Health & Social Care Partnership
South East

Living well with dementia:
A National Dementia Strategy

COMPENDIUM OF GOOD PRACTICE ACROSS THE SOUTH EAST

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SOUTH EAST COAST SHA

SOUTH EAST - GENERAL

Introduction to the Innovative Practice Compendium in the South East

The National Dementia Strategy (NDS) was published in February 2009 and as part of the Implementation Plan, regional baseline reviews of services for people with dementia and their carers were carried out in autumn 2009. During this process it became evident that there were many examples of innovation and good practice in the south east region. This triggered a discussion about a national inventory of good practice, then published in January 2011. This national inventory contained three examples from each region.

As it was difficult to adhere to the constraint of three examples from the south east, we decided to investigate innovative practices more widely and to publish a compendium that covered our region. These examples may support the work of commissioners and practitioners in the region; to help accelerate progress in localities through learning from other areas. This Compendium is a local enabler for change and seeks to improve outcomes for people with dementia and their carers.

Contributors were given a template to complete and have used this to collate the learning from local practice. Each example gives the practical and contextual aspects to the innovation and provides a flavour of the work that is being undertaken. The examples have not been peer reviewed or subjected to editorial oversight, but offer learning from sites all across the region on many different aspects of the NDS.

The good practice examples are listed by SHA. As a guide, each example is mapped to the relevant NDS objective (see page 6 for a full listing). A glossary of keywords can also be found on page 5 and each innovative practice example has been assigned relevant keywords to narrow down your search for specific examples.

Contact details are provided at the end of each good practice example for further information.

Health and Social Care Partnership team
April 2011

Glossary

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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

BRACKNELL FOREST

1. User Led Support Group	
KEYWORDS: Peer support / Information and advice / Awareness and understanding	
Aims	To establish a User Led Support Group, that will meet regularly to provide support. The support provided will take many forms including emotional, social and practical as well as shared learning and signposting. The emphasis so far has been on making friendships and not necessarily focussing on the shared diagnosis in common.
Local Context for Initiative	The Dementia Advisory Service is based within a Community Mental Health Team for Older Adults. The Memory Clinic Nurse and Dementia Adviser recognised a lack of peer support for those people newly diagnosed with Dementia and their carers. It is hoped that by initiating a support group, members will go on to develop required support, which would be highlighted by the group members themselves.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The benefits of the group will be to improve the wellbeing of the members. This is achieved by empowering individuals with the skills to cope with relevant current issues and possible future problems, through shared experiences. It is also hoped that by sharing knowledge of relevant local/national support from the voluntary sector, it will reduce the pressure on the public sector. It is also hoped that by promoting a 'User Led' group, creative and innovative ideas will develop to further equip the individuals for their journey ahead. The group have expressed an interest in meeting in established social establishments. Therefore this will assist in: maintaining social integration for those people diagnosed with Dementia and their carers; raising public awareness of Dementia and reducing stigma.
Challenges **- How these were addressed**	One challenge was to find carers/people diagnosed with Dementia who were willing to take the lead in developing the group. This was initially overcome by approaching people known to the Memory Clinic, who it was felt had the appropriate skills. We also arranged a coffee morning where we explained our intentions to develop a group and asked all attendees if they were interested in becoming committee members. A person who cares for someone has expressed an interest in managing a 'contact' database to facilitate publicising future get togethers.

Resources/ Capability/ Capacity - **What does it take to make this happen?**	The nature of the group will mean that resources, capability and capacity will be governed and sourced by the group members themselves. It is intended that this group will be self-sufficient. The group will also be signposted to any relevant funding/support streams.
Transferable Learning	By listening to the needs of the people and recognising them as the experts in their support needs means that the support design will be governed by those people who are involved in the service. Therefore it will provide a service dovetailed with the needs of the group. Many people expressed a need to keep the group small; this may mean that lots of smaller groups develop as opposed to one large group.
Validation/ Evaluation	As this is being developed as a 'User Led' group validation/evaluation will be decided by the group committee.
Sustainability/ Next Steps	A 'Handover' meeting is arranged for all those people who have shown an interest in becoming committee members. Once the Dementia Adviser has informed them of relevant local contacts who may be able to provide assistance, then the group will be independent of any professional input.
Key contact/Locality	Kim Knights - Joint Commissioning Officer Bracknell Forest Council Kim.Knights@Bracknell-Forest.gov.uk
Dementia Strategy Objectives	**Objective 1** - Improving public and professional awareness and understanding of dementia. **Objective 3** - Good-quality information for those people diagnosed with dementia and their carers. **Objective 4** - Enabling easy access to care, support and advice following diagnosis. **Objective 5** - development of structured peer support and learning networks. **Objective 6** - Improvement community personal support services.

