Events in the Last Months of Life - Prognostic indicators, planning, staying put</li> <li>• A Practical Guide to the Mental Capacity Act and Deprivation of Liberty Safeguards</li> <li>• Eating Difficulty and Compromised Swallowing</li> <li>• The value of life stories</li> </ul> <p>The group produced for the conference 'Compromised Swallowing – a practical guide to nutrition, hydration and medication in advanced dementia'. The guide was distributed to participants, every Care Home in Peterborough, all GP practices in the area and the Out of Hours service.</p> <p>Use of the various tools produced by the group has increased family carer involvement in advance care planning.</p> <p><b>Benefits</b> Health staff have clear evidence of increased confidence and improved practise in care staff, which has improved quality of care and reduced emergency care home admissions.</p> <p>The audit of emergency acute hospital admissions was repeated for 2008/9 and shows a significant drop in emergency admissions and a rise in the numbers dying in care homes as opposed to hospital from around 55% to 75%.</p>
<p><b>Challenges</b>  - How these were addressed</p>	<p>Key challenges were:</p> <ul style="list-style-type: none"> <li>• Engagement of GPs, out of hours staff and care homes staff</li> <li>• Improving confidence and practice in care staff in end of life care for people with dementia.</li> </ul> <p>These were overcome by good leadership, high commitment of staff, and a common focus.</p> <p>Tools were developed to support practice and this was backed up by training.</p> <p>Work by the PCT on aligning GP practices and care homes has supported improved joint working and relationships.</p>
<p><b>Resources/ Capability/ Capacity</b>  - What does it take to make this happen?</p>	<p>Commitment by a core group of staff to give their time and expertise with managerial support.</p> <p>Funded from within existing services for meetings and venues.</p> <p>Conferences delivered free of charge to delegates to encourage maximum participation by all sectors especially the care home sector.</p> <p>Administrative support provided from within the core team's resources.</p> <p>Some support from drug companies for conferences with refreshments.</p>

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	<p>Support from care home group with conference costs and the printing of limited copies of the Compromised Swallowing booklet.</p> <p>The guidelines etc have been published on a website which is hosted by the GP practice of the lead GP of the PCDG. The charge for uploading material has been borne personally by the GP.</p>
<p><b>Transferable Learning</b></p>	<ul style="list-style-type: none"> <li>• Most of the resources created by the group are accessible on the internet so are transferable. The Compromised Swallowing Guide (which covers nutrition, hydration and medication in advanced dementia) is available as a download.  <a href="http://www.endoflifecareforadults.nhs.uk/publications/compromised-swallowing-a-practical-guide">http://www.endoflifecareforadults.nhs.uk/publications/compromised-swallowing-a-practical-guide</a></li> </ul> <p>However the success of the group has depended on good leadership and commitment by a core of staff. Resources on their own will not make a difference; they need to be backed by training. Conversely the application of training is supported if tools such as guidelines already exist.</p> <p>A partnership approach which shows appreciation of other partners' problems, and values what everyone brings to the issue is essential, plus a willingness to learn from what goes wrong.</p> <p>Lessons learned have been disseminated through conferences and at local practise level. Documents and work done are available on the following website:  <a href="http://www.dementia.jennerhealthcentre.co.uk">www.dementia.jennerhealthcentre.co.uk</a>  and have been publicised throughout the Eastern Region.</p>
<p><b>Validation/ Evaluation</b></p>	<p>The 2010 conference evaluations gave the overall content, relevance, and presentations scores of 4.3 or above (out of 5). Two thirds of additional comments were positive:</p> <p>“Excellent day. Inspired by the singing group to look for funding to get activities like this to improve quality of life ....as well as lots of practical stuff re end of life care.”</p> <p>“Very informative and well put together. Nice to have an in-depth study day dedicated to a vital part of care and to be so well covered, a need for a modified session to be passed down to those delivering the care”</p> <p>The End of Life Care strategy makes mention of the Lead GP approach to patients in care homes (The Gables) as does the Nuffield Council for Bioethics report Dementia: Ethical Issues (P 53). The current GP chair is now a Research Fellow at Oxford as a result of her active involvement. Dr Evans presented on GP involvement in End of life Care in Care Homes at the 3<sup>rd</sup> National Care Homes Congress-</p> <p>Health staff have clear evidence of increased confidence and improved practise in care staff. The audit of emergency acute hospital admissions was repeated for 2008/9 and shows a significant drop in emergency admissions and a rise in the numbers dying in care homes from around 55% to 75%. This</p>

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	is more fully explored in a paper by Dr Gillie Evans which will be published in the Journal of Evaluation in Clinical Practice later this year.
<b>Sustainability/ Next Steps</b>	<p>The group will continue to meet. The work of the group has been disseminated within the Eastern region, especially amongst people working on palliative care and dementia to reduce duplication of effort and improve quality of care.</p> <p>The group would like to make the tools and educational material that they are producing available to the wider medical, nursing and care home sectors (including all the current documents and protocols on the website <a href="http://www.dementia.jennerhealthcentre.co.uk">www.dementia.jennerhealthcentre.co.uk</a>) and also speakers' presentations, journal articles, contributions to books etc. Ideally they would like to create a website which could be a national resource, but they have not been able to secure funding.</p>
<b>Key contact/Locality</b>	<p>Dr Gillie Evans (chair of group), GP, Jenner Health Centre Whittlesey Cams PE7 1EJ <a href="mailto:gillieevans@tiscali.co.uk">gillieevans@tiscali.co.uk</a> or <a href="mailto:gillie.evans@nhs.net">gillie.evans@nhs.net</a></p>
<b>Dementia Strategy Objectives</b>	11, 12.

8. Flexible Enhanced Domiciliary Care for people with dementia – Waveney, Suffolk	
<b>Aims</b>	To provide a flexible and enhanced level of domiciliary care for people with dementia at moments of crisis or strain. The service gives an opportunity to stabilise situations, and allow for clearer assessment as to people’s ongoing needs.
<b>Local Context for Initiative</b>	The service was originally commissioned as a pilot service on a spot purchase basis, utilising Residential budgets to support people through moments of crisis, rather than allowing the crisis to develop resulting in inappropriate admissions to hospital or into residential services. It is provided by an independent domiciliary care agency that recruited and trained staff to work specifically with referrals to it. The service works directly with the Older People’s Mental Health Social Work service which acts as gatekeepers to it.
<b>Achievements/ Benefits</b>  <b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> - <b>User/Carer Involvement</b>	Experience from the service is that it has over the past 18 months worked with 110 people and successfully: <ul style="list-style-type: none"> <li>- Supported a number of people to maintain their independence, before being handed back to mainstream domiciliary care</li> <li>- Avoided 46 hospital admissions</li> <li>- Avoided 16 placements into residential care</li> <li>- Supported 9 other people who would otherwise either have gone into hospital or into residential care</li> <li>- Avoided at least 25 breakdowns in family care arrangements</li> <li>- Avoided a number of safeguarding issues, including abuse and self-harm</li> </ul>
<b>Challenges</b>  - <b>How these were addressed</b>	<ul style="list-style-type: none"> <li>- Budgetary pressures: the service was established with a presumption that its existence would save on the residential budget. Experience has borne this out, and also demonstrated the impact on hospital admissions, which is underpinning the business case for joint funding of the service</li> <li>- How to avoid the service being clogged up: the service is established to see people through a period of crisis and reach a period of stability. With this in mind, it is important that there is a hand-off back to mainstream services. This has been managed by having clear gate keeping to the service, clear expectations that it remains a short-term service and clear dialogue between to avoid gatekeepers, the service and mainstream services.</li> </ul>
<b>Resources/ Capability/ Capacity</b>	<ul style="list-style-type: none"> <li>- “Leap of faith”</li> <li>- Clear gate keeping</li> <li>- Close working between provider and assessor services</li> <li>- Skilled, flexible workforce able to provide a “same-day” service that is</li> </ul>

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<b>- What does it take to make this happen?</b>	flexible up to and including “live-in” care for the period of crisis <ul style="list-style-type: none"> <li>- Good working relations between social care and health</li> </ul>
<b>Transferable Learning</b>	<ul style="list-style-type: none"> <li>- The service has been most effective due to clear and on-going dialogue between the provider agency and the Older People’s Mental Health Social Work Team</li> <li>- Staff working on the service have found the experience liberating by contrast with mainstream domiciliary care, giving them time to work effectively with people rather than allow crises to escalate</li> <li>- The enhanced, flexible nature of the service has allowed more effective assessment of people’s ongoing needs</li> <li>- Whilst the service specification does not require clinical input/assessment, the service and staff who work on the dementia project have benefitted from the experience, support, mentoring and supervision of an experienced mental health nurse line managing staff and assessing the clients.</li> </ul>
<b>Validation/ Evaluation</b>	Outcomes from the service have been continually monitored, giving support and evidence for the on-going need for the service and its effectiveness. This has particularly shown the links between effective support in the community and reductions in hospital admissions.
<b>Sustainability/ Next Steps</b>	The service was established on a pilot basis and was procured through a tender exercise, utilising social care residential budgets. These are under increasing strain, at the same as the contract is due to expire, bringing a requirement to re-tender. This, along with the clear intermediate care impact of the service has brought a dialogue between Social Care and PCT for the joint-funding and re-tendering of the service.
<b>Key contact/Locality</b>	John Lambert Suffolk Adult Community Services <a href="mailto:John.lambert@suffolk.gov.uk">John.lambert@suffolk.gov.uk</a>
<b>Dementia Strategy Objectives</b>	6, 7, 9.



**LONDON**

**9. Commissioning support for London  
Dementia Services Guide and Appendices**

[http://www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon\\_Dementia-services-guide.pdf](http://www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon_Dementia-services-guide.pdf)

The Dementia services guide offers an integrated care pathway which provides guidance about effective services.

The appendices offers a wide range of information and tools to support implementation:

- Appendix 1: Needs assessment
- Appendix 2: Workforce competencies for integrated care pathway
- Appendix 3: Workforce competencies for general hospital care pathway
- Appendix 4: Role description for dementia clinical lead
- Appendix 5: Role description for dementia adviser
- Appendix 6: Investigation into the cost of dementia in London and the savings needed to ensure investment in memory services is cost neutral
- Appendix 7: Consideration of the impact of the introduction of mental health Payment by Results (PbR) and the introduction of personalised health budgets on dementia services
- Appendix 8: Outcomes
- Appendix 9: Equality Impact Assessment
- Appendix 10: Memory service performance metrics
- Appendix 11: Memory service mapping
- Appendix 12: ICD-10 codes used in acute and mental healthcare
- Appendix 13: Patient information pro forma

<p><b>Aims</b></p>	<p>The Dementia services guide and appendices were designed to help advice London Commissioners and clinicians in health and social care how to design and implement an integrated care pathway for dementia which meets the needs of their own community; supporting planning, quality and performance. The integrated care pathway is based on the recommendations made in the <i>National Dementia Strategy</i> and highlights the benefits of change and the need to improve services for people with dementia and their immediate carer. The appendices offer commissioners a wide range of information and tools, including a job description for the clinical lead, a detailed needs assessment, financial modelling.</p>
<p><b>Local Context for Initiative</b></p>	<p>Recent reports had identified that although mental healthcare provision is strong in some areas of the capital, the service is not provided consistently well across London.</p> <p>The Healthcare for London strategy was established by the capital's 31 primary care trusts (PCTs) to change healthcare services and has been working to transform the way people with mental health conditions receive care.</p> <p>London has a high prevalence of people with mental health conditions compared with the national average, and levels are high in boroughs with high levels of deprivation.</p>

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	<p>The design of the dementia services guide and the integrated pathway framework Offers organisations the opportunity to develop a consistent care pathway while taking local differences into account.</p> <p>This will include local commissioning patterns of health and social care services for older people with mental health problems, as well as the availability of key staff, the critical mass required, cost effectiveness and accessibility for people who may have dementia and their carers.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>The integrated care pathway is an age inclusive pathway based on a multi-disciplinary, multi-agency, planned approach to the delivery of high quality care and support for people with dementia and their carers</p> <p>It sets out general guidance about services and interventions including effective treatment and therapies for delivering high quality care</p> <p>The pathway was developed along the principles of:</p> <ul style="list-style-type: none"> <li>• prevention</li> <li>• identification</li> <li>• assessment and diagnosis</li> <li>• early intervention and treatment</li> <li>• living well with dementia</li> <li>• end-of-life.</li> </ul> <p>The integrated care pathway fully meets the objectives of the QIPP agenda.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>Most of the challenges were around getting organisations to meaningfully engage.</p> <p>We felt this needed to be addressed at a strategic and operational level by having an effective governance system. We found that clear governance arrangements helped to overcome some of the challenges and had the power to drive change and change culture.</p> <p>The dementia implementation pan London is supported by a steering group. The membership is the London region DRD, Chair of the PCTs, Dementia lead for London ADDAS, Managers from commissioning support for London.</p> <p>There is a task and finish group which is chaired by the London Dh regional dementia lead with representatives from London councils, Commissioning support for London, the London regional carers lead and the Alzheimer's society . The group consults extensively with an extended reference group the membership is wide including people with dementia. Carers, people with an interest in dementia, clinicians, independent and third sector.</p> <p>The task group found that some parts of the pathway needed more explicit 'how to guides' and the task group has work in progress to produce theses additional guides.</p>

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<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>To make an all system change takes sign up from all partner organisations, With high level board sign up to ensure a whole cultural change.</p> <p>We found that commissioners benefited from implementation workshops especially those that contained practical examples, good practice and information about efficiencies, what good looks like, practical ideas of how to make changes.</p>
<p><b>Transferable Learning</b></p>	<p>We have found that sharing the learning is the key to successful implementation pan London.</p> <p>The appendices – have been found to be helpful by organisations, they encouraged engagement to ensure that developments in services really meet the needs of the communities and have helped to shape the services.</p> <p>The task group regularly hosts good practice events which help to move the pockets of good practice around the capital.</p>
<p><b>Validation/ Evaluation</b></p>	<p>We will be having a review of the guide in October and it will be updated where necessary.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The task group will continue to collect and share good practice and we will publish good practice evidence and contacts.</p>
<p><b>Key contact/Locality</b></p>	<p>Lesley carter, London region dementia lead DH social care and partnerships <a href="mailto:Lesley.carter@dh.gsi.gov.uk">Lesley.carter@dh.gsi.gov.uk</a></p> <p>David Truswell Commissioning support for London <a href="mailto:David.Truswell@csl.nhs.uk">David.Truswell@csl.nhs.uk</a></p>
<p><b>Dementia Strategy Objectives</b></p>	<p>The dementia services guide covers</p> <ul style="list-style-type: none"> <li>• Prevention</li> <li>• Identification</li> <li>• Assessment and diagnosis</li> <li>• Living well with dementia</li> <li>• End of life care</li> <li>• The general hospital pathway</li> <li>• Memory services</li> <li>• Liaison services</li> </ul>

<b>10. Greenview Intermediate Care Unit Woodland Hall Nursing Home</b>	
<p>An in-patient Intermediate Care resource with 12 individual en-suite rooms.</p>	
<p><b>Aims</b></p>	<p>To offer in-patient physical rehabilitation to people with dementia and/or delirium (acute confusional state) in order to give them the best possible opportunity and support to return home safely following an acute hospital admission.</p>
<p><b>Local Context for Initiative</b></p>	<p>Harrow health and social care partner agencies were concerned about the number of people who were being placed into Care Homes immediately after an inpatient admission for illness or injury, or getting “stuck” as a complex discharge, when the problem which was preventing their rehabilitation and return home was related to their mental or psychological state.</p> <p>A meeting was held for all interested parties in August 2008 where the concept was suggested. A Nursing home had been identified which already worked successfully with the PCT to provide long term Continuing Care placements, but which had some spare capacity.</p> <p>Harrow PCT – now <b>NHS Harrow</b> – Commissions the service in conjunction with Harrow Council.</p> <p><b>Care UK</b> provides the venue and the daily care and nursing staff. The <b>GP</b> attached to Woodland Hall serves the unit. <b>Central &amp; North West London NHS Foundation Trust</b> provides the Registered Mental Health nurse (1 wte) who coordinates the Unit, the Consultant Psychiatrist for Older People (1 session per week), the Speciality Doctor (0.5 wte) and Psychologist (20 hours per week). <b>NW London Hospitals Trust</b> provides the Consultant for Care of the Elderly (1 session per week) <b>HART</b> (Healthcare and rehabilitation team) coordinates the therapy input – 1 wte OT and 1 wte Physio; Point of access for service referrals.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p><b>Quality improvements</b></p> <ul style="list-style-type: none"> <li>• 58% of patients in the first year of operation returned to their own home.</li> <li>• Modified Barthel and HONOS 65 (Health of the Nation Outcome Scores) records showed a 40% improvement in functional abilities.</li> </ul> <p><b>Innovation</b></p> <ul style="list-style-type: none"> <li>• No other known Intermediate Care resource for patients with dementia.</li> <li>• A Multi-agency project – PCT Commissioning, Social Services, Central &amp; North West London NHS Foundation Trust, HART (Healthcare and Rehabilitation team - integrated Intermediate Care provider), Care UK (Woodland Hall proprietor) and the retained local GP.</li> <li>• An Inter-professional team working together with the patient and their family/carers to tailor the individual's goal-setting and treatment plan/programme, for patients with dementia and/or delirium.</li> </ul>

**Productivity (cost efficiencies)**

- Mr A – complex picture with additional problems, difficult behaviour, no known relatives, previously not accepting community support, admitted to hospital with leg ulcers and serious infection, likely to need placement. Now home again with a support package and managing well. Savings to date £12,420; annual savings provided he remains well £21,528 per annum.
- Mr B – vulnerable and subject to abuse, burnt out stage schizophrenia, fractured hip, not compliant with rehab on the ward. Now returned to sheltered Housing and accepting support. Savings to date £17,600; Annual savings £28,600.
- Mrs C – admitted to hospital with dehydration, hypothermia, neglect, infected leg ulcers and weight loss. Now home with Social work support and a trusted neighbour who encourage her to accept support services. Savings to date £10,502; annual savings provided she remains well £16,549 per annum.
- Mrs D - admitted to hospital with confusion, leg ulcers, High blood pressure and thyroid condition. Went home with husband, with a package which gave extra help on the days Mr D has to go for dialysis. After 3 months this broke down and Mrs D admitted to a care home. Savings compared to earlier placement £9,759.
- Mr E – admitted to hospital following a fall with confusion and UTI. Erratic and aggressive behaviour. Medication was stabilised and a limited care package agreed – as much as he could accept. Savings to date £11,592; annual savings provided he remains well £21,528 per annum.

**Prevention**

- Unnecessary placement in a care home
- Unnecessary repeated attendances at A&E, or Admissions to hospital.
- Reduction in unplanned moves being made in emergency situations. Greenview helps the patient and their family/carers to consider the options available to them, so that they make a measured decision.

**User/carer involvement**

- Staff work with the individual to ascertain their likes and dislikes, routines and important beliefs etc in order to help with setting meaningful goals.
- Family/carers and any pre-existing social support network are invited to assist the staff to learn about the patient and their daily patterns, family relationships etc.
- A Planning meeting part-way through their stay at Greenview will involve the patient and all the key figures in the patient's daily life, to agree where the destination is going to be and how to get there.
- As Discharge approaches, family/carers will be part of the process and will participate in Access visits, Home Visits and Discharge as appropriate.
- Greenview staff – OT, Physio and/or Registered Mental Health nurse – will follow up the patients at home to check on progress, and will discharge them from the service when satisfied that the patient is safe and supported.

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<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<ul style="list-style-type: none"> <li>• An extremely short timescale. The Unit was first proposed in August 2008 and opened the doors to patients in November 2008.</li> <li>• As a result of this the physical working environment was extremely difficult – the patient areas were re-decorated and fresh, but there was no office space or phone line for many months, and the IT resource is a collection of systems. <i>Resolution: taking a seldom-used bathroom just outside the unit out of service and converting it into an office. This still left sufficient bathrooms for all units in the care home and was approved by CQC.</i></li> <li>• A 12 bedded unit was freed up to provide a discrete area for Intermediate Care. There was overlap with a few previous service users who could not be moved, so the nursing and care staff were caring for 2 groups of people initially.</li> <li>• Multi-agency planning of such a huge project. Despite pretty good local working arrangements, it has been a major challenge to meet all the individual agencies' requirements e.g. 3 different IT recording systems and servers, corporate guidance on care planning and recording for Care UK staff, performance indicators, who pays for what. <i>Resolution: still an issue. Good communication can resolve many issues but recording is still duplicated to meet the needs of all partner agencies.</i></li> <li>• Multi-disciplinary working in a small team which is forging a new service without a blueprint. <i>Resolution: a hard slog with a lot of goodwill. Monthly team meetings established and 3 monthly monitoring/management meetings to tackle any bigger issues and monitor performance.</i></li> <li>• Performance measures which don't match e.g. the Greenview staff want to involve community staff and plan early on for discharge, but Social Service staff have to complete their assessment and arrange any services within 28 days. <i>Resolution: communication to alert other services of the patients' likely needs, with a formal referral triggered later in the process as appropriate. Still not perfect.</i></li> <li>• Throughout the project, everyone needs to be mindful that Greenview sits within a Registered care home with nursing, so the Registered Manager remains ultimately responsible for the operation of the Unit. <i>Resolution: the Registered Manager or her representative sits on the Management group, as well as having day-to-day contact with the team. Shared information about the Unit and the Care home for patients and their families.</i></li> <li>• Greenview has still not been commissioned onto a permanent footing, due partly to structural changes happening within NHS Harrow and the local Provider services. This means that staff are still employed through agencies or on fixed term contracts being renewed, which gives little security.</li> </ul>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<ul style="list-style-type: none"> <li>• A lot of hard work and goodwill!</li> <li>• Refurbishing the unit by Care UK.</li> <li>• Bringing together a small, outstanding specialist team who work collaboratively.</li> <li>• Learning some lessons from the "general" Intermediate Care unit in Harrow (the Denham Unit) but recognising that the model is not simply transferable. The Denham Unit mainly admits patients from home or from A&amp;E to prevent admission to hospital, whereas it has become evident that without proper investigation of the causes of a confusion,</li> </ul>

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	<p>or a proper diagnosis of dementia, Greenview cannot support patients safely towards their goals so most admissions are from a hospital ward.</p> <ul style="list-style-type: none"> <li>• Working with NW London Hospitals Trust to identify the need for this particular group of patients to have a specialist rehab resource</li> <li>• Flexibility and adaptability. However much planning is done, there are always things you haven't thought of. Although the criteria for admission were carefully drawn up, very quickly patients appeared "out of left field", as it were, who were also very appropriate for Greenview e.g. head injury, long-standing mental health problems.</li> <li>• All the usual Community resources – Domiciliary Care, District nursing, Falls service, Reablement, Social Work, Housing, Clinical nurse specialists for Respiratory, Diabetes, Coronary Heart disease etc etc.</li> </ul>
<p><b>Transferable Learning</b></p>	<p>This is a very specialist unit and one of a kind in the locality. Staff are learning from each other and developing the service still, but are happy to share their experience with others.</p> <p>Other spin-off learning includes:</p> <ul style="list-style-type: none"> <li>• Hospital staff understanding that just because someone can't engage in rehab on a busy ward, they are not written off and sent to a nursing home but need more specialist input to reach their potential.</li> <li>• Hospital staff understanding that patients who are Non weight-bearing but keep forgetting can be supported to do this and then helped to engage in rehab later.</li> </ul> <p>In terms of service development:</p> <ul style="list-style-type: none"> <li>• Planning the physical environment needs to take account of the staff as well. Patient areas may well take priority but staff in a new project have enough stress without having to work without reasonable resources and space.</li> <li>• The brief needs to be particularly clear in a complex partnership arrangement such as this. Recording, reporting and performance objectives/indicators which overlap are difficult to manage and will result in duplication and frustration.</li> <li>• Getting the right staff with appropriate experience and a real interest in making it work. There's no coasting.</li> </ul>
<p><b>Validation/ Evaluation</b></p>	<p>First year audit:  58% of patients went home  25% of patients went to a Registered Care home  13% of patients were transferred back to hospital for further treatment  4% of patients died.</p> <p>This will be treated now as a baseline since the unit has no direct comparators.</p> <p>See also "<b>Achievements – Productivity</b>" above.</p>
<p><b>Sustainability/ Next Steps</b></p>	<ul style="list-style-type: none"> <li>• The Unit needs to be Commissioned on a permanent basis so that the service is secured for future patients with Dementia and/or delirium. The service appears in the new Harrow Intermediate Commissioning Strategy and we await further developments when the emerging local</li> </ul>