BRACKNELL FOREST

2. A Truly Person Centred Approach
KEYWORDS: Information and advice / Diagnosis and assessment / Dementia Adviser

Aims	To work in partnership with people diagnosed with Dementia and their carers to design services which ensure people receive appropriate and timely levels of support, which meet their needs as individuals.
Local Context for Initiative	The service is based within the Community Mental Health Team for Older Adults; the Memory Clinic is fully integrated within the team. The Dementia Adviser supports anyone with a diagnosis of Dementia who is not yet receiving support from statutory services. The support is available to the individual and their Carers until such time they may require more intensive support from either a CPN or Care Manager. Board members for the Dementia Adviser role include professionals from Health and Social Care as well as people from relevant voluntary sector organisations and Carers. The population of Bracknell is just over 50,000 within a geographical area of approximately 11 square miles. Using national prevalence figures and the latest estimated population figures, there are approximately 936 people with Dementia living in Bracknell Forest. Within the Bracknell Forest area just over 2% of people are of Asian ethnicity, 1.5% of people are of Black African and Caribbean ethnicity and over 95% of people are White British.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The Dementia Adviser Focuses on a 'Person Centred' Approach. This means that it is developed in partnership with those people who use the service. The Dementia Adviser is provided with a good degree of autonomy while being supervised by members of the CMHT OA. This means that the service is developed by the individuals who are being supported, while having the benefits of guidance from appropriate professionals. The outcomes of this approach include: 1. Those people supported by the Dementia Adviser are able to decide for themselves the level of support required. This encourages choice and control over support needs. After an initial home visit, 44% of people decide they will make contact with the Adviser should they require further support. 56% request on-going home visits, with the majority requesting home visits three times a year. By listening to people about their needs, it reduces unnecessary involvement and therefore allows the advisor to allocate their time efficiently. It also provides the individual with the appropriate level of support to increase their social capital and

	therefore decreases the demands on Health and Social Care. 2. Recognising the importance of regular two way communication, the Dementia Adviser has created a Newsletter which is sent out quarterly to all those people supported by the Adviser. This provides people with regular up-dates of how the service is developing and also informs people of 'what's on' within the local community. It also provides people with an opportunity to share their views on topics which matter to them. This empowers the individuals by being regularly updated with information, ensuring their views are heard and provides feedback as to how their input is shaping the service. This is also a cost effective way of providing many people with a large quantity of relevant information. 3. During conversations with people who use the Dementia Adviser service, it became evident that there was a lack of informal local support for people with a new diagnosis of Dementia. The Dementia Adviser received many comments that people would like a social group which met up regularly at local public venues so that people could get to know others in similar circumstances. The ethos of the group would be a friendly get-together with other people who understand the impact of Dementia, without necessarily formally discussing the diagnosis. Therefore the Dementia Adviser invited all the people on her caseload to an informal coffee morning. During the morning she asked for volunteers to become committee members for a User Led Group. This was very successful and the new group now has its own committee members and is completely led by people accessing the service. The group meet up regularly and advertise their 'Get-togethers' within the Dementia Adviser Newsletter. During their last get-together they had 18 people attend – despite the awful weather! This group provides peer support without the need for professional intervention. People have been able to establish a resource designed by those who use it. The Dementia Adviser used a person centred approach which has resulted in people getting what was requested at no cost to the public sector. 4. The Dementia Adviser became aware that some of the people she supports use the Talking Point On-line forum provided by the Alzheimer's Society. It was agreed that a local on-line forum would benefit people in Bracknell. Therefore the Dementia Adviser developed a Bracknell Forest Community Group within the Alzheimer's Society Talking Point Forum. This is a very new initiative therefore we are waiting to see how this develops. However it is hoped that this resource will provide people with on-line peer support as it will enable them to share experiences and provide information relevant to the local community. There are no cost implications for this resource; however the Dementia Adviser will need to monitor the content of the forum to ensure that people adhere to Talking Point's Terms and Conditions of Use.

Challenges **- How these were addressed**	Using a person centred approach and providing the Dementia Adviser with a good degree of autonomy means that the Adviser needs to be well supported. Regular supervision ensures that any ideas of future developments are clearly discussed and planned. Regular reflection on the impact of developments is also required.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Dementia Advisers need to have a problem solving approach to their work. They also a need to develop sound knowledge of local resources so that these can be utilised and adapted to meet the needs of the people being supported. This approach is best supported in a health and social care environment which embraces person centred service development, without the support of statutory services, this would be challenging. Many of the new initiatives have been created without any additional, or very minimal, costs to the Dementia Advisory Service.
Transferable Learning	A person centred method of working can be both beneficial to the individual and cost effective for the organisation. By placing the individual at the centre of intervention and encouraging them to be involved in the service development, has led to the creation of innovative practice. Talk to local community centres/ services such as arts centres etc. They may be able to assist groups with meeting facilities and discounted rates on activities such as art classes etc.
Validation/ Evaluation	A six month evaluation of the service found that 94% of people felt better informed and well supported and 75% felt that it had made a positive difference to their wellbeing. Early indications point to a 50% reduction in referrals to statutory services since the dementia advisor service began.
Sustainability/ Next Steps	The Dementia Adviser post has enabled positive outcomes for people in Bracknell and the partners hope to continue the service going forward however this is subject to agreement of the necessary funding arrangements.
Key contact/Locality	Bracknell Forest Council Kim Knights - Joint Commissioning Officer kim.knights@bracknell-forest.gov.uk Karen White - Dementia Adviser karen.white@berkshire.nhs.uk

Dementia Strategy Objectives	**Objective 3:** Good quality information **Objective 4:** A dementia adviser **Objective 5:** Peer support and learning networks **Objective 7:** Implementing the Carers' Strategy

BUCKINGHAMSHIRE

3. Medication Reminder System	
Keywords: Equipment and activities / Telecare / Admission avoidance	
Aims	Medication mismanagement has been highlighted as an avoidable hospital admission. Care calls to prompt for medication reminders are also avoidable. Technology exists that can help negate these risks. This project is designed to look at providing technological solutions for medication management. The main objective is to reduce medication reminding care calls and the following repercussions of medication mismanagement (e.g. hospital admission) The benefits of this system will be both financial and service user related. Financial savings will be obtained by reducing current medication reminder care calls with a technological alternative. The service user and family will benefit, where appropriate after assessment, by being allowed to continue to self medicate in a controlled fashion. This will also help maintain independence and dignity for the service user and family.
Local Context for Initiative	Medication mismanagement is a regular issue highlighted by telecare assessments. There is no control centre managed medication systems in Bucks - medication is either managed through traditional blister packs or carer visits. There has been specific interest in this project from families as well as professionals.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The users and carers currently benefiting from the Pivotell system have found the medication dispenser a useful device. It has resulted in reduced medication reminder calls for family members and helped users to avoid hospital admission as a result of mismanagement. It also helps the user to maintain a greater degree of independence, whilst also helping to manage the upkeep of their health. The system helps to reduce the need for carer visits for medication reminding, in turn leading to a cost saving for the authority. If the user does not take their medication within a certain period of time, the control centre are notified and can hopefully resolve the issue over an intercom system, rather than family being asked to attend.