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	<p>Commissioning/Provider structure is progressed.</p> <ul style="list-style-type: none"> <li>• The Greenview team structure and function will continue to develop as their experience grows.</li> <li>• Greenview beds have been offered on a Spot Purchase basis to patients from neighbouring PCT's, if they present in Northwick Park or Central Middlesex hospitals with appropriate rehab and mental health needs, but none have yet been commissioned.</li> </ul>
<p><b>Key contact/Locality</b></p>	<p>The Greenview Unit is based in the London Borough of Harrow, North West London.</p> <p>Andrew Madaras – RMN – Unit Coordinator  Greenview Unit  Woodland Hall  Clamp Hill  Stanmore, Middx  HA7 3BG  0208 954 1697</p> <p>Hilary Binyon – HART Manager  Northwick Park Hospital  Watford Road,  Harrow, Middx  HA1 3UJ  0208 869 3659</p>
<p><b>Dementia Strategy Objectives</b></p>	<p>9, 14.</p>



<b>11. Assistive Technology Project Haringey Mental Health Services for Older People</b>	
<b>Aims</b>	<p>To improve access to care, health and well being for people with dementia living in Haringey through establishing how best to enable someone living alone with dementia, to manage their medication safely.</p> <p>Objectives.</p> <p>Identify a range of assistive technologies available to support medication management for people with dementia.</p> <p>Identify a range of strategies available to support medication management for people with dementia.</p> <p>Develop an assessment protocol and specific interventions for individuals referred to the project.</p> <p>Develop close working relationships with primary, community and social care services.</p> <p>Highlight some of the issues and potential solutions that arise.</p> <p>Design an information leaflet for local distribution.</p>
<b>Local Context for Initiative</b>	<p>A group of older people were identified in the earlier stages of dementia where it was unclear how they were managing their medication. As a consequence, dementia medication was not always prescribed because of the risk it would not be taken correctly.</p> <p>Therefore a one year pilot project was established to explore how to assess and support the medication management skills of people with dementia.</p> <p>Twenty people with dementia, either living alone or with elderly relatives who were unable to provide support with medication, took part in the project.</p> <p>Each person was offered an assessment in their home setting to review their current regime, share ideas and discuss any worries they might have in regard to taking their medication safely. Optimising a person’s autonomy, finding ways to support remaining skills and minimise the effect of memory loss were core concepts.</p> <p>Involving people with dementia and family carers through the project was achieved through collaborative working with individuals and their carers, providing information about the project through a service user and carer newsletter, focus groups, a consultation group exercise and final questionnaire.</p> <p>The project demonstrated the effectiveness of a specific assessment and intervention around medication management using core Occupational Therapy skills.</p>

<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>A Steering Group was established for the project and was consulted through out. Members included; Lead Pharmacist, PCT Community Matron, Memory Treatment Clinic Nurse, Mental Health Occupational Therapist, Medical Consultant. Memory Treatment Clinic Consultant.</p> <p>The project was successful in both identifying risks with medication related issues and creating person-centred solutions for managing these risks. Previously unknown problems with medication were identified and resolved and everyone seeking a solution from the assistive technology project team was able to eventually take medication safely.</p> <p>Five people were started on anti-dementia medication as a result of assistive technology project team involvement. Without the project, these individuals were likely to have not received medication as their ability to take medication safely was not clear.</p> <p>The best solutions were ‘person-centred’ approaches that incorporated the individual’s opinions and ideas adapted to their current routine and environment. This approach aims to optimise a person’s independence and autonomy through finding ways to support remaining skills and minimise the effect of memory loss.</p> <p>Where carers were not able to support with collecting and delivering prescriptions and filling medication containers, community pharmacies were frequently taking on this role, many also monitoring medication by collecting back the use containers on a weekly basis. The project helped to clarify the key role community pharmacies undertake in supporting people with dementia living at home.</p> <p>Assistive devices were demonstrated to have a key part to play in supporting someone to manage their medication safely. A majority of people seen in the project were already using some kind of device or strategy within their home. After the project intervention this was usually modified and more clearly linked to an individual’s lifestyle, habits and routines. This resulted in greater confidence that medication was being taken as prescribed and a clearer system of monitoring was in place.</p> <p>Feedback through the questionnaires (details below) was extremely positive from people with dementia and their family carers taking part in the project.</p> <p>Clarifying someone’s ability to take medication safely quickly became an integral part of the memory treatment clinic assessment process prior to prescribing anti-dementia medication, ensuring safe practice and improved access to services. There are also indications from research that safe and consistent use of medication can have positive health outcomes as well as an impact on financial resources. For people with Alzheimer’s disease, the use of dementia specific medication such as Donepezil, if taken regularly, has shown to delay the move into residential care for up to 18 months (Geldmacher et al 2003). For anybody over 65 years of age, the risks of poor medication management are associated with increased hospitalisation and increased health care expenditure (Col et al 1990, Sullivan et al 1990).</p> <p>Col N, Fanale JE, Kronhom P (1990) The role of medication, non compliance and</p>

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	<p>adverse drug reactions in hospitalisations of the elderly. <i>Archives of Internal Medicine</i>, 150, 841-845.</p> <p>Geldmacher DS, Provenzano G, McRae T, Matey V, Leni JR (2003) Donepezil is associated with delayed nursing home placements in patients with Alzheimer's disease. <i>Journal of the American Geriatric Society</i>, 51, 937-944.</p> <p>Two focus groups were conducted to explore the views and experiences of people with dementia on different assistive devices. The focus groups were attended by a total of 10 people; 5 at an NHS day hospital and 5 who attended a Social Services Day Centre.</p> <p>Items reviewed were:</p> <ul style="list-style-type: none"> <li>• Simple storage boxes for medication</li> <li>• Multi-compartment medication containers</li> <li>• Disposable blister packs</li> <li>• Automated pill dispenser</li> </ul> <p>Seven questions were asked for each type of device shown to the group members.</p> <p style="padding-left: 40px;"><i>Is the colour distinctive?</i>  <i>Is it big/small enough?</i>  <i>Is it the right shape?</i>  <i>Is the writing layout &amp; style clear and readable?</i>  <i>Is the medicine information area clear &amp; visible?</i>  <i>Is the medication easy to access?</i>  <i>Is it secure?</i></p> <p>The results from the focus groups were used to decide on the assistive device used in the project and to design an advice leaflet on medication management strategies and assistive devices.</p> <p>The project workers also facilitated a discussion with a mixed group of 20 people with dementia and family carers about the project. This was carried out towards the end of the project to share some of the initial findings and 'sound out' the initial conclusions with the group. A draft of the information leaflet was discussed and feedback incorporated into the final layout and content.</p> <p>A report on the project was published in the Haringey MHSOP Service User and Carer Newsletter Spring 2009.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p><b>Funding:</b></p> <p>Funding for the project came from a local charity. A robust project proposal, incorporating local knowledge of the gap in services and a wider evidence base helped the success of the bid. We also kept the funding body updated with progress informally and with a formal interim and final report.</p> <p><b>Collaborative working:</b></p> <p>The initial work of establishing a steering group with senior members (detailed above) who became increasingly committed to the project was key. Not only was the steering group a valuable 'sounding board', it helped the project</p>

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	<p>established a high profile and supported partnership working.</p> <p><b>Consulting with service users:</b></p> <p>This was achieved through links with existing services where people with dementia and their carers met. Explaining the purpose of the project and the role of consulting ‘opened the door’ on all occasions.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>This was a one year project. The project leader (a Band 7 Occupational Therapist) was employed one day a week and a Band 3, project worker for three days a week. Additional costs included equipment, travel and postage.</p>
<p><b>Transferable Learning</b></p>	<p>The project demonstrated that with the appropriate assessment and support, people with dementia living at home on their own can manage their medication.</p> <p>The project is on the Department of Health website <a href="http://www.dhcarenetworks.org.uk/demetia">www.dhcarenetworks.org.uk/demetia</a> as a case example meeting two of the National Dementia Strategy objectives</p> <p>A brief report on the establishment and aims of the project was published in <i>Occupational Therapy News</i> January 2009</p> <p>A poster presentation was given at the BEH-MH NHS Trust National Conference, September 2009</p> <p>An information leaflet on medication management strategies was designed and printed. This was launched at the November 2009 conference and remaining copies distributed through Haringey Mental Health Services for Older People.</p> <p>A paper is being prepared for submission to the British Journal of Occupational Therapy, the peer reviewed journal of the College of Occupational Therapy. This describes the projects aims and objectives, design, findings and conclusion. It is currently at the proof reading stage and will be submitted July 2010.</p>
<p><b>Validation/ Evaluation</b></p>	<p><b>Service User and Carer Feedback:</b></p> <p>Service user and carer feedback was collected by two methods: questionnaires and discussion in a support group for carers and people with dementia.</p> <p><b>Questionnaires:</b></p> <p>10 questionnaires were returned from a total of 28 distributed; 5 from people with dementia and 5 from carers. Feedback was extremely positive, particularly emphasising the benefits of using information sharing and the use of a client centred problems solving approaches. This was echoed again in the discussion within the group when participants spoke about the importance of</p>

personalised routines and techniques adapted for their own situations. There was also concern expressed about services available to support them and the anxieties medication issues can provoke for carers.

**Results:**

80% respondents found it helpful to meet with someone to talk about different ways for themselves or family member to take tablets.

Comments included:

*“It helped to clarify the difficulties that were likely to arise. It helped to work through the process with B and a third party. It was good for B to engage in what was a problem solving exercise – something he could really relate to”* – a carer

*“It was helpful in making clear the need to take the tablets regularly and the importance of ensuring they were taken regularly”* – person with dementia

70% respondents reported that they had been helped to take their tablets regularly.

Comments included:

*“The pill box has been very helpful in ensuring regularity. It has been kept in the kitchen where it is always visible after meals”* – person with dementia

*“We bought a calendar clock which has helped”* – a carer

*“My aunt was already using a pill box, which she was organising herself, not very well. She has now agreed to allow the local pharmacist to make up her pill box weekly. She was full of praise for the people who called and said they were very kind”* – a carer

**Group Feedback / Comments**

Project findings were presented and discussed in detail with a service user and carers group that meet monthly in the day hospital. The group included approximately twenty people with dementia and their carers.

**Results**

Feedback included:

People agreed that supporting someone with dementia to manage their medication is difficult.

One carer described how her husband had difficulty swallowing his medication yet had about eight different tablets that he had to take one after another.

Another carer raised the issue of how often medication reviews occurred and that if a person was unable to get to the surgery to discuss their medication, whether this would still occur?

Most people were in agreement that each case needs to be considered on an

## Good Practice Compendium – an assets approach

	<p>individual basis as everyone is different and therefore have different needs and solutions. Most people in the group said they did not have internet access and would find purchasing items difficult.</p> <p>People spoke about their own medication, how much they had to take and how a strict routine was essential to help them manage it.</p> <p>Several carers commented on how positive it was to have a project that considered medication issues and encouraged someone to remain independent but questions where also asked about how people access support and who considers these matters when the project stops.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The project has now ended. A full report has been written and distributed locally. The challenge now is to find a way for this specific intervention to be incorporated in the memory clinic through existing staff resources. To this end the project is being discussed within local services and in the context of the 2010 Haringey Older people’s Strategy, currently at the consultation stage.</p>
<p><b>Key contact/Locality</b></p>	<p>Lynn Malloy, Head Occupational Therapist Barnet Enfield and Haringey MH NHS Trust <a href="mailto:Lynn.malloy@beh-mht.nhs.uk">Lynn.malloy@beh-mht.nhs.uk</a></p> <p>Linda Smith, Senior Occupational Therapist Assistive technology project lead <a href="mailto:Linda.Smith@candi.nhs.uk">Linda.Smith@candi.nhs.uk</a></p>
<p><b>Dementia Strategy Objectives</b></p>	<p>6, 10.</p>

12. Haringey Dementia Forum	
<b>Aims</b>	<p>To improve access to information, knowledge and skills for all professional carers to improve dementia care for those people living in Haringey.</p> <p>Provide a local forum to share innovation and best practice.</p> <p>To support and energise networking and shared practice.</p> <p>To involve all services, sectors and organisations.</p> <p>To promote user and carer involvement in care.</p>
<b>Local Context for Initiative</b>	<p>A Dementia Forum was established in the London borough of Haringey almost three years ago long before ‘learning networks’ were supported in the consultation document or the final publication of the national dementia strategy (DoH 2009) but does find itself well placed to serve several of the objectives as laid out within it.</p> <p>The mental health services for older people, who had an established lunchtime seminar programme, saw an opportunity to open and expand this forum to enable all local health, social, private and voluntary staff groups to come together to promote shared learning and to further develop practice in dementia care. So as with the country as a whole, the dementia strategy was timely but importantly for the work of the forum it underpinned what we were already doing in Haringey and served to strengthen its purpose.</p> <p>Through the London Dementia Centre and CSIP we made a call to see if any such groups were in existence in the locality and in wider London. We found one that essentially was a carer’s educational group and discussed topics such as carer benefits and behaviour problem solving etc. But we found nothing that was aimed at the community of health and social care staff such as we were proposing.</p>
<b>Achievements/ Benefits</b>  <b>To Include:</b>	<p>A launch event was planned to give the forum a high profile and status and from its outset and worked with clear aims and objectives. We engaged high profile speakers Nadine Schofield OPMH lead for CSIP and Maria Parsons the lead for the London Dementia Centre to discuss the importance of such a forum and framed its purpose within the national agenda for dementia care. Forum’s such as ours were potentially the tendrils of these regional networks, aimed to reach right into the hearts of local communities.</p> <p>We developed a flier that would be instantly recognisable as the Forum’s – a logo if you like so that any ongoing work would be identified. It was important that we find out what people wanted – we had a notion of what we could present over many sessions but we needed to ensure that we made the forum attractive and designed it to meet people’s information needs.</p> <p>So after each session we evaluate how that particular one went and if they had any more ideas or requests for subjects and content.</p>
<ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	

## Good Practice Compendium – an assets approach

	<div data-bbox="683 215 1246 629" style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;"><b>Dementia Forum</b></p> <p>Monday March 2nd 2009 12.00 to 1.30pm <small>(A sponsored lunch has been arranged)</small>  Lecture Theatre Block 6, St Ann's Hospital,  St Ann's Road, Haringey N15 3TH</p> <p>The Dementia Forum is an opportunity for <b>workers/staff</b> across ALL AGENCIES in the borough of Haringey to meet to share news &amp; information on issues concerning our work with people with dementia.</p> <p><b>Chair</b>  Karen Harrison Dening, Consultant Admiral Nurse</p> <p><b>Speakers</b>  Mike Phillips, Trainer and Consultant  <b>'Putting it all together'</b></p> <p><small>The experience of working with four dementia care homes in East London to implement a 6 month in-house training programme 'Working with People with Dementia and their Carers. This presentation will cover the Training Needs Analysis phase we conducted (including Dementia Care Mapping) and the steps we took to make the training sustainable.'</small></p> <p><small>To reserve your place contact  Karen Harrison or Yvonne Harvey - 0208 442 6233 or email:  <a href="mailto:karen.harrison@beh.mhl.nhs.uk">karen.harrison@beh.mhl.nhs.uk</a>  <a href="mailto:Yvonne.Harvey@beh-mhl.nhs.uk">Yvonne.Harvey@beh-mhl.nhs.uk</a></small></p> <p style="text-align: center;">Improving dementia care for Haringey</p> </div> <p>We are starting to receive contact from other areas seeking information on how to set up and maintain such a group. This has increased since details of the forum were posted on the department of health care networks site <a href="http://www.dhcarenetworks.org.uk/Dementia/Topics/Browse/Objective1/">www.dhcarenetworks.org.uk/Dementia/Topics/Browse/Objective1/</a> and since the forum being featured in The Journal of Dementia Care Vol:18(1) 2010.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p><b>Funding:</b></p> <p>Though minimal funding is required (i.e. for catering, speakers expenses etc) this was an issue until regular support has been gained from local and national companies and organisations.</p> <p><b>Database:</b></p> <p>Establishing a local database to include all stakeholders was essential; ensuring this is current is an ongoing task.</p> <p><b>Evaluation:</b></p> <p>Evaluation of the events and consulting delegates on topics they wish to hear about is also an ongoing task. Some topics are frequently requested which perhaps indicates staff turnover and some very difficult issues in care; e.g. challenging behaviour, medication in dementia.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>The dementia Forum has been running for over 3 years and takes minimal time and input.</p> <p>Whilst initially the mental health trust supported all catering etc financial constraints led to seeking external support. This is now in place with the venue still offered at no cost by the Trust.</p> <p>The Dementia Forum is led by one person within the borough who coordinates the programme of speakers, administration and evaluations.</p>



## Good Practice Compendium – an assets approach

<b>Transferable Learning</b>	<p>The forum presents a good example of shared learning and the development of learning and supportive networks</p> <p>A concurrent session on the forum, its establishment and functioning was given at a Journal of Dementia Care event in Birmingham in 2009</p> <p>Delegates from many neighbouring boroughs now attend forums with a delegate database of over 300 people now.</p>
<b>Validation/ Evaluation</b>	<p><b>Evaluation and Feedback</b></p> <p>Each session is individually evaluated to ensure that speakers get feedback on their presentation content and style and also the organisers to ensure that the programme and the format of the forums represent what delegates want.</p>
<b>Sustainability/ Next Steps</b>	<p>The forum is sustainable if there is sound ownership or a champion within a locality and this is managerially supported for the (minimal) amount of time organising such a group takes.</p> <p>A second step was to develop an annual event locally to provide an annual lecture – The Haynes Lecture (in dementia care) and local annual care awards – The Haynes Award for Innovation in Dementia Care and Practice. The inaugural event was on 20 May 2010 at Alexandra Palace.</p>
<b>Key contact/Locality</b>	<p>Karen Harrison Denning, Consultant Admiral Nurse  D1 St Ann’s Hospital  St Ann’s Road  London N15 3TH  <a href="mailto:Karen.harrison@beh-mht.nhs.uk">Karen.harrison@beh-mht.nhs.uk</a></p>
<b>Dementia Strategy Objectives</b>	<p>The forum arguably ‘straddles’ several of the strategy’s objectives but two key ones are:</p> <p><b>Objective 1:</b></p> <p>The forum serves the purpose of raising professional awareness of issues around dementia and whilst the wording of this section talks about raising public awareness and reducing stigma we wanted to reach those services such as acute hospitals, primary care teams, palliative care teams, social care etc, that are all caring for people with dementia and their carer’s in some way and need to be better informed and better aware of the issues but importantly to put them in touch with each other.</p> <p>For example as a quote in the strategy from a person with dementia cites:</p> <p><i>“The GP said that you can expect to lose your memory a little when you pass 70“</i></p> <p>We wanted to address this locally. Only 31% of GPs believe they have received sufficient basic and post qualification training to diagnose and</p>

manage dementia, which is a decrease from the data in the Forget Me Not report (2004). We know from early results of a study in Haringey that many local GPs do have patients with dementia on their books and that a significant portion of these have no formal diagnosis, they and their carers' are not receiving appropriate support services and are not 'visible' until a point of crisis. We also kept hearing stories of people with dementia not receiving appropriate care when admitted to acute hospitals and that staff in these hospitals did not understand the needs of people with dementia. The forum specifically set out to invite these staff groups to contribute to the forum.

**Objective 13:**

This objective encompasses the development of skills and knowledge necessary to provide best quality care in the roles and settings where staff groups work. Whilst the Forum is not in any way a structured educational programme it does contribute to this overall objective and brings important information to its members.

Word has got around and we now receive bookings from bordering boroughs, which has been great for extending our network wider and has certainly enriched some of the discussions after the talks. It has opened up the focus and enabled people from within to look out beyond their 'own patch'.

We now have a database of over 200 local contacts and that is growing each month with word of mouth as new people sign up to receive information and reserve their place.

We are starting to receive contact from other areas seeking information on how to set up and maintain such a group.

13. Tom's Club, Haringey	
<b>Aims</b>	<p>To provide a supportive, therapeutic and social environment for carers of people with dementia to attend with or without the person they care for.</p> <p>To include psycho educational support for carers of people with dementia.</p> <p>To provide a safe and supportive environment for peer support</p> <p>To include therapeutic sessions for people with dementia e.g. music, arts, cognitive stimulation etc.</p>
<b>Local Context for Initiative</b>	<p>Tom's Club is an initiative set up by Haringey Admiral Nurse Service. It has been running since April 2009, and was officially launched by the Mayor of Haringey, on June 10<sup>th</sup> 2009. Its aim is to provide a supportive and social environment for carers of people with dementia to attend with or without the person they care for. The club is planned with the needs of both in mind.</p> <p>Its name refers to Tom, who had dementia and was cared for by his wife until his death in 2007. All monies raised at Tom's funeral were donated to support the setting up of this project in his honour.</p>
<b>Achievements/ Benefits</b>	<p>A launch event was planned to give the forum a high profile and status and from its outset and worked with clear aims and objectives. We engaged high profile speakers Nadine Schofield OPMH lead for CSIP and Maria Parsons the lead for the London Dementia Centre to discuss the importance of such a forum and framed its purpose within the national agenda for dementia care. Forum's such as ours were potentially the tendrils of these regional networks, aimed to reach right into the hearts of local communities.</p> <p>We developed a flier that would be instantly recognisable as the Forum's – a logo if you like so that any ongoing work would be identified. It was important that we find out what people wanted – we had a notion of what we could present over many sessions but we needed to ensure that we made the forum attractive and designed it to meet people's information needs.</p> <p>So after each session we evaluate how that particular one went and if they had any more ideas or requests for subjects and content.</p>
<b>To Include:</b>	
- <b>Quality Improvements</b>	
- <b>Innovation</b>	
- <b>Productivity (cost efficiencies)</b>	
- <b>Prevention</b>	
- <b>User/Carer Involvement</b>	

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<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>As numbers increase a challenge can be in offering each carer and person with dementia a sense that they have adequate 'time' to address their issues.</p> <p>A programme that is flexible to meet all needs is essential, hence it was decided fairly early on by carers that to be able to confidently consider their own needs there needed to be activity for the person with dementia; activity that was therapeutic and meaningful. From this point a range of options have been built into the day and input from Occupational Therapy has complemented the Admiral Nursing team to deliver this range.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>Tom's Club is in its second year and has demonstrated consistency in the steady increase in number of attendees. Capacity may be in an issue if numbers continue to rise, plans to counter this would be in setting up a second club or securing larger premises – these issues will be an ongoing consideration.</p> <p>Resource needs are minimal and are currently funded through the initial prime pumping donation and in other subsequent one.</p> <p>Local trade's people and supermarkets provide much of the catering and hospitality in the spirit of community involvement.</p> <p>This initiative requires a champion/organiser – in Haringey this is in the form of Admiral Nursing.</p>
<p><b>Transferable Learning</b></p>	<p>This is a form of Alzheimer Café and provides not only peer support but access to the dementia expertise of the Admiral Nursing team for both the carer and the person with dementia.</p>

<p><b>Validation/ Evaluation</b></p>	<p><b>Evaluation and Feedback</b></p> <p>The review of Tom’s Club has been in two parts. The first is based on a review that took place at a Tom’s Club meeting in March 2010.</p> <p>Twenty two people were present on this day. The evaluation took the form of small group discussions framed around a set of questions, followed by a general feedback and discussion session within the whole group. Participants were also invited to provide individual written feedback if they wished.</p> <p>The second is based on a series of telephone interviews that were conducted with people who were not present at this meeting but who had attended in the past or expressed an interest in attending and were on the mailing list.</p> <p>Twenty carers of people with dementia where interviewed on the telephone. Ten had attended Tom’s club at least once. The remaining ten had not yet attended but were on the mailing list. The format of the survey was based on the evaluation described above. In addition, those who had not attended were asked about what had prevented them from coming to the club.</p> <p>Overall, a total of 42 people contributed to the evaluation. If you would like to see the full review results please see contact details at the end.</p> <div data-bbox="496 987 1430 1547" data-label="Figure"> <table border="1"> <caption>Attendance rates for 2009-2010</caption> <thead> <tr> <th>Month</th> <th>Attendance</th> </tr> </thead> <tbody> <tr><td>April</td><td>15</td></tr> <tr><td>May</td><td>17</td></tr> <tr><td>June</td><td>15</td></tr> <tr><td>July</td><td>17</td></tr> <tr><td>Aug</td><td>17</td></tr> <tr><td>sept</td><td>7</td></tr> <tr><td>Oct</td><td>17</td></tr> <tr><td>Nov</td><td>22</td></tr> <tr><td>Dec</td><td>19</td></tr> <tr><td>Jan</td><td>2</td></tr> <tr><td>Feb</td><td>32</td></tr> <tr><td>March</td><td>22</td></tr> </tbody> </table> </div> <p>Attendance rates for 2009-2010. (Bad weather and the postal strike in Jan is thought to be the reason for low attendance in January)</p> <p>Overall the feedback from carers was extremely positive. It appears that Tom’s Club is highly valued, with its mix of fun activities alongside therapeutic and information-giving sessions. The parallel session, introduced in January 2010, appears to be working well in supporting both carer and cared for to be able to have a pleasant and stimulating experience together and separately.</p>	Month	Attendance	April	15	May	17	June	15	July	17	Aug	17	sept	7	Oct	17	Nov	22	Dec	19	Jan	2	Feb	32	March	22
Month	Attendance																										
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Nov	22																										
Dec	19																										
Jan	2																										
Feb	32																										
March	22																										
<p><b>Sustainability/ Next Steps</b></p>	<p>The group is sustainable as this intervention clearly sits within the remit of the Haringey Admiral Nursing Service.</p> <p>Several of the carer attendees are starting to assume more organisational responsibilities within the group with elements of self governance emerging.</p>																										

## Good Practice Compendium – an assets approach

	A next step would be to relocate the club where access is better.
<b>Key contact/Locality</b>	Kaye Efstathiou, Admiral Nurse Team Leader D2 St Ann's Hospital St Ann's Road London N15 3TH <a href="mailto:kaye.efstathiou@beh-mht.nhs.uk">kaye.efstathiou@beh-mht.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	Improving access to peer support.

**NORTH EAST**

14. Durham Dales Partnership	
<b>Aims</b>	<p>To improve services within the Durham Dales area for people with dementia through integrated partnership working from Primary to Secondary care.</p> <p>Increase the number of early diagnosis.</p> <p>Reduce the diagnosis gap.</p>
<b>Local Context for Initiative</b>	<p>The Durham Dales area is extremely rural with small dispersed villages. Alongside this geographical issue, the population has been ageing for some time. Many of the people are from farming backgrounds with some living in tied houses which belong to estates.</p> <p>It was recognised that unless there were changes in the way that services were delivered, people would not receive the level of services required to maintain them in their own homes. With dementia becoming an increasing problem with the rural community, a local GP took the lead in developing the Durham Dales Partnership.</p>
<b>Achievements/ Benefits</b>	<p>Achievements are many and varied and include:</p> <ul style="list-style-type: none"> <li>• Developing a partnership approach across health, social care and the third sector that has worked to improve services.</li> <li>• Partnership relationships have been developed to the benefit of local people.</li> <li>• Dementia care for people entering hospital has improved through using the LEAN approach</li> <li>• There has been a 48% increase in dementia diagnosis causing a significant reduction in the diagnosis gap.</li> <li>• People have been able to receive appropriate services to maintain them at home.</li> </ul>
<b>To Include:</b>	
<ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	
<b>Challenges</b>	<ul style="list-style-type: none"> <li>• Developing the partnership</li> <li>• Engaging GPs</li> <li>• Coverage of rural area</li> </ul>
<b>- How these were addressed</b>	<p>There was already a GP who was keen to lead this project and therefore was able to engage with peers in a meaningful way. Durham has good partnership but this project brought people from a range of agencies who wanted and had the passion to succeed.</p>

## Good Practice Compendium – an assets approach

<b>Resources/ Capability/ Capacity</b>  <b>- What does it take to make this happen?</b>	Using existing resources in a different way e.g. using a cross fertilisation approach.
<b>Transferable Learning</b>	Durham is considering ways to share this practice across the region. One potential route is to use a dementia event in October to do this.
<b>Validation/ Evaluation</b>	No evaluation completed as yet.
<b>Sustainability/ Next Steps</b>	To be clarified.
<b>Key contact/Locality</b>	Denise Williams – Commissioning Manager Durham County Council <a href="mailto:denise.williams@durham.gov.uk">denise.williams@durham.gov.uk</a>
<b>Dementia Strategy Objectives</b>	3, 6, 8, 11.



15. Darlington Collaborative Acute Care Project	
<b>Aims</b>	<p>The Darlington Dementia Collaborative is focusing on a large-scale change project looking in detail at the admission, assessment, discharge and funding processes related to those people with dementia when admitted to a medical elderly care ward in Darlington Memorial Hospital.</p> <p>The key functions of the project are:</p> <ul style="list-style-type: none"> <li>• Elimination of waste</li> <li>• Improved patient experience through                             <ul style="list-style-type: none"> <li>- Reduced waiting times for services</li> <li>- Reduced length of stay in hospital</li> <li>- Improved access to specialist services</li> <li>- Improved communication and joint working between services</li> </ul> </li> <li>• Improving quality and productivity whilst reducing cost</li> <li>• Managing processes and exploiting economies of scale</li> <li>• Sharing the learning, organisationally and collectively</li> <li>• Supporting partners involved in the project</li> <li>• Leading the way:                             <ul style="list-style-type: none"> <li>– developmentally</li> <li>– taking forward priorities</li> </ul> </li> </ul>
<b>Dementia Strategy Outcomes</b>	<p>The delivery of this project will lead to improved outcomes for people with dementia who have to be admitted to an acute hospital and prevent some admissions which don't need to take place.</p>
<b>Local Context for Initiative</b>	<p>Within North East England the Regional Dementia Oversight Board has the overall lead for the implementation of the National Dementia strategy and have agreed priority objectives including improved general hospital care for people with dementia.</p> <p>The Darlington collaborative is a group of four organisations who are pioneering the North East Transformation System (NETS) approach, across organisational boundaries. These organisations are:-</p> <ul style="list-style-type: none"> <li>• County Durham and Darlington NHS Foundation Trust (CDDFT)</li> <li>• Darlington Borough Council (DBC)</li> <li>• Darlington Primary Care Trust (DPCT)</li> <li>• Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)</li> </ul> <p>Collectively they are organisations who are pioneering the NETS approach across both health and social care in the pursuit of excellence. By sharing, learning and working together they can make a significant and sustained contribution to delivery of the NHS North East vision including improved dementia care. They are committed to sustained quality improvement across organisational boundaries.</p>

## Good Practice Compendium – an assets approach

<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The project has 30, 60 and 90 day “report outs” which monitor the implementation of any improved processes. At the time of writing the 30 day “report out” indicated there had been amongst others the following achievements:</p> <ul style="list-style-type: none"> <li>- Cognitive assessment checklist developed to recognise cogitative impairment. – to be used on A&amp;E and Medical Assessment Unit.</li> <li>- The mini-mental State examination is now completed within 12 hours of admission on all patients.</li> <li>- Use of the “This is Me” document.</li> <li>- New signage and colour scheme introduced to help with orientation.</li> <li>- Anti-dementia drugs held as stock on the ward and in hospital emergency cupboard.</li> <li>- Ward staff able to have access to GP dementia registers.</li> <li>- Psychiatric liaison staff now based in the hospital not off site and are attending daily ward review.</li> <li>- Pharmacy attendance at the daily review.</li> <li>- Involvement of carer in rapid improvement process workshops.</li> <li>- Evidence of reduced behaviour which challenges.</li> <li>- The patient’s access to all professionals involved in their treatment has reduced from 7 days to 24 hours.</li> </ul>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>Challenges</p> <ul style="list-style-type: none"> <li>• The Rapid Change Management Programme is initially very resource intensive in terms of time, financial (venues), back filling staff, support from wider staff groups e.g. estates.</li> <li>• Senior management approval and “buy in” by all organisations. Addressed by</li> <li>• Training was being provided to the key leaders in the organisations on the North East Transformation System (NETS) and the opportunity to gain accreditation as NETS Certified Leaders.</li> <li>• Chief Executive sign up and attendance at key events.</li> <li>• Arranged some funding from the Department of Health Social Care Team to support the implementation of the project.</li> </ul>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>TEWV facilitate the project (2010). This includes the training of senior staff within DBC, DPCT and CDDFT to become certified leaders in the use of the NETS approach across both health and social care.</p> <p>Rapid Process Improvement Workshops (RPIW) will involve staff providing care and carers of people with dementia to explore the current processes and, using the key functions outlined above, will design and implement more efficient and effective processes and use of resources.</p> <p>Cost £80k project support to sustain the project in 2010 /11.</p> <p>The cost of the current Project Manager, staff training and support and current RPIW work has been split between the 4 organisations for 2009/10.</p>
<p><b>Transferable Learning</b></p>	<p>The collaborative are confident that this challenging piece of work will provide a platform for further collaboration and multi agency improvements to address the Dementia Strategy in it’s entirety over the coming years.</p>

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	<p>At the conclusion of the current project the collaborative will be expected to take forward any further training and shared learning within their own organisations. As DBC, CDDPCT and DPCT are fledgling organisations in the use of NETS methodologies and tools the project lead TEWV believe that these organisations will require the provision of additional co-ordination and support from experienced NETS staff who could provide coaching, additional training, facilitation of Kaizen events, re-certification of trained staff and assistance in the role out and the sharing and spread of learning within Darlington and ultimately across the region.</p>
<b>Validation/ Evaluation</b>	<ul style="list-style-type: none"> <li>• The 30/60/90 day “report outs” provide the opportunity to measure progress against target sheets.</li> <li>• Carry out data comparison one year on.</li> <li>• Integrate into organisational clinical governance and governance audits and processes.</li> </ul>
<b>Sustainability/ Next Steps</b>	<p>Provide evidence which can't be challenged.</p>
<b>Key contact/Locality</b>	<p><a href="mailto:jan.maddison@tevv.nhs.uk">jan.maddison@tevv.nhs.uk</a> 0191 333 3096</p>
<b>Dementia Strategy Objectives</b>	<p>Primarily objective 8 Improved quality of care for people with dementia in general hospitals. However nationally 7 objectives have been prioritised for early delivery and we are confident that this project will impact on at least 4 of these objectives:</p> <ul style="list-style-type: none"> <li>• Early intervention and diagnosis for all</li> <li>• Improved community personal support services</li> <li>• Improved quality of care for people with dementia in general hospitals</li> <li>• An informed and effective workforce</li> </ul>

16. Outcome Based Commissioning – South of Tyne	
<b>Aims</b>	<p>To develop thinking and knowledge with commissioners on Outcome Based Commissioning for people with dementia.</p> <p>To translate knowledge into development and commissioning of innovative services.</p> <p>To provide knowledge transfer of other good practice models involving people with dementia and their carers.</p>
<b>Local Context for Initiative</b>	<p>In the North East, a commissioning leads group has been set up for over a year. This is made up of commissioners across the region that meets every quarter. The group set their own agenda to develop their knowledge and thinking around dementia care services.</p> <p>At a commissioning leads event arranged through the leads group, Mental Health Concern were invited to present their work on the Outcome Star model. This generated such interest, that this subject became a top ten priority for the leads group.</p> <p>One commissioner from the group is now working Mental Health Concern, a provider of mental health and dementia services to develop the outcome star model for working with people with dementia.</p> <p>The PCT involved is changing its contracting process using the model noted below.</p> <p><b>Commissioning for Quality and Innovation (CQUIN) payment framework</b></p> <p>The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.</p>
<b>Achievements/ Benefits</b>	<p>The Outcome Star model is already used for people experiencing mental ill health and is being adapted for people with dementia.</p>
<b>To Include:</b>	<p>Benefits include:</p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul> <p>Having a clearer methodology of working with people with dementia            Improving quality through contract being incentive based through use of CQUIN's model as noted above.</p> <p>The incentives within the contract are linked to innovations, specifically in this case, with the Outcome Star model.            Improved quality of care for people with dementia using 6 domains to measure quality of life areas.</p>

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<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>What represents an outcome for people with a progressive, terminal illness? Discussions with stakeholders to develop solutions to this.</p> <p>Would the same dimensions used for people with mental ill health be appropriate for people with dementia? Stakeholder discussion ended with agreement that existing domains would work.</p> <p>How would the work be funded? Innovation monies were awarded and Newcastle University are partners in this work to pilot and evaluate.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>PCT Commissioner has been passionate and pro-active in making this work happen in the South of Tyne area.</p> <p>Mental Health Concern (a charitable organisation) had already developed the model with people experiencing mental ill health.</p> <p>Newcastle University Institute for Ageing are pro-active in the region championing the cause of people with dementia.</p> <p>Funding was required to develop the model and this became available through innovation monies. An academic will be appointed for 6 months to develop the model and identify pilot areas for testing.</p>
<p><b>Transferable Learning</b></p>	<p>Mental Health Concern attended a commissioning leads group and presented on their Outcome Star work in the South of Tyne area.</p> <p>The commissioning leads group made this area one of their top ten priorities in implementing the dementia strategy in the North East, requesting more focused sessions be provided.</p> <p>The Outcome Star work being developed in the South of Tyne area will be shared region wide.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Pilots will be used to test the Outcome Star model and pilots will subsequently be evaluated with results published through Newcastle University.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The current model has been found to be useful when working with people with mental ill health. Post evaluation, it is anticipated that the Outcome Star model will prove itself sustainable through the measured outcomes for people with dementia identifying improved quality of life.</p>
<p><b>Key contact/ Locality</b></p>	<p>Wendy Kaiser – Lead Commissioner for Dementia – South of Tyne  <a href="mailto:Wendy.kaiser@stw.nhs.uk">Wendy.kaiser@stw.nhs.uk</a>            Tel: 07932400984</p>

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<b>Dementia Strategy Objectives</b>	6, 11, 14.
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**NORTH WEST**

**17. EDUCATE**  
**Early Dementia Users' Cooperative Aiming To Educate**

<b>Aims</b>	<p>The EDUCATE project aims to enable volunteers in the early phase of dementia to bring their skills and experience to raise awareness about dementia in Stockport and to educate others about their experience. These EDUCATErs can be powerful in changing attitudes, raising awareness, changing perceptions and reducing the prejudice and stigma associated with dementia and, hopefully, contribute to improving dementia care services.</p> <p><b>With the help of people with dementia and their carers EDUCATE can:</b></p> <ul style="list-style-type: none"> <li>▪ Be a voice of and for some people with dementia locally</li> <li>▪ Positively influence policies and promote improved services in Stockport</li> <li>▪ Develop and participate in information, education, awareness and training in the field of dementia care.</li> </ul> <p><b>How we support EDUCATErs?</b></p> <ul style="list-style-type: none"> <li>▪ Provide opportunities to meet and work together with other people in the same situation</li> <li>▪ Provide guidance and support to be able to fulfil the role of an EDUCATEr</li> <li>▪ Provide public travel expenses.</li> </ul>
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<b>Local Context for Initiative</b>	<p>In addition to national campaigns to raise awareness we wanted to implement a local group.</p> <p>The nurses in the Stockport Dementia Treatment Clinic, Pennine Care NHS Foundation Trust noticed several people they visited were willing to tell their story and experiences of dementia and of care to others. Other Stockport Community Mental Health Team staff had similarly come across people with dementia in their visits or through post-diagnostic and community-based support groups who were keen to contribute in this way</p> <p>The EDUCATE group is win-win: their contribution is very valuable and powerful in reducing prejudice and stigma associated with dementia as well as informing staff working with people with dementia and the public. The EDUCATErs find their work very rewarding and confidence building as they overcome aspects of their disability in doing it. 'It keeps us going' is one of the many comments. Another important aspect is the support and encouragement they receive from meeting with each other.</p>
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<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p><b>Prevention / Awareness Raising</b></p> <p>EDUCATErs have taken part in local training course on communication and dementia for people from a range of professional backgrounds, training for acute hospital nurses, a number of sessions for Health and Social care further education students, a Young Onset dementia Conference, manned a stall and had a workshop at a large Dignity in Care event to name but a few of the things in their first months of operation</p> <p>They include awareness raising of how dementia affects people's life, whether they be younger or older, and what can be done to support them. They offer positive examples of living well with dementia thus educating staff and the general public and inspiring others with dementia.</p> <p><b>Innovation / user involvement</b></p> <p>Staff and service users actively engaging to improve social care and health care system through their training, but are also about to participate in a local Health and Social care managers' meeting where dementia services will be looked involving EDUCATErs in the discussions.</p>
<p><b>Challenges</b></p> <p>- <b>How these were addressed</b></p>	<ul style="list-style-type: none"> <li>• Most people are not allowed to drive: arrange transport / taxi.</li> <li>• Communication needs: We meet these as the needs arise e.g. some people may need prompts: remind people day before and on the day about the meeting they are having. Also, at the meetings we ensure we are clear in what is said, reiterate if necessary and give people time to contribute and generally try to compensate for difficulties so allowing them to maximise their very positive contributions.</li> <li>• Some people need support to accompany them to and from meetings: recruited buddies / volunteers.</li> <li>• How to manage to support people when they are not being able to contribute to EDUCATE as their condition has deteriorated: ensure they will have access to another peer support network to fill the gap.</li> <li>• Data collection: time investment to sit together with EDUCATE and fill in evaluation forms and feedback forms after they have given a training.</li> </ul>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- <b>What does it take to make this happen?</b></p>	<p>Project manager.</p> <p>Admin support to prompt people and arrange training events / network meetings.</p> <p>Facilitators for monthly network meetings.</p> <p>People to assist EDUCATErs to training &amp; information events.</p>
<p><b>Transferable Learning</b></p>	<p>Documentation, evaluation forms etc. available.</p> <p>EDUCATE has been presented at conferences and shared information.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Project is part of national demonstrator site project for peer support networks. End-evaluation will be ready after March 2011. Monthly highlight reports record activities for the month, including learning points, successes and problems, planned activities for the next month and any issues or concerns there might</p>



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	<p>be.</p> <p>After almost every session the EDUCATErs deliver they fill in an evaluation form and the participants/audience are encouraged to feedback, preferably in written evaluations.</p>
<b>Sustainability/ Next Steps</b>	<p>Sustainability is on the agenda for 2010/2011. We have not a clear solution yet, but we do know that sustaining the EDUCATE project will need continuation of steering from our current partners in the project: Stockport Dementia Care Training and CMHT (both Pennine Care Foundation Trust). Also links with services like dementia advisers (when implemented) and our voluntary organisations like Alzheimer's Society and Age Concern feel crucial. Finally to facilitate the work of the EDUCATErs a budget for expenses, training, a support worker to facilitate the network meetings and a project manager with some admin. support is needed.</p>
<b>Key contact/Locality</b>	<p>Sally Mendham            Stockport Dementia Care Training            Tel: 0161 419 6016            E-mail: <a href="mailto:sally.mendham@nhs.net">sally.mendham@nhs.net</a></p>
<b>Dementia Strategy Objectives</b>	<p>1, 3, 13, 14.</p>

**18. Flexible Outreach Service – Age Concern Lancashire [ACL] and Age Concern Central Lancashire [ACCL]**

<p><b>Aims</b></p>	<p>The purpose of the Flexible Outreach Service is to enable individuals who are experiencing the early stages of dementia type illness to have support in continuing to pursue interests, maintain their independence and retain and/or develop social contacts.</p> <p>The aim is to enhance the quality of life and well-being of individuals which can so quickly become compromised when a person is living with concerns about their memory.</p>
<p><b>Local Context for Initiative</b></p>	<p>Following an independent review of services for people with dementia in Lancashire, gaps in service provision were identified for those with early stage dementia/ memory problems.</p> <p>To support people with early stage dementia and their families/carers the Flexible Outreach Service was commissioned. This is delivered by a partnership of Age Concern organisations working cohesively across Central Lancashire.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>Individually tailored, flexible programmes of support enabling service users to engage in meaningful activities of their choosing:</p> <ul style="list-style-type: none"> <li>• continue participation in running and cycling for a keen sportswoman recently diagnosed with Alzheimer’s</li> <li>• continue with gardening and vegetable growing</li> <li>• learn how to text message a granddaughter</li> <li>• continue an interest in golf through a weekly visit to the local golf driving range</li> <li>• resume active participation in [and winning!] games of chess</li> </ul> <p>The Service helps to:</p> <ul style="list-style-type: none"> <li>• retain community links</li> <li>• maintain independence</li> <li>• reduce dependence on formal support services</li> <li>• prevent early admission to residential care</li> <li>• reduce primary/secondary care dependency</li> <li>• reduce carer stress</li> <li>• support service users/families/carers through process of diagnosis.</li> </ul> <p>Innovative working structures directly working alongside statutory and other third sector partners inc. Memory Assessment Service, CMHT, the local authority social workers and more recently Dementia Adviser provides excellent links with other services.</p>

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<p><b>Challenges</b></p> <p>- How these were addressed</p>	<p>Raising awareness of new service – presentations to partner organisations and promoted through local media.</p> <p>Meeting increased demands on the Service – time management exercise, increasing capacity, use of volunteers, clear objective setting, effective discharge planning, excellent knowledge of and links with community resources to move individuals through the Service.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- What does it take to make this happen?</p>	<p>Excellent partnership working across all sectors.</p> <p>Dedicated staff/volunteers - the Service is supported in its work by a small number of volunteers and social work students.</p> <p>Clear understanding of role/purpose of service in maintaining independence not creating dependency.</p>
<p><b>Transferable Learning</b></p>	<p>Development of positive working relationships between staff across all services and sectors.</p> <p>An awareness of not creating dependency by provision of this service, service user throughput into other community based supports is essential.</p> <p>Personalised, flexible care plans based around personal hobbies/interests can help to maintain independence and prevent hospital/residential care admissions and crises occurring.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Service User and Carer Satisfaction Surveys.</p> <p>Use of 'Life Checker' evaluation, a simple quality of life tool and 'One Off Outcomes' measures.</p> <p>'Comments, Compliments and Complaints' received.</p> <p>Case studies.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>To increase the number of volunteers to maintain/increase capacity.</p> <p>One major challenge is to demonstrate the full effectiveness of the Service in reducing the demand for formal support services e.g. day and residential care placements.</p>
<p><b>Key contact/Locality</b></p>	<p><b>Commissioners:</b> Alex Walker – NHS Central Lancashire</p> <p><b>Providers:</b> ACL: John Coppin, Service Coordinator <a href="mailto:jcoppin@ageconcernlancs.org.uk">jcoppin@ageconcernlancs.org.uk</a> 01257 479024 or 01695 571522</p>

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	<p>ACCL: Chris Robinson, Service Coordinator <a href="mailto:chrisrobinson@55plus.org.uk">chrisrobinson@55plus.org.uk</a> 01772 552850</p>
<b>Dementia Strategy Objectives</b>	<p>The Service's approach is consistent with three of key steps of the National Dementia Strategy which seek to:</p> <ul style="list-style-type: none"><li>• Ensure better knowledge about dementia and remove stigma. Eg. Information provided to service users and carers; training given to colleagues; community events</li><li>• Ensure early diagnosis, support and treatment Eg. Service users supported and encouraged to seek diagnosis and request Community Care and Carers assessments</li><li>• Develop services to meet changing needs better Eg. Within its remit the Service strives to offer a flexible approach to meet service users' needs; highlights gaps in services; works with partner organisations.</li></ul>

**19. Shore Green Extra Care Sheltered Housing Scheme for Older People with Dementia and Other Memory Loss Conditions**

<p><b>Aims</b></p>	<p>Shore Green is a 10 unit specialist extra care scheme in Baguley, South Manchester. The scheme offers flexible and responsive personal care support services for older people with dementia and a range of memory loss conditions.</p> <p>The scheme aims to enable tenants to maintain their independence and enhance their quality of life for as long as possible. Each person has their own tenancy and is encouraged to exercise as much choice and control over the care and support they receive as possible.</p> <p>The scheme is specially designed to provide a safe yet welcoming environment and uses assistive technology to help reduce instances of wandering and appliances being left on.</p> <p>Shore Green, along with the other extra care schemes in Manchester aims to reduce unnecessary admissions to residential and nursing care by offering care and support services that adapt to changing and increasing needs.</p>
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<p><b>Local Context for Initiative</b></p>	<p>Shore Green is one of four extra care sheltered housing schemes in Manchester. However in contrast to the other schemes Shore Green is the only specialist scheme for dementia and other memory loss conditions.</p> <p>The Strategy for Extra Care Sheltered Housing in Manchester (2008) acknowledged the growing need for more specialist schemes and recommended that further specialist extra care provision for sufferers of dementia be developed.</p> <p>The focus on increasing extra care provision across Manchester is driven by the following priorities:</p> <ul style="list-style-type: none"> <li>• Review of sheltered housing provision in city identified a need for more choice in supported housing options for older people and flexible care services that could meet changing needs and help maintain independence.</li> <li>• Services for sufferers of dementia and memory loss identified as a great need in the city.</li> <li>• Reducing unnecessary admissions to residential care identified as a priority.</li> </ul>
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<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>Shore Green is currently the only purpose built extra care scheme and also contains a unique feature by incorporating self contained bungalows. This enables couples to stay together whereas previously they would have been forced to part when the dementia sufferer needed to go into a care home. The bungalows allow couples to remain together whilst providing the support facilities of a care home but without too much disruption for the couple. A guest room sleepover facility allows relatives to visit and stay.</p> <p>It is noted that the many of the people who move into the scheme actually require a reduction in care package as their independence improves.</p> <p>Since it began, Shore Green has had 34 tenants. Eleven live there now so 23 have moved on. Of these four were carers who stayed with their loved one until they died. This leaves 19 others. Of these:</p> <ul style="list-style-type: none"> <li>• 10 (53%) lived at Shore Green to the end of their life, and</li> <li>• 9 (47%) moved to a nursing home when Shore Green could not meet all their needs.</li> </ul> <p>Incident records show that in the last 12 months collectively the 11 tenants:</p> <ul style="list-style-type: none"> <li>• Have only attended A&amp;E five times and have only been admitted to hospital on nine occasions (one person accounted for three of these). Given the high needs of this group, this is a very low level of activity.</li> <li>• An average length of stay in hospital of only 22 days. This is low when you consider that on average the length of stay for dementia patients is 44% longer than normal.</li> </ul> <p>In a recent CSED case study the following was included in relation to cost efficiencies; 'Given the quality of the service at Shore Green we conclude it is good value for money even though care costs at Shore Green are £7k p.a. higher than alternative residential/ nursing costs. We would argue that much better outcomes were being achieved at a marginal extra cost. That said, we could not identify cashable savings on this basis for social services</p> <p>However, this cost comparison is before any savings related to A&amp;E, hospital, ambulance or police (in relation to less incidents of wandering) are taken into account. It is therefore reasonable to conclude that the Shore Green model would provide people with dementia with a better quality of support <b>AND</b> cost the wider health and social care system less than traditional nursing and residential support options.'</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>While Shore Green offers a mix of accommodation through its mix of apartments and bungalows it has at times been difficult to use the bungalows to their full potential. Whenever a bungalow becomes available a marketing campaign is put in place to advertise the benefits of the accommodation for couples.</p> <p>The scheme operates an allocations panel to avoid inappropriate referrals to the scheme. The small size of the scheme is ideal for the delivery of care and support to tenants but often means that demand for places almost always outweighs supply.</p> <p>An important aspect in the success of the scheme is the close working relationship between housing support provider and care provider. In order to avoid confusion over roles and responsibilities partner organisations worked</p>