Challenges **- How these were addressed**	The assessment process is an important step in the provision of this system to a service user. Some users will be deemed unsuitable for the system – e.g. they may have a level of cognitive impairment that makes the system too difficult for them to manage. Users without family or friends to load/unload the pill tray will also be unable to use the system at this stage. Though those without family support will receive their medicine through Boots, due to legislation, the Boots delivery driver is unable to manage the physical swap over of this tray. We will need to try and look at alternatives to this as in its current form, it will eliminate some vulnerable users from benefiting from the system.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Resources required are: ➢ Telecare assessor, ➢ a telecare system in place where the dispenser can be linked to 24/7 call centre ➢ the cost of telecare package which will be something around £250.00 (one off cost) and £40.00 per year for those with a family member who can help or £290.00 per year if the service is delivered through Boots
Transferable Learning	Use of existing Telecare system has helped in the delivery of this service.
Validation/ Evaluation	This has been run since last August and early evaluation indicates a reduction in reminder medication calls at the control centre, indicating that users are being compliant with their meds. Family members have also been pleased with the system.
Sustainability/ Next Steps	We are currently looking into how this can be rolled out on a larger scale and with greater health input.
Key contact/Locality	Adam Willison - Telecare Project Officer Telecare Service, Buckinghamshire County Council ASC awillison@buckscc.gov.uk
Dementia Strategy Objectives	Not linked into this as project currently in early stages. It is monitored by our Telecare dementia working group and Telecare Partnership Board though.

BUCKINGHAMSHIRE

4. Safer Walking Device – Holiday Scheme

KEYWORDS: Telecare / Equipment and activities / Carers

Aims	To enable carers who have a spouse, relative or friend with dementia to have peace of mind if they want to take their loved ones with them on holiday.
Local Context for Initiative	The service is funded by Buckinghamshire County Council and will be run by Carers Bucks on the council's behalf. It will offer carers the free loan of a 'Buddi' while they are away. Although initially the service is intended for holidays in the UK and Europe it can be extended worldwide if there is sufficient demand. Margaret Morgan-Owen, whose husband Alasdair was diagnosed with vascular dementia in 2005, understands exactly the peace of mind 'buddi' will bring to carers. She wishes it had been available when she took her husband away for a few days to Wales last year. Margaret suddenly realised that Alasdair was no longer with her and was in a complete state of panic. She said: "I found him standing in a square and he was in a state of panic too as he didn't know where he was or remember where he was staying. We were both very upset by the whole experience."
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	This scheme will use technology beyond its current application in order to give more freedom to carers and family members while on holiday with a loved one with dementia.
Challenges **- How these were addressed**	

Resources/ Capability/ Capacity **- What does it take to make this happen?**	
Transferable Learning	
Validation/ Evaluation	
Sustainability/ Next Steps	
Key contact/Locality	Adam Willison - Telecare Project Officer Telecare Service, Buckinghamshire County Council ASC awillison@buckscc.gov.uk
Dementia Strategy Objectives	