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	together to produce a scheme protocol document.
<b>Resources/ Capability/ Capacity</b>  - What does it take to make this happen?	<p>The scheme was opened in 2003. The proposal for the scheme received funding for both the capital and revenue costs from the Housing Corporation which is estimated to be around £675,000.</p> <p>2009/10 annual contract price for Shore Green allocation of 204 standard care hours plus 63 waking night hours = £175,642.98.</p>
<b>Transferable Learning</b>	The scheme provides good examples of how building design and assistive technology can help sufferers of dementia.
<b>Validation/ Evaluation</b>	<p>The use of care hours in the scheme is monitored by the Older People's Commissioning Strategy Team to ensure that the hours are being used efficiently and that the level of care hours is sufficient. If there are more care hours allocated than are being used Adult Social Care will negotiate a reduction in the allocation of hours.</p> <p>Any complaints or POVA issues that arise are reported to and investigated by the Contracts Unit in Adult Social Care.</p> <p>Shore Green produce a quarterly contract monitoring report that includes details of staffing, incidents, complaints, compliments, service developments and service user profiles. Service user satisfaction questionnaires are also carried out regularly.</p> <p>The Older People's Commissioning Strategy team is in the process of producing evaluation reports on the current schemes in the city, although the Shore Green report is not yet available.</p>
<b>Sustainability/ Next Steps</b>	<p>The intention is for Shore Green to continue supporting older people with dementia and other memory loss conditions.</p> <p>The Extra Care Sheltered Housing Strategy for Manchester recommended that further specialist schemes are developed to cover all localities in the city. The possibility of developing a similar scheme on a larger scale is being explored.</p>
<b>Key contact/Locality</b>	<p>Pip Cotterill, Lead Commissioner for Older People South Locality Tel: 0161 245 7120 E-mail: <a href="mailto:pip.cotterill@manchester.gov.uk">pip.cotterill@manchester.gov.uk</a></p>


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<b>Dementia Strategy Objectives</b>	<p>Shore Green responds to the Dementia Strategy's objective to develop a range of services that fully meet the changing needs of people with dementia and their carers in the future.</p> <p>Shore Green considers the needs of people with dementia and their carers when planning housing and housing services and tries to help people to live in their own homes for longer.</p>
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20. Lancashire Outcomes Framework for Dementia	
<b>Aims</b>	In response to the National Dementia Strategy, Lancashire County Council, NHS North Lancashire, NHS Central Lancashire, NHS East Lancashire, NHS Blackpool, NHS Blackburn with Darwen, Blackburn with Darwen Borough Council, Blackpool Borough Council, Lancashire Care NHS Foundation Trust and the Alzheimer's Society have worked in partnership to develop the Lancashire Outcomes Framework for Dementia. The framework provides a set of user and carer defined outcomes.
<b>Local Context for Initiative</b>	As agencies who are partners to this agreement, we have adopted these outcomes and have committed to use them as the foundation for development of local joint commissioning strategies for dementia. In doing so we will ensure that delivery of the National Dementia Strategy across Lancashire is firmly rooted in the expectations and aspirations of local people who are affected by dementia, either as sufferers themselves or as family members, friends or carers. In addition, a range of indicative outcome measures have been included in the framework to assist partners in developing local measures to track progress and improvement, as part of their dementia commissioning strategies.
<b>Achievements/ Benefits</b>  <b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> - <b>User/Carer Involvement</b>	This framework was developed through a high level of engagement. People with dementia and their carers attended a series of workshops across Lancashire where they were supported to consider the outcomes that they would want, as they relate to the stages of the dementia timeline. The dementia timeline sets out the various phases that people with dementia experience and the challenges they often face, as their condition develops. A similar process also took place with several dementia and carer support groups across the county. The workshops deliberately focused on people with dementia and their carers, to the exclusion of professionals and other interested parties, in order to ensure that this outcomes framework is firmly rooted in the expectations and aspirations of those affected by dementia. Qualitative analysis of the feedback received through the events and support group sessions was undertaken to produce a set of outcomes and work was undertaken within the partner agencies to develop the indicative outcome measures.
<b>Challenges</b>  - <b>How these were addressed</b>	N/A
<b>Resources/ Capability/ Capacity</b>	Commitment from all partners throughout process. Support from Business Intelligence Team to collate data. Lead organisation to drive project.

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<b>- What does it take to make this happen?</b>	
<b>Transferable Learning</b>	We are currently working on a similar process for Stroke, so this model of co-production can work with any service users and carers.
<b>Validation/ Evaluation</b>	User experiences surveys in Memory Assessment Services. Discovery interviews at 6 monthly intervals. Data collection. Co-production consultation locally to see if things have progressed.
<b>Sustainability/ Next Steps</b>	Imbed outcomes framework into local Joint Commissioning Strategies for Dementia.
<b>Key contact/Locality</b>	Sam Leonard, Locality Commissioning Manager Lancashire County Council Tel: 07833095105 E-mail: <a href="mailto:Samantha.leonard@lancashire.gov.uk">Samantha.leonard@lancashire.gov.uk</a>
<b>Dementia Strategy Objectives</b>	All 17 objectives.   \\CorpData01\ LCCUsers5\$\sleonard

**SOUTH EAST**

**21. A 'whole system' collaborative approach for improving dementia services through the Sussex Dementia Partnership (SDP)**

<p><b>Aims</b></p>	<ul style="list-style-type: none"> <li>• To Improve dementia services across the whole county in line with the National Dementia Strategy ( NDS );</li> <li>• To ensure the development of new integrated care pathways for dementia;</li> <li>• To strengthen collaboration between organisations and agencies involved in dementia care and share learning;</li> <li>• To reduce unexplained variation in services across the county.</li> </ul>
<p><b>Local Context for Initiative</b></p>	<p>Sussex has a very high prevalence of dementia –one of the highest in the country and so it is a major health and social care priority. The demographic profile with an ageing population places a spotlight on dementia care and services.</p> <p>The SDP comprises 11 statutory health and social care organisations plus representation of Dept of Health South East (DHSE) and Alzheimer’s Society.</p> <p>The current and projected financial pressures on health and social care economies create the need to reappraise the investment profile for dementia services.</p> <p>There are well established partnership relationships between health and social care commissioners in each of the three localities: East Sussex, West Sussex and Brighton &amp; Hove. There is also a commitment to working with the third sector and people with dementia and their carers and families.</p> <p>Sussex has two national demonstrator sites: Dementia Advisor in East Sussex and Peer Learning Networks in Brighton &amp; Hove.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>The SDP acts as an umbrella body to provide strategic leadership and to identify specific issues which benefit from a pan-Sussex approach. There are considerable benefits of partnership working both at the strategic level and also within localities. The cooperation between health and social care agencies together with a strong third sector involvement has created coherent plans with clear progress being made and new services being developed.</p> <p>Examples of local achievements in line with the NDS are the redesign of the dementia pathway to create rapid access diagnostic memory assessment, pre and post diagnostic counselling, links to other support services including dementia advisers, psychiatric liaison services and intensive dementia specific home care.</p> <p>One of the measures of quality has been the very powerful reminder by people</p>

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	<p>with dementia and their carers that 'little things make a big difference' The involvement of these participants in the consultation about new service models has been a real benefit</p> <p>Both East Sussex and West Sussex have appointed project managers to implement far reaching changes to dementia services.</p> <p>The prevention and productivity aspect of redesigned dementia services is being addressed through innovative system modelling work. This robust methodology highlights key investment options at various points on the new care pathway and is being used with dementia metrics to monitor and evaluate progress.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<ul style="list-style-type: none"> <li>• To agree a framework which recognises <b>both</b> the benefit of a pan Sussex perspective <b>and</b> the political reality on the ground of local plans and investment decisions within each of the three localities. This challenge is being overcome by a process of identifying the strategic issues for which a pan–Sussex approach is needed.</li> <li>• To ensure that dementia services are seen within a 'whole system' context involving primary care through to end of life care. This challenge has been addressed through workshop sessions focussed on redesign of care pathways with full involvement of people with dementia and carers.</li> </ul>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>The SDP Programme Board meets quarterly and includes senior representation. It is chaired by a CEO from within the Sussex system. Additionally, each of the three localities has its own local governance and accountability arrangements.</p> <p>A 12 month part-time Project Manager appointment supports the ongoing development of the Partnership's work. As mentioned previously, both East Sussex and West Sussex have also appointed project managers to help the implementation of the NDS on the ground.</p> <p>Additionally, DHSE has supported the Partnership through the contribution of Care Services Efficiency Delivery (CSED) in facilitating care pathway workshops; and system modelling consultancy support.</p>
<p><b>Transferable Learning</b></p>	<ul style="list-style-type: none"> <li>• Lay the foundation and agree principles for collaborative working. The SDP contains providers and third sector as well as commissioners.</li> <li>• Involve people with dementia and carers in design of new pathways as their views can be powerful and challenging to the current practice.</li> <li>• Use metrics and system modelling (hard evidence) to support the process of change.</li> <li>• Agree the infrastructure and links to support services for the memory assessment services. The principle of whole system working and a comprehensive approach is set at this point which can be reinforced at later stages of the care pathway.</li> </ul>

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<b>Validation/ Evaluation</b>	<p>The SDP is an ambitious and wide ranging approach to implementing the NDS across Sussex and will be independently evaluated by a two year interactive study and evaluation. This will review both the outcomes in terms of implementing the NDS as well as the process of working as a Partnership.</p>
<b>Sustainability/ Next Steps</b>	<p>The SDP will sustain itself through the continuing priority accorded to dementia services across Sussex. Next steps will include developing strategies on a pan-Sussex basis for areas such as research, anti-psychotics, workforce skills and learning. Additionally the three localities will continue with their own specific service remodelling strategies.</p>
<b>Key contact/Locality</b>	<p>The Project Manager for the Sussex Dementia Partnership is Charlotte Clow.  Her contact details are: <a href="mailto:charlotte.clow@sussexpartnership.nhs.uk">charlotte.clow@sussexpartnership.nhs.uk</a> Telephone: 01273 778383 ext 2191</p>
<b>Dementia Strategy Objectives</b>	<p>Whilst the NDS will in time address all of the 17+1 objectives, at this early stage it is particularly focussing on:</p> <ul style="list-style-type: none"> <li>• Memory services; early diagnosis and intervention;</li> <li>• Improved community personal support services;</li> <li>• Improved care in general hospitals; and</li> <li>• Joint local commissioning strategy.</li> </ul>

## 22. Using the Dementia Metrics

<p><b>Aims</b></p>	<p>DH South East has developed a framework of nationally available, dementia specific indicators to provide quantitative information on where Councils and PCTs are in relation to the priority objectives in the Strategy. These metrics provide a partial view of progress with implementation of the Strategy in relation to 4/7 of the following priority objectives:</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p><b>O2: Good-quality early diagnosis and intervention for all;</b>  <b>O6: Improved community personal support services;</b>  <b>O8: Improved quality of care for people with dementia in general hospitals;</b>  <b>O11: Living well with dementia in care homes.</b></p> </div> <p>The purpose of these dementia metrics is to:</p> <ul style="list-style-type: none"> <li>• inform a baseline measure against priority objectives in the Strategy;</li> <li>• provide a starting point to inform discussion about local, whole system organisation and effectiveness of dementia services;</li> <li>• highlight where there are gaps in current data sets; and</li> <li>• stimulate joint planning to have a direct result in improved outcomes.</li> </ul> <p>The full data set of dementia metrics is now available on the DH Dementia Information Portal <a href="http://www.dementia.dh.gov.uk">www.dementia.dh.gov.uk</a>.</p>
<p><b>Local Context for Initiative</b></p>	<p>Our work on dementia metrics is intended to support local partners to assess and peer review their own position against the Strategy. Dementia metrics improve information about dementia care. Their use in local action plans strengthens local accountability. The metrics are primarily focused on service inputs to allow the systems to be put in place to deliver improved outcomes for people with dementia.</p> <p>In SEC SHA work has been undertaken to compile a set of measures to support the work of the commissioners. This work has been led by Adam Cook from the Quality Observatory at SEC SHA and Emma Hanson from Kent.</p> <p>A summary of the indicators is given below:</p> <ul style="list-style-type: none"> <li>• Dementia diagnosis level</li> <li>• Hospital admissions in relation to prevalence</li> <li>• Length of stay in relation to prevalence;</li> <li>• Expenditure on organic mental disorders per 100,000 population</li> <li>• Assessments, reviews and packages of care for people with dementia in relation to:             <ul style="list-style-type: none"> <li>- prevalence</li> <li>- overall mental health chart type</li> <li>- all charts in the older age group</li> </ul> </li> </ul> <p>South East Coast SHA has taken this work further and created primary and</p>

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	<p>secondary care dashboards to understand progress. The dashboards are updated regularly so that staff can track progress.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>In Kent this has led to an increase in the diagnosis rate of people with dementia.</p> <p>Since early 2010 dementia metrics are being used in all DH regions and are being used to inform the development of the National Audit. In addition, local metrics to supplement the national metrics have been developed in some regions to reflect local priorities.</p> <p>Dementia metrics inform discussion about local, whole system organisation and effectiveness of dementia services and can stimulate joint planning to have a direct result in improved outcomes.</p> <p>In addition, dementia metrics are available to inform local action plans, they can be developed to inform progress with implementation of the Strategy and can have a key part in the local accountability process. Local action plans published by NHS and Social Care commissioners will include benchmarking as the quality of data for dementia improves. This will drive transparency encouraging local challenge and informed comment, so reducing cross-locality variation.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>There is recognition of the limitations of the current, nationally available dementia specific indicators. Development of the metrics has concentrated on utilising data which were already available – there was no increase in the burden of collection in health and social care. Challenges in current data includes:</p> <ul style="list-style-type: none"> <li>• collection of dementia specific data is not mandatory in Referrals, Assessments and Packages of Care (the RAP). For older age groups 85% of councils have completed relevant fields but collection varies according to age group, assessment, review or package of care;</li> <li>• classification of dementia in the RAP is by professional judgement and not based on a diagnosis;</li> <li>• there are significant gaps in the collection of dementia specific data, for example, in relation to carers; and</li> <li>• future work is required for the development of metrics which reflect the dynamics of Council placements as well as the quality of care homes.</li> </ul> <p>Some local areas have used the national indicators to build their own dementia specific metrics.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>Dementia metrics are fully available on the DH Dementia Information Portal at <a href="http://www.dementia.dh.gov.uk">www.dementia.dh.gov.uk</a></p> <p>The metrics are easy to access and use; they are available by local area and do not require specialist skills. They have been developed to inform local, whole systems action planning.</p>

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<b>Transferable Learning</b>	<p>Dementia metrics are local and comparable. They have been widely used in the South East where they were developed and real benefits are apparent from there wide application, particularly in Kent, Sussex and Oxfordshire.</p> <p>Dementia metrics form part of an overall approach used by SE Coast SHA.</p>
<b>Validation/ Evaluation</b>	<p>Dementia metrics have been developed in conjunction with SE Coast SHA and the NHS Information Centre.</p> <p>They provide a whole system view, although it is important to note that improvements to data quality are required to strengthen their usefulness.</p>
<b>Sustainability/ Next Steps</b>	<p>Improvements to data quality are required to enable a move towards benchmarking as a means of understanding and raising performance.</p>
<b>Key contact/Locality</b>	<p>Alison Blight, Special Projects Lead, DHSE  <a href="mailto:Alison.blight@dh.gsi.gov.uk">Alison.blight@dh.gsi.gov.uk</a></p> <p>Emma Hanson, West Kent Commissioner  <a href="mailto:Emma.hanson@kent.gov.uk">Emma.hanson@kent.gov.uk</a></p> <p>Adam Cook Quality Observatory, NHS SEC  <a href="mailto:Adam.cook@southeastcoast.nhs.uk">Adam.cook@southeastcoast.nhs.uk</a></p>
<b>Dementia Strategy Objectives</b>	<p>These metrics provide a partial view of progress with implementation of the Strategy in relation to 4/7 of the following priority objectives:</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p><b>O2: Good-quality early diagnosis and intervention for all;</b>  <b>O6: Improved community personal support services;</b>  <b>O8: Improved quality of care for people with dementia in general hospitals;</b>  <b>O11: Living well with dementia in care homes.</b></p> </div>





23. Medicines management and improving anti-psychotic prescribing in Hampshire	
<b>Aims</b>	<p>The aim is to support local implementation of the National Dementia Strategy objective to reduce anti-psychotic prescribing and deliver a coherent medicines management programme for the Hampshire Joint Commissioning Strategy for Older People’s Mental Health (Hampshire Strategy).</p> <p>The medicines management objectives of the Hampshire Strategy are:</p> <ul style="list-style-type: none"> <li>○ to support older people with mental health problems and their carers in understanding and taking their medication;</li> <li>○ to promote good prescribing practice for dementia and depression in old age in all settings, looking at care pathways and shared care agreements between primary care and specialist mental health services;</li> <li>○ to explore opportunities for community pharmacists’ medicines use reviews to identify and support older people with mental health needs and their carers; and</li> <li>○ to review implementation of National Institute for Health and Clinical Excellence guidance across Hampshire and develop methods to monitor and audit their implementation.</li> </ul>
<b>Local Context for Initiative</b>	<p>During development and consultation on the Hampshire Strategy, professionals and carers wished to include explicit action on medicines management.</p> <p>The development of Hampshire guidelines for anti-psychotic prescribing and managing behaviour problems for people with dementia was led by Professor Clive Holmes, Professor of Biological Psychiatry at Southampton University and Consultant Psychiatrist. The guidelines were approved through the various medicines management, medical and prescribing committees in Hampshire in 2009.</p> <p>There has been a growing awareness and interest locally about the need to address prescribing patterns, particularly in care homes. The national report – ‘The use of anti-psychotic medication for people with dementia: Time for action’ (DH, 2009) has acted as a catalyst for local action.</p>
<b>Achievements/ Benefits</b>  <b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> - <b>User/Carer</b>	<p>The Hampshire medicines management programme is ‘work in progress’ and is structured around:</p> <ol style="list-style-type: none"> <li>1. Identification and awareness raising with target groups: care homes, GPs and other prescribing practitioners, specialist clinicians, pharmacists, people with dementia and carers;</li> <li>2. Development and application of prescribing guidelines and supporting interventions; also implementation of measures of progress and evaluation;</li> <li>3. Engagement programme with all groups through training, education, and professional and peer support.</li> </ol> <p>The agreed Hampshire guidelines for anti-psychotic prescribing and managing</p>

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<p><b>Involvement</b></p>	<p>behaviour problems for people with dementia have been disseminated to GPs, mental health clinicians, pharmacists and managers of care homes.</p> <p>The structured programme to support implementation of the guidelines:</p> <ul style="list-style-type: none"> <li>○ specialist mental health clinicians and pharmacists are using the guidelines in their contacts with GPs and care homes;</li> <li>○ through GP medicines management/prescribing fora and audit;</li> <li>○ inclusion of the guidelines in the training programme for care home staff and structured engagement through the Hampshire Care Home Forum;</li> <li>○ incorporation of the guidelines into local implementation of DH requirements for safety in care homes.</li> </ul> <p>Further engagement is planned with community pharmacists and with carers. It is expected that carers will be involved via a Dementia Café peer support network and the third sector.</p> <p>An Audit of anti-psychotic therapy is included in the GP Quality Outcomes Framework menu for 2010/11 - to find out the rationale for prescribing and about review arrangements. It is expected that practices will complete the 1st audit in autumn 2010 and the re-audit in March 2011. The audit findings will provide a benchmark, and identify areas of good practice and challenge to inform action plans from 2011.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>1. The multiplicity of stakeholders in this agenda raises challenges in making connections and securing their involvement.</p> <p>Progress on this agenda is founded upon partnerships between NHS Hampshire, Hampshire County Council and Hampshire Partnership NHS Foundation Trust, then extending this to link with care homes and others.</p> <p>2. GPs' perceptions and questions about the benefits of auditing anti-psychotic prescribing.</p> <p>Patient safety is the starting point for dialogue and for raising awareness, which is necessary to enable change in practice. The guidelines provide an opportunity for clinical engagement and discussion with GPs. The medicines management model for influencing prescribing behaviours is 'tried and tested'.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>Local partnerships being in place to enable shared approaches to learning.</p> <p>Clear national direction and guidance that this is an issue that needs to be addressed.</p> <p>Local clinical and medicines management leadership.</p>

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<p><b>Transferable Learning</b></p>	<p>These Hampshire documents are for sharing:</p> <ul style="list-style-type: none"> <li>○ Guidelines for Prescribing and Managing Behaviour Problems in Patients with Dementia.</li> <li>○ GP audit of anti-psychotic therapy in dementia patients.</li> </ul> <p>The learning is in using the guidelines and audit as a starting point for dialogue and challenge with local audiences.</p> <div style="text-align: center;">   </div> <p>H:\HEALTH.pol\ SOCIAL CARE\Older f      H:\HEALTH.pol\ SOCIAL CARE\Older f</p>
<p><b>Validation/ Evaluation</b></p>	<p>The Hampshire guidelines were developed from a systematic review of the national / international research and evidence base and with consultation of health care professionals' views across the trust and prescribing representation from PCTs.</p> <p>They will be reviewed and evaluated against the current evidence base and are due for review in Nov 2010.</p> <p>The GP QOF audit was developed in line with the evidence base and NICE guidelines. It has been piloted with practices before its introduction.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>Next steps will be informed by:</p> <ul style="list-style-type: none"> <li>○ audit outcomes and action plans;</li> <li>○ evaluation of the guidelines; and</li> <li>○ feedback and challenge from all those engaged.</li> </ul> <p>e.g. next steps might include development of targeted training tools.</p> <p>The aim is to move the mind sets of GPs and care homes' staff so that they recognise the need for individual patient assessment and review for anti-psychotic therapy.</p>
<p><b>Key contact/Locality</b></p>	<p>For further information about the Hampshire medicines management programme:</p> <p>Neil Hardy Head of Medicines Management, NHS Hampshire. <a href="mailto:neil.hardy2@nhs.net">neil.hardy2@nhs.net</a></p> <p>For further information about the Hampshire guidelines for Prescribing and Managing Behaviour Problems in Patients with Dementia:</p> <p>Professor Clive Holmes Professor of Biological Psychiatry at Southampton University and Consultant Psychiatrist, Hampshire Partnership Foundation Trust. <a href="mailto:clive.holmes@hantspt-sw.nhs.uk">clive.holmes@hantspt-sw.nhs.uk</a></p>

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<b>Dementia Strategy Objectives</b>	Reduction in anti-psychotic prescribing.
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### 24. NHS West Kent Dementia Crisis Support Service

The Dementia Crisis Support Service DCSS is a crisis or emergency response service providing enhanced support delivered in the person’s home which can be up to twenty four hour care including night sitting. The service will be delivered for a maximum of 6 weeks but in most case will be significantly less.

<p><b>Aims</b></p>	<p>To prevent the breakdown of a caring situation or a care package that would normally have led to hospital admission or long term admission to a care home, by supporting carers and/or individuals in crisis situations.</p> <p>To enable individuals to remain living in their own homes with appropriate support, including night sitting where necessary, whilst carers are relieved and/or that individual is safe. For example, an individual has suffered an acute episode that may increase confusion but that in itself does not require hospitalisation and enables the individual to remain at home.</p>
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<p><b>Local Context for Initiative</b></p>	<p>The service was designed in direct response to consultation with users and carers, when the lack of 24 hr crisis/emergency services was identified as a gap in provision, which led to poor management of crises and poor outcomes – often unnecessary acute admissions.</p> <p>Through analysis of reasons for admission to residential care, acute hospital care and mental health admissions it was evident that there were people who were being unnecessarily admitted to these settings following carer breakdown.</p> <p>The service was agreed and funded as part of a programme to create responsive and effective services by reinvesting funds from decommissioned inpatient mental health beds. It forms part of a wider programme of dementia service redesign articulated by the West Kent Dementia Strategy.</p> <p>The Dementia Crisis Support Service (DCSS) provides short-term home based emergency support in crisis or emergency situations. The service is designed to support people with dementia through times of emergency or crisis whether or not they have a carer. The support is provided in the person's normal home to cover emergency or crisis period or to provide sufficient time to make alternative arrangements. In exceptional cases the support will be provided for the full 6 weeks but if only if clearly articulated in a care plan and needed to promote independence and a return to no formal care being provided.</p>
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<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The service has been operational since April 2010 and in that time has assisted 34 people with dementia. Early evidence has shown that 19 people received the service because their carer was either physically or emotionally unwell and unable to provide care, while in 5 cases the carer had been hospitalised with their own acute health needs.</p> <p>5 people received the service because they were psychologically distressed and unsafe being left on their own, and a further 4 people received the service because they were physically unwell and required temporary support to recover from an illness or infection. Of the people receiving the service, in 10 cases admission to acute hospital were prevented, and in 15 cases admissions to an emergency care home bed was no longer necessary. In the remaining 9 cases the service helped the carer continue their caring role providing crucial support to keep them going and sustain the caring relationship until other longer-term services could be arranged.</p> <p>The outcomes are being measured and analysed with quarterly reports on progress fed back to the commissioning delivery team. There is also a qualitative review underway with all the families and carers to ascertain their views of the service and the value the support was to them. This is being undertaken by a third party through in-depth telephone interviews and face-to-face visits. The information will be used to aid in the continuous development and refinement of the services. As well as part of the overall review of the service.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>The biggest challenge was using NHS resources to meet needs in the community in a more responsive way. There was a degree of local and political opposition to the closure of inpatient beds necessary to fund the service – decommissioning in order to recommission required having a clear vision and being able to articulate that vision and bring others along to see the benefit of the changes. This was in part addressed through having the data to support the changes needed and having the backing of the local population who had been consulted on what service model they wished to have in place. There is a dementia strategy in place in this area so that contributes to the feeling of confidence that there is a plan in place with certain milestones along the journey.</p> <p>The second challenge was how to define a crisis and how the services should be used to best effect. Agreement was required on how the referral pathways should be developed and how people accessing the service would be assessed, supported and eventually moved on. This required the partner organisations to communicate effectively, share skills and knowledge and take on new and different roles.</p> <p>The third challenge was the tender process as this involved working across 2 organisations with the joint commissioner having to balance the needs to two sometimes fundamentally different cultures; the project used the NHS resources in a less than usual manner. The local authority was able to assist with the tender process and adapting the contracting documents from the contracts for domiciliary care.</p> <p>The fourth challenge was around moving away from the medical model of responses to crises and this was achieved through commissioning a number of providers from the voluntary and private sector to provide the service. The</p>

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	<p>service is being provided by 2 domiciliary care providers and a third sector provider. Kent set up a bespoke training course for all these providers in dementia care and this provided a turning point for the providers to see the partnership working and the opportunities to work differently.</p> <p>There have been ongoing issues with the contracts and the building of relationships with the statutory providers and these have been addressed through regular meetings between all parties chaired by the joint commissioner. This has helped to build trust and has aided communication.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>Funding was released from the closure of a number of acute mental health beds in the district. With an overall population of 670,000 the response areas have been broken down into 3 areas each with approx 220,000 people and a budget of £100,000 per provider has been tendered for. Two of the contracts were awarded to private domiciliary care providers and one to a partnerships formed by Crossroads with Alzheimer's Society and Carers First.</p> <p>Links have been established with the South East Coast Ambulance Service, GP out of hours service, Acute Hospital A and E Departments, West Kent Community Health Rapid Response or IMPACT teams and the Kent Adult Social Services out of hours teams.</p> <p>Referrals are also being accepted from GP's, Community Nurses, Kent Contact Assessment Service and Kent and Medway Partnership Trust CMHT.</p> <p>As this is a NHS service it will be free at the point of delivery. It is intended that this is a time limited crisis intervention or emergency service to provide enhanced support designed to prevent admission to hospital or a care home setting. The service will provide for <b>up to a maximum period of 6 weeks</b> for each service user.</p>
<p><b>Transferable Learning</b></p>	<p>The key bits of learning from this innovative service are around:</p> <ol style="list-style-type: none"> <li>1. Involving users and carers in the service redesign.</li> <li>2. having a strategy to underpin the changes to the system.</li> <li>3. involving all partners in the pathway and communicating with them regularly.</li> <li>4. having regular meetings with the providers during the teething period of the project.</li> <li>5. contracting with a range of providers to offer greater choice and flexibility for the consumer.</li> </ol>
<p><b>Validation/ Evaluation</b></p>	<p>A full evaluation of the project is being undertaken, with evidence being gathered about how the service has met the need and objectives it was created for. They are working out a way of calculating acute bed days saved.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The above project focuses on admission avoidance but through doing this work it has become clear that there is a cohort of people who are admitted to the acute sector and who are then having longer stays than those not diagnosed with dementia and there is a need for a service to support on discharge. This is particularly around the area of addressing perceived risks</p>

## Good Practice Compendium – an assets approach

	and the mitigation of these. Funding has been agreed from the reimbursement funds to pilot a project with the same providers offering a service on discharge from the acute sector. This will increase the amount of business going to the providers and will use the skills that their staff have acquired through working with people with dementia at home. Again this has been based on analysis of data on the outcomes for people with dementia following a hospital stay.
<b>Key contact/Locality</b>	Emma Hanson, Joint Commissioner, West Kent PCT and Kent Adult Social Services <a href="mailto:emma.hanson@kent.gov.uk">emma.hanson@kent.gov.uk</a>
<b>Dementia Strategy Objectives</b>	6, 7, 8, 12, 14.



**SOUTH WEST**

**25. Engaging GPs in the National Dementia Strategy**

<b>Aims</b>	<ul style="list-style-type: none"> <li>• To increase the awareness and engagement of GPs in relation to dementia care.</li> <li>• Increased number of people with dementia receiving a diagnosis</li> <li>• Improved access to local support for people with dementia and their carers.</li> </ul>
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<b>Local Context for Initiative</b>	<p>Gloucestershire had an existing dementia training and education strategy and a programme for working in care homes funded through its POPP workstreams.</p> <p>There was early acknowledgement of the key role played by primary care and the difficulties of achieving GP engagement. The PCT agreement to recruit a GP clinical lead for 2 days a week to support GP engagement</p>
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<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p><b>Making dementia a PCT priority</b> – for both people with dementia and their carers This was achieved through:</p> <ul style="list-style-type: none"> <li>✓ QOF contract re register</li> <li>✓ QOF – annual health check of needs for patients with dementia</li> <li>✓ Focus points for practice visits</li> <li>✓ Maintaining carers registers and recording the support offered.</li> </ul> <p><b>Establishing clear pathways</b></p> <ul style="list-style-type: none"> <li>✓ Awareness to diagnosis</li> <li>✓ Diagnosis to end of life</li> </ul> <p><b>Providing support</b> – named for each Primary Care Team</p> <ul style="list-style-type: none"> <li>✓ Community Dementia Nurse</li> <li>✓ Dementia Advisor</li> <li>✓ Carers Link</li> </ul> <p><b>Providing Education</b></p> <ul style="list-style-type: none"> <li>✓ Annual primary care dementia summits</li> <li>✓ Direct offers to localities/practices.</li> <li>✓ E learning</li> </ul> <p><b>Undertaking audits</b></p> <ul style="list-style-type: none"> <li>✓ County audit plan</li> </ul> <p>The work has been underpinned by a vibrant project management board and supportive Professional Exec Committee and PCT structure. Success has been promoted through strong multi-professional working and good links with other trusts, carers and the voluntary sector.</p>
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## Good Practice Compendium – an assets approach

<p><b>Challenges</b></p> <p>- How these were addressed</p>	<p>Gaining credibility. The use of peer GP and strong endorsement by PEC.</p> <p>Converting ideas and plans to implementation. Focus on practical outcomes, collocation of services.</p> <p>Risks of operational conflicts. Strong engagement across agencies, culture of willingness to listen and adapt. Close working with mental health provider to deliver services at primary care level.</p> <p>Financial threat to plans.</p> <p>Maintaining dementia as a priority at national, regional or local level.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- What does it take to make this happen?</p>	<p>Funding for GP 2 days a week over x years.</p> <p>Funding and commitment to annual primary care summits</p> <p>Development costs for GP toolkit.</p>
<p><b>Transferable Learning</b></p>	<p><b>Importance of peer lead approach</b> Engagement of a “jobbing”, “ordinary” GP who can relate the experiences, values of colleagues and sell the benefits from a GP perspective.</p> <p><b>GP toolkit</b> Practical advice and tools designed to be at hand for GPs to use.</p> <p><b>Value of practice visits</b> The importance of taking the debate to practices, eyeballing and engaging in discussion.</p> <p><b>Benefits of primary care summits</b> Two summits have now taken place, gaining momentum with significantly increased attendance.</p> <p><b>Locating and coordinating services around GP practices</b> GPs have direct, visible access to services and can see the practical benefits of recognising dementia.</p> <p><b>e-learning training tools</b></p>
<p><b>Validation/ Evaluation</b></p>	<p>To date direct feedback has been very positive and the toolkit well received.</p> <p>There has been no formal evaluation of the impact however the combined impact of the initiatives undertaken will be monitored in respect of increasing diagnosis rates.</p>

## Good Practice Compendium – an assets approach

<b>Sustainability/ Next Steps</b>	This will be important to consider in the context of GP commissioning.
<b>Key contact/Locality</b>	Helen Bown Joint Commissioning Manager, Gloucestershire NHS <a href="mailto:Helen.Bown@glos.nhs.uk">Helen.Bown@glos.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	2

**26. Improving the clinical care provided by ambulance clinicians  
Great Western Ambulance Service (GWAS)**

<p><b>Aims</b></p>	<p>To enable ambulance clinicians to provide a more informed approach and a higher standard of care to people with dementia.</p> <p>To understand the challenges faced by ambulance clinicians in providing support when attending to people with dementia and provide evidence to support this.</p> <p>To increase awareness of dementia amongst ambulance clinicians and provide them with some basic knowledge and skills.</p> <p>To reduce the number of people with dementia unnecessarily conveyed to A&amp;E.</p>
<p><b>Local Context for Initiative</b></p>	<p>Great Western Ambulance Service NHS Trust provides emergency and urgent care, and patient transport services across Wiltshire, Gloucestershire and the former Avon areas. The Trust employs more than 1,680 staff across 33 operational sites – 30 ambulance stations and three emergency operations centres. The Trust covers an area of 3,000 square miles with a population of approximately 2.2 million people. Last year (2008-09), GWAS responded to more than 233,000 emergency calls. By far the highest proportion of calls are to the elderly many of whom are likely to have dementia.</p> <p>There had been a number of occasions where ambulance clinicians had been faced with difficulties when attending to people with dementia for example, people being found to be at high levels of risk, problems with completing medical assessments and clinicians facing escalating aggression.</p> <p>Following discussion between the ambulance trust clinical lead and the Department of Health SW lead for dementia a survey was undertaken to test a) dementia awareness of ambulance clinicians b) the level of difficulty being encountered. The results indicated that awareness levels were low and there were a range of difficulties being encountered.</p> <p>Following the review of the collated data five key areas were identified:</p> <ul style="list-style-type: none"> <li>• the need for training</li> <li>• the need for care / referral pathways including inter agency communication</li> <li>• the need to improve the use of communication tools</li> <li>• access to assessment and treatment tools for responding to people who have dementia.</li> <li>• additional support and information to share with individuals and carers</li> </ul>

## Good Practice Compendium – an assets approach

<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The progress made to address these key areas include:</p> <ul style="list-style-type: none"> <li>• the production and dissemination of an information leaflet for GWAS clinicians that provides baseline knowledge of the condition, tips on communication and an awareness of the medications an individual with dementia might take.</li> <li>• An on line dementia training module is being developed for staff</li> <li>• information on where to find out more including useful websites has been shared with all staff.</li> <li>• communication with other health care providers has begun which will start the process for agreeing alternative care routes, the plan is to include rapid assessment at home, treatment at home, respite and place of safety beds all accessed directly by GWAS clinicians.</li> <li>• GWAS are encouraging the local primary care trusts to adopt the use of a communication tool at individual's home address. The communication tool can include a variety of information such as likes and dislikes, previous occupation and other useful information which will assist in gaining the patients trust and minimising anxiety.</li> </ul> <p>The implementation of this joint piece of work will support the national strategy through improved awareness and quality of care. In addition, the individual and carer will receive the right care in an environment they are familiar with reducing stress and anxiety for all involved. Unnecessary hospital admissions will be avoided, which in turn will result in a potential cost saving for the NHS. The individual and carer will receive the appropriate care and support necessary to support a good quality of life.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>Ensuring senior management support: the project was formally proposed and authorised to ensure effective governance and support and inclusion in business plan.</p> <p>Releasing staff for training:</p> <p>Training has been included on emergency care assistant induction, patient transport service training, access to e learning is being implemented. A module on dementia will be included in the 11/12 statutory mandatory training day. Higher education partners are reinforcing the need for additional dementia training.</p> <p>Achieving congruence across varied localities each with different levels of service provision, protocols and information systems.</p> <p>GWAS are taking the lead in co-ordinating activity to make progress on care pathways.</p>
<p><b>Resources/ Capability/ Capacity</b></p>	<p>Basic awareness and training: the leaflet is available for others to use. It simply requires circulation and printing. Basic, generic training packages are available on the SCIE website, ambulance clinicians can be required to complete these</p>

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<p><b>- What does it take to make this happen?</b></p>	<p>as part of their annual learning and development plan and update their portfolios. Dementia awareness will be incorporated in basic training module using these materials as a basis for reflection and discussion.</p> <p>This is effectively minimal, zero cost activity. Accessing SCIE materials does require the availability to access the web, all ambulance stations have internet access. An e learning package is being developed and the ability to monitor completion included.</p>
<p><b>Transferable Learning</b></p>	<p>The ambulance leaflet is available for others to use and adapt.</p> <p>The results of the study are available for others to consider.</p> <p>Any tools developed for the assessment and treatment of people with dementia, care pathways for ambulance clinicians will be made available.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Questionnaire to ambulance clinicians and semi structured interviews at a regional event. Feedback was very positive.</p> <p>Funding for audit evaluation and development has been requested.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>GWAS have recently launched an in house Journal of Clinical Practice “Quality and Innovation”, an article on dementia awareness, additional knowledge and information is being written for inclusion in the summer edition. Services available for care and referral pathways are being reviewed with the intention of having a directory of services available to this patient group throughout the GWAS area.</p> <p>Work has begun to look at assessment tools currently available and adaptation to accommodate pre hospital care. An information leaflet will be developed to provide individuals with dementia and their carer’s advice on the additional help, and support that is available within their area.</p> <p>Taking the training forward has been recognised and is being rewarded as a CQUIN target.</p>
<p><b>Key contact/Locality</b></p>	<p>Vicky O’Leary Paramedic Clinical Lead, Great Western Ambulance Service NHS Trust <a href="mailto:Vicky.O’Leary@gwas.nhs.uk">Vicky.O’Leary@gwas.nhs.uk</a></p>
<p><b>Dementia Strategy Objectives</b></p>	<p>Links to directly to: 13 Links indirectly to: 8, 9</p>

**27. LINK worker training, Gloucestershire**

<p><b>Aims</b></p>	<p>To improve the quality of care being provided by training LINK workers in care homes, people who are able to link theory into practice.</p> <p>LINK workers lead on best practice, act as a point of reference for other staff, helping with their training and development and providing advice when there are problems.</p> <p>LINK workers promote the best interests of people with dementia by enabling staff to feel more confident and improving the resilience of care homes.</p>
<p><b>Local Context for Initiative</b></p>	<p>Gloucestershire made a conscious decision to make substantial improvement in the care provided in local dementia care homes. There had been a history of concerns and the council was fortunate to secure POPPs funding which provided the platform for making investments in training in dementia care and the development of the LINK worker scheme.</p> <p>The LINK worker training scheme is accredited and just one component of a series of joined up dementia training pathways which have been developed by the council and PCT. These include e-learning, high quality workbooks, face to face sessions , two one- day dementia programmes and a distance learning programme.</p> <p>The training packages are accessible, offer flexibility and choice and are incremental. They are matched against dementia competencies. To complete the whole programme to become a LINK worker takes 12 – 18 months.</p> <p>Best practice forums have been established to provide support networks for LINK workers.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>87% of care homes in Gloucestershire now have dementia link workers who have completed or are undergoing training.</p> <p>There is clear evidence of improved outcomes for people with dementia based on dementia care mapping. There are also consistent reports that care homes are less reliant on in-reach support, that people are less likely to be admitted to hospital and that medication usage is being reduced.</p>

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<p><b>Challenges</b></p> <p>- How these were addressed</p>	<p>The initial challenge was the low skill base and the large number of staff requiring training. In addition there were different cultures and approaches across organisations.</p> <p>Joint investment and long term project joint planning (delivering over 3 years) have been essential to establish models of training that are high quality and of value to wide range of staff.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- What does it take to make this happen?</p>	<p>The wider training strategy is jointly funded by the local authority and PCT and covers staff across a wide range of sectors across health and social care.</p> <p>The staff resources include a full time project manager, full time administrator and 3 whole time dementia education nurses.</p>
<p><b>Transferable Learning</b></p>	<p>Gloucestershire has made the training pathways and learning materials available for others to use and adapt.</p> <p>The concept of LINK workers is transferable to a number of settings.</p> <p>The use of dementia education nurses to develop and support staff is a particularly effective means of improving competence front line staff.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Evidence to date based on dementia care mapping has demonstrated improvements in well being as a result of improved staff competence.</p> <p>Gloucestershire workforce development group are seeking support from the Department of Health / SHA to assist with an independent evaluation.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The LINK worker scheme has already been extended to domiciliary care services and is being developed and extended into hospital and primary care settings.</p> <p>Workforce development grants have underpinned investment to date. Future??</p> <p>The independent evaluation will allow the cost benefits to be better understood and will assist in decisions about future investment.</p>
<p><b>Key contact/Locality</b></p>	<p>Jan Ellis Dementia Training Implementation Lead, Gloucestershire County Council <a href="mailto:Jan.Ellis@gloucestershire.gov.uk">Jan.Ellis@gloucestershire.gov.uk</a></p>
<p><b>Dementia Strategy Objectives</b></p>	<p>11, 13.</p>



<b>28. STAR Toolkit, Cornwall Reducing medication in care homes</b>	
<b>Aims</b>	<p>The STAR (Stop, Think, Assess, Review) Initiative is a county wide, multi-agency educational toolkit aimed at reducing the use of inappropriate medication in people with dementia. It provides information regarding behavioural and psychological symptoms of dementia (BPSD), explanations of factors contributing to BPSD, alternative strategies to medication, and information about prescribing to assist health workers.</p> <p>It also promotes a '3 monthly' checklist to review, monitor and reduce the prescribing of medication, and an 'at a glance' summary and pathway, plus a laminated information booklet with practical observational tools to monitor behaviour.</p> <p>'STAR' enables health and social care staff to take positive action to resolve the challenges of prescribing with practical and safe alternatives.</p>
<b>Local Context for Initiative</b>	<p>The STAR initiative was developed by CIOS PCT, Royal Cornwall Hospitals Trust and Cornwall Care. It was developed as a result of national and local recognition of the overuse of medications prescribed to people with dementia and the impact that these drugs may have on physical health and quality of life.</p> <p>There are over 8000 people living with dementia in Cornwall and the Isles of Scilly, with approximately 4,000 newly-diagnosed cases annually. It is estimated that one third of those diagnosed live in long term care settings. An independent review has found that an estimated 150,000 people with dementia in the UK are being inappropriately prescribed antipsychotic drugs and these are contributing to 1,800 deaths a year (Alzheimer's Society Report, 2009).</p> <p>Cornwall's key aims and objectives are to reduce inappropriate prescribing of medications used in the management of BPSD and in addition to:</p> <ul style="list-style-type: none"> <li>• raise awareness of and reduce the use of unnecessary medications</li> <li>• reduction of unnecessary medications with GP pharmacist reviews.</li> <li>• increase recognition of dementia and BPSD to all health and social care professionals</li> <li>• establish well-informed work forces across all care settings</li> <li>• increase access to high quality care and management for the person with dementia</li> <li>• improve life outcomes (physical, psychological, social, environmental and emotional) for people with dementia</li> <li>• increase the choice of treatments</li> <li>• improve the experience of people with dementia in care homes.</li> <li>• reduce the number of people with dementia admitted to</li> </ul>

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	<p>acute hospitals from care homes</p> <ul style="list-style-type: none"> <li>• reduce poly-pharmacy</li> <li>• prevent the number of stroke related incidents as a result of antipsychotic medications</li> <li>• reduce the number of falls sustained as a result of medications and poly-pharmacy</li> <li>• ensure alternative strategies to medication are understood and utilized</li> <li>• reduce and eliminate the incidence of undetected and untreated pain</li> <li>• Provide safe, appropriate and cost-effective treatment plans</li> <li>• Reduce costs.</li> </ul>																																
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>An initial audit took place in Cornwall Care's 18 care homes (4 with nursing services) prior to the start of the education programme and the launch of the STAR initiative. There were approximately 600 residents living in these care homes at the time of the audit. 149 (25%) of these individuals were prescribed at least one of the target medications, with a total of 192 prescribed target medications. The most commonly prescribed medications were:</p> <table data-bbox="766 891 1157 1160"> <tr> <td>Lorazepam</td> <td>35%</td> </tr> <tr> <td>Diazepam</td> <td>16%</td> </tr> <tr> <td>Quetiapine</td> <td>14%</td> </tr> <tr> <td>Carbamazapine</td> <td>9%</td> </tr> <tr> <td>Sodium Valproate</td> <td>7%</td> </tr> <tr> <td>Olanzapine</td> <td>6%</td> </tr> <tr> <td>Risperidone</td> <td>5%</td> </tr> </table> <p>and the reason for prescription given was:</p> <table data-bbox="718 1236 1209 1523"> <tr> <td>Aggression</td> <td>21%</td> <td>21%</td> </tr> <tr> <td>Agitation</td> <td>20%</td> <td>20%</td> </tr> <tr> <td>Anxiety</td> <td>18%</td> <td>18%</td> </tr> <tr> <td>Sexual Disinhibition</td> <td>2%</td> <td>2%</td> </tr> <tr> <td>Unclear rationale</td> <td>13%</td> <td>13%</td> </tr> <tr> <td>Other factors</td> <td>26%</td> <td>26%</td> </tr> </table> <p>Given these initial results, it was clear that people were administering medications without a clear understanding of the reasons for prescription, the side effects or the need for regular review. A high percentage of individuals no longer displayed the behaviour and the prescription was based on historical fact rather than current need.</p> <p>It is of note that the population in long term care settings fluctuates rapidly and audit results reflect this.</p> <p><b>Results from one residential care home. medication reviews using STAR.</b>  <b>Temazepam</b> 5mls nocte reduced 2.5mls with further review to discontinue.  <b>Olanzapine</b> 5mgs once daily discontinued.  <b>Lorazepam</b> 1 mg tds reduced and discontinued.  <b>Olanzapine</b> 5mgs once daily discontinued.</p>	Lorazepam	35%	Diazepam	16%	Quetiapine	14%	Carbamazapine	9%	Sodium Valproate	7%	Olanzapine	6%	Risperidone	5%	Aggression	21%	21%	Agitation	20%	20%	Anxiety	18%	18%	Sexual Disinhibition	2%	2%	Unclear rationale	13%	13%	Other factors	26%	26%
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	<p><b>Zopiclone</b> 3.75 mgs discontinued  <b>Lorazepam</b> 0.5mgs tds discontinued.  <b>Diazepam</b> 2mgs bd discontinued  <b>Diazepam</b> 2mgs once daily discontinued.</p> <p>Following the launch of the STAR initiative, GP’s and community pharmacists commenced the first annual care home medication review the lead pharmacist for the reviews said:</p> <p>Using the S.T.A.R gave staff the opportunity to monitor pain, mood and behaviour over a week prior to the visit, this helped pharmacists understand the appropriateness of the prescribed medications in particular Antipsychotic and Benzodiazepines.</p> <p>One care home using the S.T.A.R looked at alternatives to medications, inspired staff provided individual plans of occupation and stimulation instead of medication resulting in discontinuation of benzodiazepines for many residents.</p> <p><b>Carers feedback</b>  All relatives at a care home were informed of S.T.A.R initiative, the relatives were all pleased that we were all working with the GPs and pharmacists to review medication thoroughly.</p> <p><b>Quote from Cornwall Care Home Manager</b>  “Following the STAR initiative, I felt that I could more effectively advocate for my residents and have since challenged the need for certain medications for several individuals. I have done this as I now have a much more in-depth understanding of medications and the alternatives that we can provide”.</p>
<p><b>Challenges</b>   <b>- How these were addressed</b></p>	<ul style="list-style-type: none"> <li>• Timeframe to ‘roll-out’ education programme</li> <li>• Releasing staff to attend education sessions.</li> <li>• Individual challenges such as levels of knowledge, and staff ‘turnover’.</li> <li>• Ensuring new staff receive the education and existing staff are updated to keep the initiative focused and to further embed in individual services.</li> <li>• Challenging the perception of the innovation as a “tick box” response to the Dementia Strategy</li> <li>• ‘Sign up’ from all organisations, This is particularly so in respect of GPs.</li> <li>• Format and content of checklist to ensure simplicity of use and ease of information gathering given other responsibilities</li> </ul> <p>Addressing the above has primarily depended on the enthusiasm and drive of the project lead but will be embedded in service level agreements.</p> <p>The key to success rests on engagement of GPs and establishing who is accountable, “owns”, the prescription. There can be some reluctance for anyone to take the initiative and responsibility in reducing medication.</p>
<p><b>Resources/ Capability/</b></p>	<p>The STAR initiative has been a collaborative venture between health and social care providers, led by CIO SPCT.</p>

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<p><b>Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>The partners involved in this project have key roles in implementing change. The partners are:</p> <ul style="list-style-type: none"> <li>• Clinical Lead Nurse for Dementia, CIOSPCT; Care of the Elderly Consultant Physician RCHT - Responsible for development, introduction, production, audit and county wide roll-out of STAR innovation.</li> <li>• Pharmacists, CIOSPCT – Development of the STAR booklet G.P education programme. Care home reviews</li> <li>• Care of the Elderly ward manager and nursing team, Care of the Elderly specialist pharmacist, RCH – Development and introduction of STAR and have led on the launch in the acute hospital setting.</li> </ul> <p>Cornwall Care – Development, introduction and audit of STAR innovation in all 18 of their county wide care homes.</p>
<p><b>Transferable Learning</b></p>	<ul style="list-style-type: none"> <li>• Easy to use toolkit</li> <li>• Twice year GP and Pharmacist review.</li> <li>• Cornwall Care (Cornwall's largest independent care provider) have included the STAR initiative in their Medication policy and Pain Assessment Pathway.</li> <li>• County-wide e-learning package open to staff from all care settings</li> <li>• Outlook South West (commissioned to provide education to carers of people living with dementia) include STAR in their education programme.</li> <li>• STAR education will continue with annual refreshers for staff who have undertaken the complete programme plus regular sessions for new employees.</li> <li>• CIOSPCT have developed a care home checklist to ensure quality of care delivered in care homes. Implementation and continuation of the STAR initiative is included in the criteria.</li> <li>• Tool for monitoring impact on well being following changes in medication is available.</li> </ul>
<p><b>Validation/ Evaluation</b></p>	<p>Initial results based on feedback from a small number of homes (see above) show promising outcomes.</p> <p>However capturing reliable evidence across a wide range of care services requires local audits within care homes. CIOSPCT are in the process of commissioning an independent review to capture:</p> <p>a) changes and reduction in medication profiles b) any changes / improvements in the function.</p> <p>Note: A detailed tool has been developed to monitor changes in wellbeing following changes in medication.</p> <p>The results will be available later in the year.</p>




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<b>Sustainability/ Next Steps</b>	<p>The programme is self-sustaining, primarily dependant on ongoing co-operation between agencies.</p> <p>Refinements and further developments will depend on the evaluation.</p>
<b>Key contact/Locality</b>	<p>Bev Chapman Clinical Lead for Dementia, Cornwall and Isles of Scilly PCT E-mail: <a href="mailto:Beverley.chapman@cornwall.nhs.uk">Beverley.chapman@cornwall.nhs.uk</a> Tel: 0777 475 2372</p>
<b>Dementia Strategy Objectives</b>	<p>11, 18.</p>

**29. The Charter Mark Standards for Royal United Hospital (RUH) Patients with Dementia**

<p><b>Aims</b></p>	<p>Provide a 'gold standard' for staff to ensure care for people with dementia on all adult wards, not just those specifically for older people, is the very best it can be</p> <p>Each ward is being given the opportunity to apply for the Charter Mark, with three levels available - gold, silver and bronze. The standards cover four main areas of care: respecting and caring for people with dementia, the ward environment, meeting nutritional needs and suitability of staffing</p> <p>Within each of these areas there are then further markers of 'excellent care'. These include ensuring that care is person-centred and that feedback from patients and their carers show a high level of satisfaction.</p> <p>To be awarded the gold standard Charter Mark, wards must hit the highest level in each of the main areas, following an inspection. These would include ensuring that signage meets the needs of people with dementia, and that there are appropriate activities to prevent boredom and restlessness.</p>
<p><b>Local Context for Initiative</b></p>	<p>RUH, working in partnership with Avon and Wiltshire Mental Health Partnership NHS Trust and voluntary organisations such as Alzheimer's Support</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>The high standards (attached) are set for each adult ward to ultimately provide the very best care possible for patients with dementia and ensure their stay in our hospital is as stress-free as possible</p> <p>In order to apply for the Charter Mark, each ward manager sends a written application before taking part in a preliminary informal review. A formal review then takes place involving patient representatives followed by an observation period to really see work in practice on the ward</p> <p>For example, Improving the mealtime experience - Carers will be encouraged to visit if they wish to and patients will have the chance to sit at a table more socially if they would like. More flexibility in the provision and presentation of food will be encouraged, with snacks and finger foods offered 24 hours a day to make it easier for patients with dementia to keep their independence and still maintain their weight</p> <p>RUH believes such a methodology has not been used before to raise standards of care for people with dementia in acute hospitals. If successful and care standards are optimised then National Audit Office analysis would suggest they could save many hundreds of thousands of pounds.</p> <p>The charity Alzheimer's Support based in Wiltshire was the main source of carer feedback.</p>

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<p><b>Challenges</b></p> <p>- How these were addressed</p>	<p>Ensuring the charter mark is achievable, yet challenging to wards. Hence the decision to have different levels.</p> <p>The marking system will be based on judgement by the assessing team, not by an absolute points system.</p> <p>A prize of £1000 is available from the Trust as added incentive, which can be used by the ward for staff training.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p>- What does it take to make this happen?</p>	<p>The charter mark was developed by the RUH dementia strategy group and several key individuals led the development. The charter mark has been launched and publicised on the RUH dementia webpage. It has been publicised internally through the communications department, and applications are managed through the older people's matron.</p>
<p><b>Transferable Learning</b></p>	<p>The charter mark could be used and adapted by any other Trust's, they are welcome to request copies from the Trust.</p>
<p><b>Validation/ Evaluation</b></p>	<p>We have not evaluated the charter mark as it has only recently been launched, however all the standards are measurable and objective.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>All wards will be expected to apply, the dementia strategy group will monitor. Older Person's wards are 1<sup>st</sup> in line.</p>
<p><b>Key contact/Locality</b></p>	<p>Dr Chris Dyer, Consultant Geriatrician  <a href="mailto:chris.dyer@ruh.nhs.uk">chris.dyer@ruh.nhs.uk</a>            Sue Leathers, Matron Older People's Services  <a href="mailto:sue.leathers@ruh.nhs.uk">sue.leathers@ruh.nhs.uk</a></p>
<p><b>Dementia Strategy Objectives</b></p>	<p>This was one of our dementia strategy objectives to audit wards and set standards for care. Other standards we are working on include improving the environment and increasing training opportunities for all staff and volunteers.</p>
<p><b>Further Information</b></p>	<p>               H:\HEALTH.po\ SOCIAL CARE\DRD\RSOCIAL CARE\DRD\RSOCIAL CARE\DRD\         </p>

**WEST MIDLANDS**

**30. SPECIALIST INTERMEDIATE CARE**  
*'Partnership working and integrating technology into service provision'*

<b>Aims</b>	<p><b>The Customer Group</b></p> <p><b>Older People with Mental Health Difficulties</b></p> <ol style="list-style-type: none"> <li>1. Adults of any age with a clinical diagnosis of dementia</li> <li>2. Individual over 65 years of age with a functional mental diagnosis</li> </ol> <p><b>Key objectives</b></p> <ul style="list-style-type: none"> <li>• Give people increased choice about remaining at home</li> <li>• Prevent unnecessary hospital admissions</li> <li>• Reduce long-term residential or nursing care admissions</li> <li>• Reduce the need for emergency residential respite care provision</li> <li>• To prevent the breakdown of caring support arrangements</li> <li>• To enable individuals to return to independent living outside of residential settings</li> <li>• Improve support structures and partnership working with family carers</li> <li>• To enable individuals to regain or maintain skills but intervene when risk levels increase to help prevent and manage crisis.</li> </ul> <p><b>The services provided</b></p> <ul style="list-style-type: none"> <li>• Specialist intermediate domiciliary care (working in partnership with <i>Sure Care Services</i>)</li> <li>• Roving night service (co-ordinated by the Council's Intermediate Care service)</li> <li>• Assistive technology (<i>Just Checking</i> activity monitoring, <i>Telecare</i> exit sensors, Safe Walking Technology etc.)</li> </ul> <p><b>Service details</b></p> <ul style="list-style-type: none"> <li>• This project involved the development of a 24-hour care service incorporating improvements in Assistive Technology to maximise independence and improve risk assessment</li> </ul>
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- The service supports individuals to remain living in the community, reducing the need for care home placements. The support is person-centred and responsive to the needs of older people with mental health issues. This is based upon the key person-centred principles of continuity of care, flexibility and improved communication. Along with Activity Monitoring, these principles created a dynamic and responsive approach to care provision.
- The service is delivered through a partnership arrangement with an independent domiciliary care provider whereby carers are trained in the reablement of people with dementia, placing therapy based approaches at the heart of service intervention.
- Therapists (Occupational Therapist, Physiotherapist, Nurse / Intermediate Care Facilitator) provided 'in-house' with reablement support workers supplied by care agency through a fixed weekly hour contract.

### **Involvement and Partnership**

#### **Domiciliary Care Provider**

A key decision was to work in partnership with a domiciliary care provider rather than develop the service 'in-house'. Developing intermediate care in isolation of longer-term support structures was a counter-productive approach. With Council support the care provider could evolve into a specialist home care service thereby facilitating a longer-term strategy.

A key aim was to improve the flow of information by making the Reablement Support Workers central to the partnership between service user and carer. The service was focussed on the needs of the individual rather than expecting the service user to accept what is most convenient for the service to provide. Specialist training and improving communication systems were placed at the heart of service development. A Care Facilitator role was identified to take lead responsibility for the co-ordination and communication between the care provider, Mental Health services and Adult Social Care. Reablement Support Workers were encouraged to liaise directly with professionals rather than passing concerns onto an organiser back in the office. They were given a degree of autonomy to alter the timing of the programme to accommodate requests from service users and carers without needing further approval, attending all reviews to personally explain areas of concern or particular successes. This provided improved communication and supported a culture where professionals valued Reablement workers knowledge and skills and there was a greater sense of being part of a wider multi-disciplinary team.

#### **Family Carers / Service Users**

A key aim was to work closer in partnership with family carers and provide improved support to enable them to carry out their caring role. Many carers had concerns about their relatives remaining in the community especially for individuals who lived on their own. New assistive technology was commissioned to provide a clearer idea of an individual's daily routines and patterns of activity. This information was made available to family carers through a secure website. This greatly improved partnership working between family carers and professionals and enabled risk assessment to be based upon objective information. This technology gave service users a real voice in

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	<p>the decision-making process by identifying their strengths and capabilities rather than concentrating upon negative assumptions or fears.</p> <p>The pilot project set a clear evaluation framework where service users, family carers, Reablement Support workers and professionals were all given the opportunity to give feedback and contribute to the development of the service provision.</p>
<p><b>Local Context for Initiative</b></p>	<ul style="list-style-type: none"> <li>• A net ‘importer’ of older people, with a large geographical area, Herefordshire had historically encountered difficulties in organising domiciliary care in rural areas.</li> <li>• Prior to the project a disproportionate number of Older People with Mental health need were entering institutional care</li> <li>• Analysis of Residential admissions in Herefordshire had identified that mental health functioning was a key determining factor in why people entered institutional care</li> <li>• Prior to the project there were insufficient domiciliary care services with specialist mental health skills or knowledge to work intensively with service users from older people’s mental health services</li> <li>• Extremely limited access to generic Intermediate Care Services for older people with mental health need</li> <li>• Minimal mental health expertise in local Intermediate Care</li> <li>• Risk aversion culture in community services with extremely limited resources to sustain older people with mental health need at home during crisis periods leading to the overuse of emergency respite or hospital admissions</li> </ul>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p><b>One Year Evaluation Results</b></p> <ul style="list-style-type: none"> <li>• A Longitudinal Study in March 2008 examined the long-term outcomes of 37 individuals who were provided with a service in the first three months of service operation. The total cost of investment for the 37 identified individuals was £79,363. This produced potential savings of over £180,000 in the first year by mitigating the Council’s liability for nursing or residential care.</li> <li>• 78% of service users at risk of long-term Residential or Nursing care admission still living at home at the six month stage of project.</li> <li>• 57% of service users at risk of long-term Residential or Nursing care admission still living at home at the one year stage.</li> <li>• The majority (63%) of individuals supported by the Specialist Intermediate Care service who still live at home continued to have low-level care needs at the one year stage indicating that they would continue to remain living in the community.</li> <li>• Service users were actively involved in the decision making process and given a real ‘voice’ in risk management and a choice to remain living in their local community.</li> </ul>

- Evidence of strong partnership working between professionals and family carers with risk management decisions based upon objective information rather than negative assumptions of an individual's ability.
- Evidence of family carers being supported in their caring role and provided with the reassurance that their relative was coping independently on their own. The family carer questionnaire comments illustrated high levels of satisfaction with the service including the integration and co-ordination between differing service elements.
- Self-funding individuals were supported to regain skills and remain living in the community rather than consider long-term care provision.

### **Two Year Evaluation results**

- 25% reduction (57 placements) in funded care home placements over 2 year period with potential saving of between £1.5 - £1.7 million
- Reduced use of emergency respite / hospital admissions including acute Mental Health wards with reduced crisis interventions and older people awaiting hospital discharge
- 81% of individuals (110 out of 136) provided with a service in 2009 and at risk of residential or nursing home admission were still living in the community on the 1<sup>st</sup> Feb 2010.
- The majority (75%) of individuals supported by the Specialist Intermediate Care service who still live at home continue to have low-level care needs indicating that they will continue to remain living in the community.
- Identified improvements in service user functioning and dependency levels after service intervention with decreases in Modified Dependency Rating Scale tool assessment scores in 37% of cases whilst 59% maintain their current levels of functioning. The improvements in assessment scores are smaller than generic Intermediate Care but they are significant in either providing increased confidence or stabilising home situations and preventing a further deterioration in functional skills.
- Self-funding individuals were supported to regain skills and remain living in the community rather than consider long-term care provision.
- The hourly unit cost for the Specialist Intermediate Care Service (approx £29) provides a more cost effective solution for intermediate care provision compared with our generic in-house intermediate care (approx £69)
- Analysis of the client / reablement support worker contact time highlights a high percentage (70%) of contact time in comparison with generic intermediate care services (37%)
- The evaluation concluded that the service model for Specialist Intermediate Care based upon a partnership approach (e.g. clinical and therapy provided by health & social care and the domiciliary

reablement outsourced to an independent care provider) is delivering positive outcomes for the service user group and enabling the establishment of appropriate on-going care support structures.

On-going Care Support	Need Category	Service User Numbers
Independent	Low	43 (39%)
Up to 7 hrs/week	Low	14 (13%)
7 – 14 hrs/week	Low	25 (23%)
14 – 21 hrs/week	Medium	17 (15%)
Over 21 hrs/week	Medium / High	7 (6%)
24 hour support at home	High	0 (0%)
Current Service User (Feb 2010)	N/A	4 (4%)

- On-going care need outcomes for the 110 individuals still living in the community show an improvement on the results from the 2008 evaluation and continue to identify how a high percentage (75%) of individuals have low level on-going needs. 39% of service users are independent, supported by their family or a have a low level service (e.g. Supporting People / Telecare / Day Opps / Meals service etc).

**The views of customers**

- The great majority agree that that they are involved in making decisions about how they live, including everyday choices about what they do; are treated with dignity and respect; are helped to feel safe, secure and independent in their own home; and have confidence in their own ability.

- Typical comments include:

*“I like the carers and felt they helped me to be able to talk about my feelings”*

*“I feel the service is wonderful and the carers are really nice. I would like this to continue...”*

*“Roving nights is a wonderful service and we want it to continue.”*

**The views of family carers**

- The great majority feel they are treated with dignity and respect; involved in decision-making; know who to contact and how to access information; and feel able to have as much contact with other people as they want.

- Typical comments include:

*“This is a very good and caring service run by a professional crew...I thought this was going to be a difficult service to pull together but it was seamless.”*

	<p><i>“I am very happy with the service – made it possible for Dad to stay at home.”</i></p> <p><i>“The Just Checking service is brilliant. When I was first told about this I was very concerned but now haven’t a bad word to say.”</i></p>
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<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p><b>Limited timescales</b></p> <p>The major challenge of the project was the limited timescale to get the services up and running. We were attempting to develop a new approach to local service provision with close partnership arrangements and the integration of complex technology. This involved detailed commissioning processes, corporate procurement issues and complex information technology challenges all within tight timescales.</p> <p><b>Technology Integration</b></p> <p>The authority had already established a comprehensive Telecare service in partnership with a local Care Line organisation. Research had highlighted advances in Assistive Technology based around activity monitoring for individuals with dementia. A corporate business case was produced to enable the commissioning of the Just Checking system with the potential to integrate this with smart phone technology. This enabled the establishment of a responsive service that encouraged service user independence but provided flexible support when required without undermining this independence.</p> <p>Herefordshire is an extremely rural sparsely populated county with the 4<sup>th</sup> lowest population density in England. Mobile phone network coverage is extremely patchy and non-existent in certain rural areas. The Just Checking system, Safe Walking Technology and smart mobile phones rely upon mobile phone networks to operate and this created a major difficulty to identify workable solutions. This required working closely with Just Checking / Buddi to commission a range of systems based upon different network providers whilst carrying out a comprehensive analysis of mobile network coverage across Herefordshire.</p> <p><b>Partnership Working</b></p> <p>The new services consisted of a Specialist Intermediate Care Service with domiciliary care support from an independent care provider, a Roving Night team provided ‘in-house’ and external agencies like Just Checking and Care Line supporting technology developments. To co-ordinate all these services and ensure the provision of integrated 24 hour support required a high level of planning and management. Providing the project with dedicated Project Management enabled the services to be pulled together with joint aims and objectives and clear risk and decision-making processes.</p> <p><b>Training</b></p> <p>For the project to work we placed person centred training at the heart of service development. Over a twelve-month period a comprehensive training programme was established. Training staff from separate agencies whilst running the service was extremely difficult to organise especially with such an ambitious training plan. This required high levels of motivation and strong partnership working to succeed.</p>
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<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p><b>Invest to Save</b></p> <p>You require the initial first year investment to cover therapy costs, domiciliary care provider contract, technology products. In Herefordshire this worked out at about a £400,000 investment in 2008. We started piloting the project in rural South Herefordshire and evaluated at 3 and 6 month periods. This soon identified cost saving and some major reductions (43%) in residential admission levels. This encouraged us to incrementally extend the service across Herefordshire. The evaluation in Feb 2010 identified a 25% reduction in funded Care Home placement over the two year period of project.</p> <p><b>Commitment &amp; Motivation</b></p> <p>To pull all these services together you require a strong team of dedicated individuals with the right drive and desire to make it work. Someone needs to lead the project who does not have day-to-day responsibility for clinical management – projects tend to create problems especially in the initial stages that need resolving and someone needs to be promoting and evaluating outcomes. Without direct Project Management involvement you may struggle to prove the benefits and cost savings.</p>
<p><b>Transferable Learning</b></p>	<p><b>Partner Selection</b></p> <ul style="list-style-type: none"> <li>• Ensure you are clear within your tender details when requesting agencies to put in expressions of interest</li> <li>• When you make the selection decision about partner organisation make sure you place quality care and assessment response times at the top of the agenda. Do not select predominately on cost basis - we used a 70:30 split to ensure that quality was the top criteria – if you don't get the right partner you will struggle to succeed.</li> </ul> <p><b>Integrated Technology</b></p> <ul style="list-style-type: none"> <li>• Integrate technology into service provision rather than attempting to use it in isolation to maximise the potential of the solution, improve ethical considerations / principles, and ensure ownership and understanding across partners and agencies</li> <li>• Technology must <b>enable and empower</b> rather than <b>disable and compound</b>. It holds many new opportunities but we must make sure that we use it to give people a <b>greater voice</b> and <b>more control</b> – <b>augment</b> and <b>supplement</b> human care <b>not</b> replace it.</li> <li>• Identify your local networks and ensure you procure a selection of either roaming 'simms' (more costly but enables generic solution if all operators signed up by providers – checked this out to avoid issues later) or systems that meet your local needs. You need to be able to provide a workable solution on the first day in order to avoid the chances of the home situation breaking down – once individuals with memory difficulties are admitted into institutional setting it becomes difficult to get them back home and there is a far greater risk of long term admission to care.</li> </ul>

	<p><b>Training at the HEART</b></p> <ul style="list-style-type: none"> <li>• The main key to the success of this initiative is ensuring that training is central to everything. Staffs requires the skills and confidence to work with people with memory difficulties by raising awareness and tackling underlying discrimination and ensuring the service user needs are paramount.</li> </ul> <p><b>Greater Voice &amp; Positive Risk Taking</b></p> <ul style="list-style-type: none"> <li>• Key learning from this project is that people with memory difficulties who live on their own are more capable than other people believe.</li> <li>• We give too much weight to the negatives and tend to blow incidents out of proportion without examining the true risks involved including frequency and severity.</li> <li>• Technology allows you to make an objective assessment based upon an individual’s daily routine. Using this information gives the service user a ‘real voice’ in the risk assessment process and enables care support to be targeted appropriately and with relevance.</li> <li>• Individuals with memory difficulties cope best within familiar environments and with the right interventions you can stabilise situations and support people to remain living at home. Decisions about institutional care should be made based upon someone’s functioning in a familiar home environment rather than an institutional setting if possible.</li> </ul> <p><b>Carer Information &amp; Support</b></p> <ul style="list-style-type: none"> <li>• Family carers have a strong influence and say over the viability of maintaining people with memory difficulties in the community.</li> <li>• The more you can work in true partnership by sharing information, providing quality support during times of crisis, and active involvement in risk management the greater chance that individuals will be supported to remain living at home.</li> <li>•</li> </ul>
<p><b>Validation/ Evaluation</b></p>	<p><b>Two Year Evaluation Process</b> (see Achievements / Benefits Section for details)</p> <p><b>Independent recognition</b></p> <ul style="list-style-type: none"> <li>• West Midlands regional finalist in the Health and Social Care Awards 2009 (Innovative Health &amp; Social Care Technology Award)</li> <li>• Invited to hold workshops at the National Telecare and Telehealthcare conference in November 2009, Ceretas Home Care Conference 2009, Dementia Technology Conference June 2010, Putting People First Summit July 2010.</li> <li>• <i>“...hard measurement seems really difficult to get, so this is a great result.”</i></li> </ul> <p><b>Neil Hunt, Chief Executive, Alzheimer’s Society</b></p>

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	<ul style="list-style-type: none"> <li>• <i>“I have been praising your scheme – not just the IT but the total services, including the contract with the domiciliary care provider...”</i></li> </ul> <p><b>John Bolton, Finance Director, Department of Health</b></p>
<b>Sustainability/ Next Steps</b>	<ul style="list-style-type: none"> <li>• Service now mainstreamed and funded through core budget via Care Home placement savings.</li> <li>• Further develop the evidence base for technology solutions and develop alternative approaches to community based support.</li> <li>• Investigate the potential of touch screen technology to support people with memory difficulties to make the most of their lives through engaging staff and local communities to improve communication, meaningful activity and understanding of life experience.</li> <li>• Develop further partnerships with community services to drive forward a change agenda without increasing overall costs.</li> </ul>
<b>Key contact/Locality</b>	<ul style="list-style-type: none"> <li>• Jodie Thomas / Helena Spencer (Specialist Intermediate Care Service) Tel no. (01432) 361650 or <a href="mailto:Jodie.Thomas@herefordpct.nhs.uk">Jodie.Thomas@herefordpct.nhs.uk</a> / <a href="mailto:Helena.Spencer@herefordpct.nhs.uk">Helena.Spencer@herefordpct.nhs.uk</a></li> <li>• Cheryl Poole (Team Leader, Older People’s Mental Health Services) Tel No. (01432) 361600 or <a href="mailto:Cheryl.Poole@herefordpct.nhs.uk">Cheryl.Poole@herefordpct.nhs.uk</a></li> <li>• Angela Gilchrist (Care Manager, Sure Care Services) Tel No. (01432) 347960 or <a href="mailto:angela@surecarehereford.co.uk">angela@surecarehereford.co.uk</a></li> <li>• Andrew Morris (Integrated Commissioning) Tel No. (01432) 344344 or <a href="mailto:Andrew.Morris@herefordpct.nhs.uk">Andrew.Morris@herefordpct.nhs.uk</a></li> </ul>
<b>Dementia Strategy Objectives</b>	6, 9, 10, 13



**31. Working, Learning and Achieving Together: Action Learning in Dementia services leadership, commissioning and direct care.**

<p><b>Aims</b></p>	<p>To provide a means of adult leaning across the City to support the implementation of the national, regional and local dementia strategy.</p> <p>To develop shared knowledge, skills and attitudes of service managers, commissioners and direct care staff in regard the needs of people experiencing dementia and their families and carers</p> <p>To make real a person centred approach to practice which supports the person with dementia and their family to achieve their goals</p> <p>To bring together service managers form care homes, specialist housing, domiciliary care and the acute hospital to facilitate a shared value base and knowledge set to provide a platform for problem solving between service boundaries.</p>
<p><b>Local Context for Initiative</b></p>	<p>The vision for older people is to enable older people in Wolverhampton to live life to the full by optimising opportunities for health and participation in social, economic, cultural and civic affairs and by providing access to high quality health and social care services which respect the individuality and lifestyle choices of those who need them.</p> <p>This vision is grounded in the belief that successful ageing is about interdependence, and control, through being able to determine care and other services, which support an individual’s preferred way of life.</p> <p>The vision, therefore, underpins strategic action to enable older people to have the same choice, control and freedom as other citizens and to live as independently as possible as part of their local community, with practical and emotional support based on their own choices and aspirations.</p> <p>Wolverhampton City Council recognise the need for improving and sustaining the quality of care for people with dementia across the city and has developed a Dementia Strategy Forward Plan which addresses four of the priority objectives for social care set out in the National Dementia Strategy:</p> <ul style="list-style-type: none"> <li>• To improve community personal support</li> <li>• To improve the experience of living in a care home</li> <li>• To develop an informed and effective workforce</li> <li>• To develop good quality housing and telecare opportunities</li> </ul> <p>The aim of the Forward Plan is to address some of the gaps in service provision and to ensure that all services have a person centred approach that allow people with dementia and their carers to live well with dementia.</p> <p>Because prevalence of dementia increases with age – two thirds of people with dementia are over 80 years of age, this means that for an increasing number of older people living in Wolverhampton, dementia will be a feature of their older age. The POPPI data reveals 2,943 people with dementia currently living</p>

	<p>in Wolverhampton (7.2% of Wolverhampton’s older person population).</p> <p>The number of older people with dementia in Wolverhampton is projected to increase by an average of 43 people year between 2009 and 2015 and by 61 people per year between 2015 and 2020 (POPPI). The largest increase is within 85+ age group, which is predicted to increase by 78%.</p> <p>Responding to the National Dementia Strategy requirements, commissioners have recognised the need to build on these earlier training opportunities with Professor Dawn Brooker from the recently established Association for Dementia Studies at the University of Worcester.</p> <p>The focus of the Association for Dementia Studies (ADS) is securely set on a body of work that will improve the lives of people living with dementia, their families and those who work to support them. Established under the leadership of Professor Dawn Brooker in May 2009, we work in partnership with health and social care providers, practitioners, commissioners and government agencies to provide research, education and expert consultancy in the field of person centred dementia care and support. The West Midlands lead for Dementia UK, Kate Read, is employed as a Senior Lecturer at ADS and the office for Dementia UK West Midlands is based in Wolverhampton.</p> <p>Professor Brooker was commissioned by NHS West Midlands in July 2009 to be the expert input into a radical programme of care for people with dementia at New Cross Hospital – part of the Acute Trust in Wolverhampton. Lessons learnt from this programme at New Cross will inform future practice for Acute Trusts across the Region and possibly more widely. Part of the work at New Cross is recognising that in order to make acute hospital care effective for people with dementia, there has to be good communication and shared practice between the hospital, care homes and care at home. Bringing together the leaders and managers from these different service settings will facilitate this.</p> <p>Professor Brooker has worked for many years with the ExtraCare Charitable Trust which provides specialist housing in the city. The package of learning provided here builds on the evidence base from the Enriched Opportunities Programme research programme that was developed by ExtraCare and Professor Brooker’s research team.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p><b>Quality Improvements</b></p> <p>We have developed three courses of learning together. These will commence delivery in July 2010 and will span the next 12 month period. The courses will be delivered as follows:</p> <p><b>Course 1: Leading Person Centred Services for People Living with Dementia for Service Managers</b></p> <p>This involves a 6 day course; 2 blocks of 3 days of face to face workshops and a work based assignment. This can be taken as a stand-alone learning experience or as a ‘negotiated learning module’ worth 20 university credits. 25 places are available on this course.</p> <p>Indicative Course Content:</p>

- Developing understanding of person centred care and the application to the VIPS framework (tool to assess strengths and weaknesses)
- Person centred care management
- Developing a person centred workforce
- Risk, safety and empowerment
- Working with families and volunteers
- Working with organisations and communities
- Assuring the quality of person centred care

### **Course 2: Specialist Practice in Dementia (person centred care) for Dementia Champions**

This course involves face to face and work based assignments over a 12 month period, 1 day per month for 12 months. The programme could be taken as a stand-alone learning experience or as a 'negotiated learning module' worth a minimum of 20 university credits. Indicative Course Content:

- Undertaking individualised person centred assessments
- Person centred recording and communication with the staff team
- Developing care plans based on the enriched model of dementia care
- Utilising cognitive capacity, strengths and needs
- Developing and applying cultural competence in working with people with dementia
- Physical health needs in the context of dementia
- Life-story and getting to know the person with dementia, developing touchstones
- Relationships, activity, occupation and fun
- Working with families
- Ethical challenges, maximising freedom & choice
- Helping people who have extreme distress and complex needs.
- Developing supportive and interesting environments & telecare.
- End of life care
- Assessing and managing risk and safeguarding vulnerable adults

### **Course 3 Awareness Training for Commissioners and Quality Monitoring Staff**

The National Dementia Strategy questions how commissioners and monitoring staff can ensure high quality person centred services if they have no understanding or awareness of what this model looks like. A third component of the programme will be the delivery of two complementary day workshops for commissioning, contracting, and monitoring staff to enhance their understanding of the person-centred model of dementia and facilitate the development of a quality monitoring tool.

The whole programme will be framed around person centred commissioning outcomes and will commence in July 2010.

#### **Innovation**

The innovation is in commissioning these 3 courses to work together across all

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	<p>the services where people with dementia receive health &amp; social care. By providing an Action Learning Set approach we will facilitate local direct service managers to come up with solutions to common problems within their own service settings but also between their respective service boundaries.</p> <p><b>Productivity</b> There is a financial as well as a moral imperative to reduce the length of stay for people with dementia in acute hospital beds. If we can decrease unnecessary admissions from care homes, housing and community because staff feel better prepared through the training then we should see a significant cost reduction across the health and social care economy.</p> <p><b>Prevention</b> People living with dementia are at risk of developing additional health problems that go unrecognised and untreated. This can lead to all sorts of complications and distress. The education programmes here will heighten awareness and prevent this from happening. In addition, providing an enriched social milieu in which people feel fulfilled and secure can prevent depression and vegetative states. This will be a focus of all three courses.</p> <p><b>User/Carer Involvement</b> People with dementia and their carers have been involved in the development of the training materials and will be used as additional tutors on specific aspects of the courses.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>The proposal to commission the learning modules were part of the consultation on Wolverhampton's Dementia Strategy Forward Plan with stakeholders who all supported the programme.</p> <p>Through a series of meetings in 2009-10 the University of Worcester and Wolverhampton City Council has jointly designed the learning and education programme.</p> <p>The Association Dementia Studies at Worcester University has been commissioned to deliver two training modules at a local venue in Wolverhampton.</p> <p>Invitations were sent to all providers for older peoples services across the city to a launch event of the learning modules which included the Wolverhampton Primary Care Trust and acute hospital.</p> <p>The cost of both modules is £30k in total.</p> <p>This learning opportunity was welcomed by all service providers who attended the launch.</p> <p>Applications have been received for both modules and a minimum fee of £100 per person has been made to cover refreshment and room bookings at a local venue.</p>
<p><b>Resources/ Capability/</b></p>	<p>A robust business case to secure funding for the modules was submitted to Wolverhampton City Council's Adult and Community departmental</p>

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<p><b>Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>management team. This training was considered a key element on the preventative agenda as the outcomes of the course would provide the necessary underpinning knowledge to deliver high-quality outcome expectations for people with dementia.</p> <p>There was also support and endorsement from the elected members as the ultimate aim of the course would improve the lives of people with dementia.</p> <p>To ensure value for money, a total number of 40 people are expected to participate in both modules. The first part of the learning begins on 6 July 2010.</p>
<p><b>Transferable Learning</b></p>	<p>These courses could form a blue-print for other health and social care economies to follow in the implementation of their dementia strategy. Lessons learnt in this next 12 months will be invaluable to others considering the same path.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Both modules will be framed around person centre commissioning outcomes and will be formally evaluated by the University of Worcester. The results of this evaluation will inform future service and practice developments on both a regional and national basis.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>Because course participants will be meeting over a significant period of time, it is planned that sustainability will be one of the things built into their action learning. This might take the form of on-going meetings on particular quality challenges or communication through websites, blogs and email.</p>
<p><b>Key contact/Locality</b></p>	<p>Santosh Kumari, Commissioning Officer – Older People  Wolverhampton City Council  Civic Centre  St Peters Square  Wolverhampton  WV6 8XL  Direct Line: 01902 555369</p>
<p><b>Dementia Strategy Objectives</b></p>	<p>6, 10, 11 12, 13.</p> <p>The objectives specifically point to the need for improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there and the commissioning of specialist in-reach services from community mental health teams. This should also be extended to encompass day services, domiciliary care and extra care housing resources.</p>

**32. Quality Improvement in 'the lived 'experience for people with Dementia living in Care Homes**

<b>Aims</b>	Worcestershire County Council has developed a three year programme to support care homes to improve the quality of care provided to residents with dementia. The aim is for homes to achieve a Dementia Care Standard and will influence the future contracting arrangements.
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<b>Local Context for Initiative</b>	<p>The Council identified concerns regarding the quality of dementia care in registered homes and in discussion with the RNCC free nursing care staff they concurred.</p> <p>Previously the council had a dementia premium payment to homes but this was to a small selection of homes and there was no evidence that the additional payment improved quality of care provided.</p> <p>At the same time the concerns were reinforced by the 2007/2008 CSCI performance assessment as a result of the number of zero and one star rated homes that we were procuring beds from.</p> <p>In 2008/09 it was decided to move away from extra payments for dementia beds and to invest in a universal learning and development programme that recognises the need for all care homes to improve their quality of dementia care.</p> <p>A programme board was set up to identify what needed to happen to embed organisational change in the care homes in Worcestershire and to ensure residents were experiencing the best care possible. Future contracting arrangements will be affected by the programme and its outcomes so that we will not be procuring beds from 0 star rated homes.</p> <p>The board had members from contracts, operational management, commissioning, PCT – RNCC staff, Older Adults Mental Health management staff, Professor Dawn Brooker</p> <p>ACT (skills for Care) had also audited dementia training in the care homes and evidenced a wide variation on the standard and quality of training across the care home sector.</p> <p>The objectives:</p> <ul style="list-style-type: none"> <li>• quality of care to improve and embed continual improvement for people with dementia</li> <li>• person centred care to be embedded in all homes</li> <li>• standardised training across the sector of a recognised high quality</li> <li>• contracting with homes that attain a recognised standard</li> <li>• health and social care to work together to develop the standard and process of attaining the standard</li> </ul>
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	<ul style="list-style-type: none"> <li>• as a result of person centred care expectations of reduction in use of medication, challenging behaviour and locked door policies</li> <li>• improve staff retention in homes.</li> </ul>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p>Concerns were first raised in 2007/8 and as a result of these a bid for growth monies was submitted to the Directorate Management Team (ACS - WCC).</p> <p>In response to the CSCI assessment and known demographic pressures the Directorate agreed extra funding from 2008/09 onwards for the delivery of improved dementia care in registered homes.</p> <p>In 2008/9 the Directorate decided to move away from making extra payments for specialist dementia beds (premium payments ceased for all new placements from April 2010),and to invest in a universal learning and development programme that recognises the need for all care homes to improve quality of dementia care.</p> <p>2008/9 work on developing the Worcestershire Standard for dementia care</p> <p>8/9 work on developing a training programme.</p> <p>8/9 WCC 50/50 fund Dementia Diploma Course (DCM) for Managers</p> <p>2009 programme launched with a conference -Feelings Matter Most - David Sheard (DCM) FOR HOME OWNERS</p> <p>2009 Expressions of interest for the leadership programme/fast track applications for Home Managers</p> <p>Observation to gather evidence for either pre - leadership course or fast track compliance.</p> <p>15 home owners/managers start Leadership Course - (DCM)</p> <p>Procurement/tender process for selection of courses - range of 1 -3 day courses covering areas such as basic dementia awareness and care planning and support, targeted at front line staff, more specialist courses for key staff and specialist support and advice on raising dementia standards for homes not taking part in the Leadership Course - Age Concern, Worcester University and DCM all successful</p> <p>2010 - 10 homes achieve the standard and given a £7,500 award to invest in the home to improve services</p> <p>2010 - Dementia Diploma 50/50 funding for managers - now 22 Care Home managers undertaken this</p> <p>2010 second conference</p> <p>2010 second leadership course started (15 places)</p>

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	<p>Project worker (a previous successful manager from a home awarded the standard) employed - work started on observations and administration of courses available.</p> <p>Sept 2010 second leadership course - Worcester University (15 places)</p> <p>Sept 2010 -Conference Feelings Matter Most - for day care providers and Domiciliary Care agencies as a result of the success of previous conferences</p> <p>March 2011 and 12 Conference followed like 2010 with 2 leadership courses (30 places) and the selection of courses</p> <p>2011/12 evaluation of programme</p> <p>Working across the different organisations posed no challenges as everyone understood the need to improve quality and understood what person centred care was in practice. Much debate on how to achieve cultural change.</p> <p>ACT were very keen to become involved from the start and as they had the connections with the homes they became pivotal.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>The challenges:</p> <ul style="list-style-type: none"> <li>• 138 care/nursing homes in Worcestershire - out of our hands!</li> <li>• going for organisational culture change - buy in from owners essential - conference for home owners to ensure they 'get it!' - David Sheard (DCM) has an international reputation and is an inspirational / motivational speaker this was the launch pad of the whole programme - David's reputation preceded him</li> <li>• Support given by CSQT throughout the process to managers to give practical guidance and support in embedding person centred care, dignity in care training also provided as individual needs arise</li> <li>• Managers who have been on the diploma course or leadership course formed a peer support group to share good practice and what worked well/or didn't</li> <li>• ACT as an outside agency as independent of health and social care has a strong relationship with homes based already</li> <li>• Project officer has been through the leadership course in a previous job and has evidence of success in improving quality of care in her home - this we expect will be a very positive move as she has a reputation with managers already as being dynamic and has a can do attitude, is easy to talk to and approachable</li> <li>• Continual updates and involvement from the care home owners forum ensured continued support</li> <li>• Capacity of the RNCC nurses to undertake assessments - negotiation with PCT to ensure still involved but flexible to ensure core job still managed and effective.</li> </ul>
<p><b>Resources/ Capability/ Capacity</b></p>	<ul style="list-style-type: none"> <li>• Commitment and vision.</li> <li>• Buy in from Home Owners.</li> </ul>



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<p><b>- What does it take to make this happen?</b></p>	<ul style="list-style-type: none"> <li>• Inspirational leadership/motivational speaker.</li> <li>• Most importantly is partnership working across Adult and Community Services and the RNCC nurses at the PCT – without this this would not have happened</li> <li>• Partnership working with ACT</li> <li>• Working with commissioning and contracts.</li> </ul>
<p><b>Transferable Learning</b></p>	<p>All of this is do-able and very transferable we are rolling something out very similar to domiciliary Care providers and Day Care providers.</p>
<p><b>Validation/ Evaluation</b></p>	<p>We are to formally evaluate at the end of the programme with University of Worcester but early signs are it has been successful.</p> <ul style="list-style-type: none"> <li>• Out of the fifteen homes who undertook the Leadership course with Dementia Care Matters and who were supported by the Care Services Quality Team, ten were awarded the grant as they gave clear evidence of having engaged with the Person Centred Dementia Standard. They were subsequently given a cash award to help them to continue to develop their dementia care.</li> <li>• The key for the award was in the "engagement" rather than fully meeting the standard. Whilst some of the homes were further on in their person centred journey all had made some changes which dramatically improved life for residents.</li> <li>• The standard provided us with evidence to show that residents were increasingly given meaningful occupation during the day and that communication between them and staff, was based on feelings and recognition of the individuals' reality.</li> <li>• Residents were increasingly involved in the day to day living in the home which included taking part in food preparation, cleaning and gardening. The numbers of pets in the homes increased and residents were involved in their care. Dolls therapy was in use for some individuals and rummage boxes available for residents to find items of interest and stimulate conversation.</li> <li>• Access to the outside world has been improved and residents are more involved in gardening activities. There have been some innovations in the use of gardens with one home having a bus stop and another home using garden sheds as a local shop, tea room and a village square.</li> <li>• Task driven, regimented care has given way to a more flexible, individual service which responds more appropriately to the emotional needs of people with dementia.</li> <li>• The obvious benefits of these changes for residents have included improved self-esteem, a sense of belonging and purpose and a lessening of distress, boredom and agitation. The use of medication for managing distressed behaviour has decreased.</li> <li>• There is the sound of laughter in the homes and people having fun together.</li> <li>• Relationships' between residents also improves as they all become</li> </ul>

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	<p>involved with ordinary living tasks.</p> <p>Staff groups report better working conditions, better job satisfaction and one carer said it was like going home when she went to work. This obviously impacts on staff morale and retention of staff.</p>
<p><b>Sustainability/ Next Steps</b></p>	<ul style="list-style-type: none"> <li>• The three year programme should give all homes the opportunity to engage if they want to.</li> <li>• Support from CSQT is ongoing.</li> <li>• Home managers who have been through the diploma course or leadership course have developed a peer support group</li> <li>• The Worcestershire Mental Health Partnership NHS Trust have set up an In reach Team to support complex dementia cases in care homes and will work with the RNCC nurses and CSQT in supporting homes in becoming person centred</li> <li>• Clear message on standardised training will continue</li> <li>• Further work on workforce development across statutory (health and social care)/voluntary organisations has been identified</li> <li>• This project has been inspirational in its vision of massive culture change across all the care homes in Worcestershire. A vision shared by our partners as both health and social care understand the benefits of person centred care and have been passionate in promoting this way of working to improve quality of care for people with dementia. At a time of financial constraints the Directorate Management Team have supported investing in the programme.</li> </ul> <p>Innovation has been around the programme going for change in such a huge way really and developing training across home owners/managers and care staff.</p>
<p><b>Key contact/Locality</b></p>	<p>Louise Clarke, Locality Manager OP/PD Annie O'Mara, Team Manager Care Services Quality Team Worcestershire County Council 01905 763763</p>
<p><b>Dementia Strategy Objectives</b></p>	<p>Meets these!</p>

**33. The Telford & Wrekin Dementia Deep Dive**  
(Driving strategic commissioning priorities, by the voice, heart and minds of clinicians, patients, carers and the public.)

<b>Aims</b>	<ul style="list-style-type: none"> <li>• To utilise the voice and experience of people with dementia, and their family carers, to drive strategic priorities and inform commissioning decision-making</li> <li>• To undertake a Joint Strategic Needs Assessment, driven by patient and public voice, which delivered a comprehensive demand and capacity model for commissioning decision-making</li> <li>• To create a partnership infrastructure to deliver on, the expectations of, clinicians, patients, carers and the public, involved in the commissioning decision-making.</li> </ul>
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<b>Local Context for Initiative</b>	<p><b><u>Locally defined needs,</u></b></p> <p>In 2008, NHS Telford &amp; Wrekin commissioned a detailed analysis of Dementia Services, (a Deep-Dive), to feed into the Joint Strategic Needs Assessment.</p> <p>In addition to undertaking the ‘Deep Dive’, NHS Telford &amp; Wrekin commissioned the Alzheimer’s Society and Senior Citizens’ Forum to interview 100 people with dementia, or their family carer to comment on their experiences of local services. These people were attracted using newspaper adverts, posters, leaflets and presentations to relevant interest groups.</p> <p>The resulting report, ‘Now you see me, Now --- ---’-highlighted service gaps and quality improvements, which spoke volumes about how peoples’ lives had been affected by either the positive or negative experiences they’d received when accessing local services. In many cases, it captured the whole patient pathway, demonstrating interactions between PCT, Local Authority and Voluntary and Community Groups. The Report therefore, though commissioned by the PCT, was able to capture the wider health economy picture and was at times, both complimentary and critical of a mixture of service areas and professions, which made dementia a concern for everybody.</p> <p>This report of personal experiences, together with prevalence data and the strategic priorities of National policy, put Dementia on the map in Telford &amp; Wrekin and created the foundations for all agencies to find solutions, to some of the areas for development in local provision.</p> <p>This was strengthened at a Senior and Corporate level across the Health &amp; Social Care Economy, with sign-up from both Chief Executive of the PCT and Corporate Director with Lead Responsibility for Adult Care and Support.</p> <p><b><u>Action-focused Partnership Infrastructure</u></b></p> <p>To reinforce the priority of ‘change’ a Strategic Commissioning Group was formed, called ‘Thinking Ahead’ to inform key decision-makers and more importantly, to ‘make things happen’. This group included Social Care, Health, Commissioners, Providers, Voluntary Sector and importantly, Clinicians and people with direct experience of dementia.</p>
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	<p>Each representation from a sector or profession came to the table with a sense of responsibility but also with the level of understanding and decision-making, required to drive through change quickly.</p> <p>This group used a Service Gap tool, which rated service provision against the recommendations of the West Midlands' Pathway Development Group and the National Dementia Strategy to create a review of current service provision.</p> <p>Using the information collated in the Deep Dive, the 'Now you see me' Report and the policy recommendations, the 'Thinking Ahead' Group' prioritised areas for improvement and spending allocation and created an Action Plan, for implementation. This now sits within the context of our local delivery model.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- <b>Quality Improvements</b></li> <li>- <b>Innovation</b></li> <li>- <b>Productivity (cost efficiencies)</b></li> <li>- <b>Prevention</b></li> <li>- <b>User/Carer Involvement</b></li> </ul>	<p><u>Quality Improvements</u> – whole-system re-design and an awareness of people's expectations of quality and what living well with dementia looks like, has driven quality of services and quality of care.</p> <p><u>Innovation</u> – raising the profile of dementia as a strategic and local priority has encouraged Providers to innovate, even in the absence of designated resources e.g. Age Concern, Shropshire, Telford &amp; Wrekin has launched a 'Diamond Appeal' to raise money locally for dementia drop-in centres offering peer support and bringing a 'sparkle' back to the lives of people living with a diagnosis of dementia. The fact that local people are raising money for a need defined locally and heard through the 'Now you see me', Report, is particularly fitting.</p> <p><u>Productivity</u> - pulling partners together meant that greater efficiencies were achieved. Over capacity by some partners, meant that under-capacity in others, were re-balanced. In some cases, Providers were prepared to shift resources and focus to meet these strategic goals.</p> <p><u>Service User Involvement</u> - There is no doubt that people make change happen and it was peoples' stories in the 'Now you see me' Report, which highlighted the need for service improvements and developments, well before the publication of the National Dementia Strategy. Champions were identified across the partnership spectrum, from Commissioner to Provider, Acute Trust and Mental Health Trust, Health and Social Care, which created a network across the health and social care economy to bolster the opportunity for change.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<ul style="list-style-type: none"> <li>• Time-commitments from a broad range of stakeholders, particularly during intense pieces of work. Solution – flexibility of meeting schedules and determination to continue momentum and keep communication live, when numbers dwindled at times.</li> <li>• Partnership working in a competitive financial climate. Solution – Revisit old messages and introduce new people, with new stories, to remind stakeholders about the mutual cause.</li> <li>• Financial challenges. Solution – regularly present the case for change to decision-makers and use best practice and a strong evidence base, to influence change. Robust, evidence-based invest-to-save arguments</li> </ul>

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	are hard to ignore when the alternative, unaffordable option is presented.
<b>Resources/ Capability/ Capacity</b>  <b>- What does it take to make this happen?</b>	<ul style="list-style-type: none"> <li>• Strong clinical, patient and public voice to grasp the commitment of local decision-makers</li> <li>• Strong Leadership and long-term, sustainable commitment</li> <li>• Broad partnerships, across health, social care, voluntary and community groups</li> <li>• Small investment to engage meaningfully with patients and the public (collate the voice, hearts and minds, to drive strategic change). In Telford &amp; Wrekin, the engagement project undertaken by the Alzheimer's Society and Senior Citizens' Forum cost less than £3,000.</li> </ul>
<b>Transferable Learning</b>	<ul style="list-style-type: none"> <li>• Utilise the rich and meaningful voice, hearts and minds of local people experiencing services, to drive strategic prioritisation and combine this with a strong evidence-base, which unequivocally, makes the case for change at a local level.</li> <li>• Identify Leaders and Champions at every level</li> <li>• Collaborative determination – to work with partners to repeat the message that 'this is important and we're going to make this happen'.</li> </ul>
<b>Validation/ Evaluation</b>	Case Study of Good Practice in the Audit Commission Report – Improving Dementia Services in England 2010.
<b>Sustainability/ Next Steps</b>	<ul style="list-style-type: none"> <li>• Creating strong partnerships, infrastructures and accountabilities, which stretch the life-span of the 3 year Action Plan for implementation</li> <li>• Re-commission a second survey of peoples' experience of dementia to in-vigour the momentum of service change and capture positive aspects of service improvements, or areas, to re-address.</li> <li>• Continue to champion dementia at a senior and strategic level across the health economy.</li> </ul>
<b>Key contact/Locality</b>	Kim Grosvenor, Joint Commissioning Manager for Older People and Carers with Lead Responsibility for Dementia Telford & Wrekin Joint Commissioning Unit <a href="mailto:kim.grosvenor@telfordpct.nhs.uk">kim.grosvenor@telfordpct.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	1, 14.

**YORKS AND HUMBER**

**34. Anti Psychotic Medication Reviews in Care Homes – Kirklees**

<p><b>Aims</b></p>	<p>To reduce unnecessary prescribing of anti psychotic medication for people with dementia in care homes and therefore reducing the side effects associated with the drugs.</p> <p>To provide daily advice to care home staff on alternative interventions; with an aim of ensuring that care home staff feel empowered and experienced to meet the needs of their client group using alternatives to anti psychotic medication.</p>
<p><b>Local Context for Initiative</b></p>	<p>The Care Homes Liaison Team became increasingly concerned about the high levels of psychotropic medication being prescribed (particularly to manage dementia symptoms) on an ongoing basis in care homes without frequent reviews. The Team were concerned about the unnecessary prescribing of such medication and the unwanted side effects/potential risks to the clients, such as over sedation, increased risks of strokes/falls and mortality.</p>
<p><b>Achievements/ Benefits</b></p> <p><b>To Include:</b></p> <ul style="list-style-type: none"> <li>- Quality Improvements</li> <li>- Innovation</li> <li>- Productivity (cost efficiencies)</li> <li>- Prevention</li> <li>- User/Carer Involvement</li> </ul>	<p>The team initially developed a sleeping caseload of all clients prescribed anti psychotic in particular care homes.</p> <p>Clients were initially reviewed through telephone contact with the care home every 6 months</p> <p>These reviews have now evolved to 3- 4 monthly visits to care homes by medic and a member of the liaison team</p> <p>The team have also developed a care home pre referral pack for all care homes in Kirklees. The pack provides care staff with advice on dementia, medication, nutrition, managing aggression, settling into care and other topics.</p>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>The team found that following a dose reduction and finally stopping the antipsychotic medication, staff in some care homes were contacting primary care services (GPs) and the medication were recommenced. This problem was addressed by changing the review process from 6 monthly telephone reviews, to visits to care homes every 3-4 months. These visits are conducted by a doctor and member of the team. This enabled a thorough review of care plans, client contact and discussions with staff</p> <p>The reviews can be time consuming for the team, which can impact on medical staff time which is limited within the team.</p>

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<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>A Care Homes Liaison Team member and medic take several half days every few months to manage the reviews. Currently the reviews happen in the less busy periods and the timeliness of the reviews can be impacted on by the acute caseload. Ideally dedicated time would be available.</p>
<p><b>Transferable Learning</b></p>	<p>In our experience some care home staff were reluctant to reduce medications when clients were 'settled' to avoid precipitating problems. Often with support and explanation the staff were open to trials of reduction, most of which were successful after the acute phase of need has passed. Few medications needed restarting or re-titrating and no admissions were needed.</p>
<p><b>Validation/ Evaluation</b></p>	<p>The team carried out an audit of the medication reviews with the following finding:</p> <p>In EMI Nursing Homes -</p> <ul style="list-style-type: none"> <li>• In June 2008 - 112 people were being prescribed anti psychotic medication at a cost of £2,592.26 per month</li> <li>• In Dec 2008 – 37 people were being prescribed anti psychotic medication at a cost of £1,189.95 per month</li> </ul> <p>In Non EMI Nursing Homes</p> <ul style="list-style-type: none"> <li>• June 2008 - 80 people were being prescribed anti psychotic medication at a cost of £1,849.92 per month</li> <li>• Dec 2008 – 27 people were being prescribed anti psychotics at a cost of £619.73 per month</li> </ul> <p>An overall initial cost of £4,441.68 per month was reduced to £1809.68, with an annual saving for PCT of £31,584 in one year</p> <p>There figures are in addition to a presumed reduction in side effects. There was no subsequent admission to in patient services as a result of medication reviews.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>The team have continued to work with care homes to provide advice and education on alternative interventions to anti psychotic medication, such as increased activity and promoting person centred care. A continual review process is needed because of the elderly population turnover -many new clients come into care homes on antipsychotic type medications.</p>
<p><b>Key contact/Locality</b></p>	<p>Julie Mellor and Julia Pashley Telephone: 01484 464485 <a href="mailto:Julie.mellor@swyt.nhs.uk">Julie.mellor@swyt.nhs.uk</a> <a href="mailto:juliapashley@doctors.org.uk">juliapashley@doctors.org.uk</a></p>

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<b>Dementia Strategy Objectives</b>	11.
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<b>35. Care Navigation – Barnsley</b>	
<b>Aims</b>	To encourage recognition of people being in control of their own health, supporting their independence and wellbeing and enabling access to comprehensive services.
<b>Local Context for Initiative</b>	Care Navigation in Barnsley was born from the local strategic vision ‘Every Adult Matters’ which enables people to maximise their aspirations for control and independence over their health and wellbeing, supported by flexible, responsive and preventative services. It was felt that the Memory Services were best placed to pilot this initiative.
<b>Achievements/ Benefits</b>	The study based in eight GP Practices with one care navigator attached to each group practice, was conducted over an 18 month period.
<b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> - <b>User/Carer Involvement</b>	<p>Within the Memory Services the care navigator role exists to guide the person with dementia and the carer through their journey and will:</p> <ul style="list-style-type: none"> <li>• Empower and motivate individuals giving them and their families’ control thereby minimising dependency.</li> <li>• Provide continuity and be a central point of contact.</li> <li>• Safeguard individuals and their carers in becoming ‘lost’ within the network of services.</li> <li>• Provide excellent partnership working to enable smooth access to all health social care and third sector organisations.</li> <li>• Promote the model and process of self directed support.</li> <li>• Promote social inclusion.</li> </ul>
<b>Challenges</b>  - <b>How these were addressed</b>	<p>Blocked direct referrals to MDT Teams outside of the Older persons mental health services, resulted in patients having to visit the GP in order to be referred to services. Referrals were unblocked by the director of nursing professionals permissions granted to make direct referrals.</p> <p>No database of all local services. This was addressed through manual searches which were performed on a demand basis. Hard/electronic personal records were created and added to. Age UK were involved in a community mapping project of local services this is updated by independent services.</p> <p>Social services, GPs and PCT IT systems still not talking to each other this continues to be a challenge.</p>
<b>Resources/ Capability/ Capacity</b>  - <b>What does it take to make this happen?</b>	<p>Permissions to refer direct to other services such as physiotherapy, memory services.</p> <p>Working relationships have been established with the eight GP practises, local and voluntary services to complement existing services in health and social services.</p>

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<b>Transferable Learning</b>	<p>The benefits of establishing working relationships with local and voluntary services in order to provide an improved care flow to the person with dementia.</p> <p>Developing professional links and relationships with Primary Care services.</p>
<b>Validation/ Evaluation</b>	<p>Staged evaluations were undertaken with the full involvement of people with dementia, their families and carers.</p> <p>Initial evaluations were kindly conducted by Alzheimer’s Society (Sheffield) identifying</p> <ul style="list-style-type: none"> <li>• Reduced isolation and increased confidence for the person with dementia.</li> <li>• Carer support as well as the person with dementia</li> <li>• Contact initiated by care navigator</li> <li>• Care navigation was linked to the whole condition whether pre diagnostic or palliative care.</li> <li>• Improved access to information related to need.</li> </ul> <p>The empirical finding from memory services, care navigators and GP Practices indicates the following:</p> <ul style="list-style-type: none"> <li>• 55% increase in referrals to navigators by GP over a 6 month period</li> <li>• 50% of people reduced their contact with GP by 50%</li> <li>• 20% reduction in admissions to dementia assessment ward from the two GP practices.</li> <li>• Earlier discharge from the dementia assessment ward with care navigator involvement.</li> <li>• Reduced length of time on memory staff caseload</li> <li>• Greater and timelier support is given by navigators thereby allowing the memory workers to focus on early detection, diagnosis and treatment.</li> <li>• Reduction in crisis care whilst awaiting initial assessment for diagnosis/treatment.</li> <li>• A reduction in the amount of inappropriate referrals made from GP practices.</li> <li>• Improvement in partnership working within health and social care agencies</li> <li>• Identified gaps in service provision</li> </ul>
<b>Sustainability/ Next Steps</b>	<p>The outcome of this pilot has enabled a central hub of five Care Navigators to work across long term conditions services</p> <p>The Memory Service has retained one care navigator from the original pilot under the developing auspices of ‘Dementia Advisor’ within the memory services.</p>
<b>Key contact/Locality</b>	<p>For information about Care Navigators contact <a href="mailto:Phillippa.Slevin@BarnsleyPCT.nhs.uk">Phillippa.Slevin@BarnsleyPCT.nhs.uk</a></p>

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<b>Dementia Strategy Objectives</b>	4
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36. North East Lincolnshire – Dementia Academy	
<b>Aims</b>	<p>This project aims to develop an informed and effective workforce, who will improve the quality of care provided to people with dementia across the locality. The project objectives are to provide training, support and information to:</p> <ul style="list-style-type: none"> <li>• Members of the public including schools</li> <li>• Family carers</li> <li>• Health and social care professionals – general and specialist</li> <li>• Voluntary and charitable agencies</li> </ul>
<b>Local Context for Initiative</b>	<p>NE Lincolnshire have experienced difficulties in retaining and attracting mental health care professionals. They have also seen an overlap across services. This has led to recognition that training, information and workforce development are key factors to the successful implementation of the National Dementia Strategy within their locality.</p> <p>Further more, the need to reduce the cost of providing dementia care whilst preparing for increased demand on the services in the coming years is pressing. There is a believe that this concept will significantly reduce that cost and equip the local health and social care community in NE Lincolnshire to cater for increased numbers of people diagnosed with dementia.</p> <p>The Dementia Academy aims to meet all these needs through one coordinated project</p>
<b>Achievements/ Benefits</b>	<p>The project consists of building four elements:</p> <ul style="list-style-type: none"> <li>• A Dementia Care Mapping Team – this team consists of 22 Bradford Dementia Group trained mappers from specialist OPMHS services, care management and Independent residential/care homes. The team carry out a programme of mapping, feedback and review of specialist service areas and EMI registered homes. They also provide support with individual care planning, DOLS and ongoing advice and training for all staff.</li> <li>• Training, Support and Workforce Development – this service is for anybody who provides care for a person with dementia in any setting. It will provide accredited and quality assured training by pooling resources across the health and social care community and developing a robust local training team and modular flexible training programme for all. This service will aim to drive up standards and remove inequalities.</li> <li>• Person Centred Care Advisory Team – this team will be headed by a qualified lead and staffed by a group of trained volunteers. The team will follow up training and Dementia Care Mapping by working within</li> </ul>
<b>To Include:</b>	
- <b>Quality Improvements</b>	
- <b>Innovation</b>	
- <b>Productivity (cost efficiencies)</b>	
- <b>Prevention</b>	
- <b>User/Carer Involvement</b>	

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	<p>an establishment or a person's home; demonstrating Person Centred Care and developing an appropriate programme for implementation. The team will also assist in developing operating procedures, protocols and associated guidelines reflective of best practice.</p> <ul style="list-style-type: none"> <li>• Support and Coordination Team – will collate and analyse data, produce reports, schedule training and mapping sessions, manage the websites, intranet and resource library, formulate funding applications and bids, and organise conferences and awareness raising events.</li> </ul> <p>Progress to Date:</p> <ul style="list-style-type: none"> <li>• A Steering Group – including reps from local health and social care community</li> <li>• An Approval Board – including the training and development, Academy lead and coordinator, carer representative, care home liaison, carers support manager, Alzheimer's Society locality manager</li> <li>• Action planning in each area – e.g. Family carers, independent sector, public, specialist staff, general hospital staff</li> <li>• DCM is operational – test wave of mapping completed, mappers going through a period of development and preparation for next wave of mapping</li> <li>• Developing links with - Libraries, Alzheimer's Society, Colleges and Universities</li> <li>• Developing and running approved training programmes – carers programme, dementia awareness, communications for front line staff.</li> </ul>
<p><b>Challenges</b></p> <p><b>- How these were addressed</b></p>	<p>There have been issues around funding for the project, although some funding has been established. Further funding is being sought from appropriate funds.</p> <p>Engagement of the whole health and social care community within NE Lincs - this is an ongoing process and is showing some successes through the Dementia Care Mapping project and other local projects as well as engaging partners in service developments.</p> <p>Delivery of the National Dementia Strategy not being a national priority, dementia not being acknowledged even amongst doctors as a disease, the falling of dementia between stools of LTC and Terminal Illness. We are addressing this with awareness raising and chipping away at prejudice and stigma.</p>
<p><b>Resources/ Capability/ Capacity</b></p> <p><b>- What does it take to make this happen?</b></p>	<p>Resources required:</p> <ul style="list-style-type: none"> <li>– Dedicated Academy staff all with training responsibilities written into their contracts</li> <li>– Funding has been secured from pooling resources across the health and social care community and developing marketable accredited training packages.</li> <li>– Dementia Care Mapping funding – this was already assured as part of OPMHS Commissioning Strategy within NE Lincolnshire.</li> </ul>

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<b>Transferable Learning</b>	<p>It is felt that this project could be replicated in other areas where there is whole system commitment and enthusiasm for such a project.</p>
<b>Validation/ Evaluation</b>	<p>The project in year 1 is estimated to cost circa £300,000 with projected savings of £1,200,000 across the health community as a whole with less investment and increased savings year on year.</p> <p>We are in the process of developing a series of metrics for the project but also use DCM data and other available statistics around admissions to acute care, length of stay, admission to residential care, safeguarding issues etc</p> <p>The project anticipates the following outcomes:</p> <ul style="list-style-type: none"> <li>• High quality delivery of person centred care across the locality with consistency in standards of care across the health and social care community.</li> <li>• Fewer admissions to residential care through better carer support and training</li> <li>• Fewer admissions to A&amp;E and crisis intervention episodes through better training and support to residential care and to people in their own home.</li> <li>• Shorter stays in acute mental health areas.</li> <li>• A decreased in respite episodes with improved health and well being of carers</li> <li>• Reduced admissions to general hospitals and reduced lengths of stay</li> <li>• Increased dementia awareness across the locality.</li> </ul>
<b>Sustainability/ Next Steps</b>	<p>Next steps:</p> <ul style="list-style-type: none"> <li>• Anyone designing or delivering a service, activity or information for people with dementia can approach the academy for information, advice and support – training if necessary</li> <li>• Staff employed in dementia care can obtain standardised packages of training from basic to specialist CPD training</li> <li>• Contracts with providers to stipulate academy approved training</li> <li>• Carers and Service Users can access support, training and information which is progressive and suits their needs throughout the journey</li> <li>• All locally provided activities and peer support groups are detailed in one publication</li> <li>• Access to information and support for all online and library</li> <li>• Effective joint working across the health and social care community</li> <li>• Destigmatising careers in dementia care and encouraging local people to consider careers in dementia care and a skills migration into the area.</li> </ul>

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<b>Key contact/Locality</b>	For further details about the Dementia Academy please contact <a href="mailto:Jeanette.Logan@nelctp.nhs.uk">Jeanette.Logan@nelctp.nhs.uk</a>
<b>Dementia Strategy Objectives</b>	3, 13.

37. Wakefield Memory Service	
<b>Aims</b>	To increase early diagnosis and the associated benefits.
<b>Local Context for Initiative</b>	The service has developed over the past 10 years in line with national policy and local need.
<b>Achievements/ Benefits</b>  <b>To Include:</b> - <b>Quality Improvements</b> - <b>Innovation</b> - <b>Productivity (cost efficiencies)</b> - <b>Prevention</b> - <b>User/Carer Involvement</b>	<p>The service now offers a responsive person centred service which provides access to assessment, diagnosis, treatment and support for people with dementia including younger people with dementia and people with learning disabilities and dementia.</p> <p>The service has a well established service user pathway that includes liaison with both the Alzheimer’s Society and Age UK. Further innovative ways of working include, New Ways of Working, non medical prescribing, nurse diagnosis, nurse led clinics, a telephone monitoring service, service user and carer network groups, and input to memory cafes.</p> <p>Through a variety of mechanisms including shared prescribing agreements and innovative diagnostic protocols, the memory service team has developed a highly valued partnership with primary care services. In addition, the team has been recognised and utilised as an education resource by primary care, social services, the voluntary sector and local acute trust and it has made a significant contribution to the research agenda.</p>
<b>Challenges</b>  - <b>How these were addressed</b>	<p>With increasing rates of referral to the Memory Service, there has been an ongoing need to critically evaluate ways of working to ensure that existing resources are fully utilised. The full involvement of all staff at all levels within the service in identifying areas for positive change has been vital in this process, alongside working with key stakeholders (such as primary care, commissioners and the Alzheimer’s Society) at all stages to negotiate improvements.</p> <p>As referral rates have increased, the pathway of dementia assessment and diagnosis has been adopted by the wider older people’s mental health service to ensure consistency in the standard of care and treatment provided by the whole service for people with dementia and to flexibly prevent unnecessary involvement of the Memory Service where other teams within the service (such as Rapid Access or CMHT’s) are already effectively engaging with the service user.</p>
<b>Resources/ Capability/ Capacity</b>  - <b>What does it take to make this happen?</b>	<p>Effective clinical leadership within the service, working with service managers and commissioners to ensure service users, stakeholders and everyone within the team has an opportunity to highlight ideas and opportunities for continual improvement.</p> <p>Effective engagement with local dementia commissioning groups and</p>



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	<p>presentation of capacity and demand information to demonstrate the need for change or investment in the service.</p>
<p><b>Transferable Learning</b></p>	<p>Involvement of the whole team, service users and other stakeholders in identifying opportunities for positive change and improvement in ways of working.</p> <p>Utilising ongoing clinical audit, research and external accreditation to validate the quality of the service provided and highlight ongoing opportunities for positive change.</p> <p>Ensuring there are clear and direct mechanisms to engage with commissioners and local stakeholders to explore options to address the challenge of increasing rates of referral and diagnosis of dementia.</p>
<p><b>Validation/ Evaluation</b></p>	<p>Referral rates to the service have consistently risen with 690 referrals to the service between April 2008 and March 2009.</p> <p>Service users and carers have been regularly consulted to provide feedback on the service provided. Specific research and projects have provided focused evaluations. For example, one recent project has led to the development of more community orientated services, with people with dementia now having a greater choice of home or clinic based appointments. A further evaluation project has resulted in improved transport services after detailed consultation with service users and carers.</p> <p>A formal evaluation of capacity and demand has also been commissioned, with an aim to provide a service that is high quality and makes best use of resources.</p>
<p><b>Sustainability/ Next Steps</b></p>	<p>There is a regular system of ongoing service user and carer evaluation, with feedback to individual clinicians on service users' experiences of assessment and diagnostic interventions.</p> <p>The service is currently participating in the Royal College of Psychiatry Memory Service Accreditation Programme in order to validate the quality of the service provided and identify any areas for improving the experience of service users.</p> <p>There is an ongoing programme of clinical audit to evaluate the standard of care and treatment provided.</p> <p>The local Dementia Strategy Management Group brings together commissioners and representatives from local providers including Memory Service Staff to track progress against the Strategy and plan strategic local priorities.</p>
<p><b>Key contact/Locality</b></p>	<p>For further information about the Wakefield Memory Service contact <a href="mailto:Richard.Clibbens@swyt.nhs.uk">Richard.Clibbens@swyt.nhs.uk</a></p>

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<b>Dementia Strategy Objectives</b>	2.
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### APPENDIX 1: Draft synthesis of outcomes desired by people with dementia and their carers

	Outcome	Descriptor	NICE QS	NDS Objective
<b>A</b>	I was diagnosed early	People will have the information they need to understand the signs and symptoms of dementia. The time people presenting symptoms to a doctor and being diagnosed will be as short as possible for everyone.	2, 3	1, 2
<b>B</b>	I understand, so I make good decisions and provide for future decision making	Everyone affected by dementia will get information and support in the format and at the time that best suits them. They will be supported to interpret and act on the information so that they understand their illness and how it will impact on their lives, including any other illnesses they may already have. They will know what treatments are best for them and what the implications are and they will be supported to make good decisions.	3, 5	3, 4, 5
<b>C</b>	I get the treatment and support which are best for my dementia, and my life	Everyone living with dementia will receive the best dementia treatment and support, no matter who they are or where they live. They will feel that their personal needs have been appropriately assessed and that their treatment and potential consequences of treatment have been well planned and delivered in a coordinated way that is appropriate to their individual needs and their preferences. They will be able to exercise personal choice in social care and ongoing support will be of a high quality.	1, 4, 5, 7, 8	2, 6, 8, 9, 10, 11, 13, 18
<b>D</b>	I am treated with dignity and respect	People living with dementia will report that they are treated with dignity and respect by all those involved throughout their dementia journey. They will also be open about living with dementia without fear of stigma or discrimination. It will be well recognised and understood by the public and professionals that dementia is a condition that increasing numbers of people will live with.	1	1, 13
<b>E</b>	I know what I can do to help myself and who else can help me	People living with dementia will be supported to self-manage the consequences of dementia and its treatment, to the degree they are able/wish to. They will know where to turn to get the clinical, practical, emotional and financial support they need when and where they need it. They will feel confident that they can practice their faith and spirituality and that others will help them when they need support.	1, 3, 4, 5	3, 4, 5, 6, 13

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	Outcome	Descriptor	NICE QS	NDS Objective
<b>F</b>	Those around me and looking after me are well supported	People living with dementia will feel confident that their family, friends and carers have the practical, emotional and financial support they need to lead as normal a life as possible throughout the dementia journey. They will know where to get help when they need it.	3, 4, 6, 10	3, 4, 5, 7
<b>G</b>	I can enjoy life	People living with dementia will be well supported in all aspects of living with dementia, leaving them confident to lead as full and active life as possible. They will be able to pursue the activities (including work) that allow them to be happy and feel fulfilled while living with dementia.	3, 4	1, 4, 5, 6
<b>H</b>	I feel part of a community and I'm inspired to give something back	People who have been affected by dementia and others will feel inspired to contribute to the life of their community, including action to improve the lives of others living with dementia. This includes having the opportunity to participate in high quality research.		1, 5, 16
<b>I</b>	I am confident my end of life wishes will be respected. I can expect a good death	People who are nearing the end of their life will be supported to make decisions that allow them and their families/carers to be prepared for their death. Their care will be well co-ordinated and planned so that they die in the place and in the way that they have chosen.	5, 9	12, 13

### APPENDIX 2: National Dementia Strategy Objectives

- 1) Improving public and professional awareness and understanding of Dementia
- 2) Good quality early diagnosis and intervention for all
- 3) Good quality information for those diagnosed with Dementia
- 4) Enabling easy access to care, support and advice following diagnosis
- 5) Development of structured peer support and learning networks
- 6) Improved community personal support
- 7) Implementing the Carers Strategy for people with Dementia
- 8) Improved quality of care for people with Dementia in general hospitals
- 9) Improved intermediate care for people with Dementia
- 10) Housing and Telecare
- 11) Living well with Dementia in care homes
- 12) Improved end of life care for people with Dementia
- 13) Workforce development and training in Dementia
- 14) Joint commissioning strategy for Dementia
- 15) Performance monitoring and evaluation including inspection
- 16) A clear picture of research evidence and needs
- 17) Effective national and regional support for implementation of the strategy
- 18) Anti-Psychotics

### APPENDIX 3: NICE Quality Standards

- 1) People with dementia receive care from staff appropriately trained in dementia care.
- 2) People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
- 3) People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.
- 4) People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.
- 5) People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of: advance statements, advance decisions to refuse treatment, Lasting Power of Attorney, Preferred Priorities of Care.
- 6) Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
- 7) People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.
- 8) People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older peoples mental health.
- 9) People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.
- 10) Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.