EAST BERKSHIRE

5. "UNDERSTANDING A LIFE WITH DEMENTIA": Training in Primary Care

KEYWORDS: Training and education / Awareness and understanding / GP surgery

Aims	• A project to raise awareness and understanding of dementia in the primary care setting across East Berkshire by the delivery of non-clinical training sessions by the Alzheimer's Society suitable for all staff in GP surgeries. • To improve patient and carer experience and engagement with GP practices. • To raise awareness of the needs of these vulnerable groups in Primary Care and help give staff confidence in their dealings with them. • To promote good quality national and local information by providing Resource Manuals to every GP surgery to enable staff to signpost patients and carers to the appropriate services. • To enable easy access to care, support and advice following diagnosis and to ensure patients can access appropriate planned care in the right place. • To prevent crisis and provide support for people in their own home or in their local community so that their health can be managed in a way that prevents unnecessary admission to hospital, in support of the PCT strategic plan. • To support people to stay healthy in the community and adopt healthy lifestyles and behaviours in support of the PCT strategic plan. • To support the Demonstrator Site Pilot by introducing the Dementia Adviser to GP practices in Bracknell Forest. • To raise awareness of adult safeguarding issues.
Local Context for Initiative	• At present, no training exists for non-clinical staff in GP surgeries across East Berkshire. • Consultations with patients with dementia and their carers have identified a need for a greater level of understanding by staff in primary care to enable minor, reasonable changes to be made to support these vulnerable groups to access services. • Following a mapping exercise across East Berkshire, this is an identified area of work in support of the National Strategy and delivery of local action plans. • The mapping exercise highlighted both Dementia Awareness and Advocacy as areas for development in Berkshire East. However at that time there was ongoing funding for advocacy projects, whereas Dementia required investment.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	• From April – November, 2010, 300 staff trained, including 36 GP's (GP's were also offered training at their clinical events in early 2011), 100+ Practice Nurses, and 140 administration staff, Practice Managers and Receptionists. • Target is 400+ staff. We are expecting to exceed the target and to have trained 450 including Local Authority staff. (See Challenges and Transferable Learning) • Cost per session = £250.00 (including cost of respite, transportation of carers to sessions and provision of a Resource Manual for each surgery). • Excellent feedback so far from staff via evaluation. • 2 Carers from each of the three localities across Berkshire East attend every training session and join in the discussion groups to give their perspective and first hand experience in dealing with primary care services. • Carers say they are enjoying having input to the sessions and feeling that their experience is valued. • GP surgeries say this has provided valuable new insight into the lives of carers and patients and has opened up a new dialogue and understanding. • Primary care staff report feeling more confident in their dealings with people with dementia and their carers and more aware of their needs in the primary care setting. • The provision of a Resource Manual to each surgery is already proving beneficial in facilitating easier signposting to national and local services, saving staff time and effort. • This is an innovative project in primary care which has been enthusiastically received by GP surgeries and could be easily replicated and adapted, e.g. for Long Term Conditions. • Training sessions are held in house in GP surgeries during Protected Learning Time. This represents a significant saving in terms of venue costs and travelling time/expense for staff. No other in-house costs are involved. • Adult Safeguarding issues are highlighted in the training session. • Regular consultation and engagement activities and events with Carers across East Berkshire provide opportunities to listen to their concerns, identify problems and respond to their needs.
Challenges **- How these were addressed**	• Consultation and good communication with our Practice Managers and GP's before the project commenced has been vital in securing their support and co-operation. • A risk assessment identified concerns about capacity issues for the Alzheimer's Society in terms of staffing 30 sessions over a one year period. This was discussed and negotiated so that extra staff to deliver the training were made available if necessary. • Arranging the sessions to meet the individual needs of each surgery in terms of timing of the session and availability of staff to attend has caused some difficulties and administration is time-consuming. However, we felt that a tailor-made approach was important to promote good publicity about the project within the

	practice networks and ensure its success. • Tactful reminders around the provision of refreshments/chairs for speakers and carers have been necessary to ensure a welcoming atmosphere! • Financial constraints around back up funding for in-house training in GP surgeries from January, 2011, meant that we had to diversify and explore other avenues for training delivery outside Primary Care (see Transferable Learning).
Resources/ Capability/ Capacity **- What does it take to make this happen?**	• £8,000 was made available through the PCT Operating plan 09-10. The Business Case was agreed for delivery through 2010-11. • A "rehearsal" of the training session providing useful and constructive feedback was attended by Health Panel (Lay) members, carers, our Head of Education and Training and other health professionals • Project Manager time to ensure uptake and good engagement with Practice Managers and GPs. • The Alzheimer's Society had the capacity to develop, deliver and evaluate the training sessions and provide the Resource Manuals with national information. We provided local information. • Good communication and consultation with our Practice Managers and GP's before the project commenced has been vital in securing their support and co-operation.
Transferable Learning	• The project has enabled the Alzheimer's Society to develop their training toolkit, so that they are in a position to adapt the content to suit the needs of other organisations. This opportunity has been taken up enthusiastically by Local Authorities with sessions arranged for domiciliary staff. • Opportunities are also being explored in the Acute Trust to complement existing training for hospital staff. • The session could be used as a model for other Long Term Conditions. • Each Practice receives a Resource Manual, which can be used by staff not able to attend the training session.
Validation/ Evaluation	• Staff attending the training sessions are asked to complete a questionnaire rating content, speakers, the DVD presentation, and relevance to their individual role. • Attendees are also asked to tell us 3 things they have learnt from the session about dementia and carers and what actions they are able to take within their role in the surgery to make life easier for a person with dementia or carer. This will be followed up for later evaluation via Practice Managers with a view to sharing best practice. • The Alzheimer's Society will provide quarterly reports detailing

	activity, numbers of staff trained and feedback from staff evaluation • They will also provide a report at 6 months and 12 months with details of informal and formal feedback from people with dementia and their carers to include evidence of raised awareness in GP surgeries. • We will conduct our own evaluation through local organisations and services. • A decision was made to target Bracknell Forest in the evaluation of patient and carer experience as this was the area of highest take-up of training by surgeries.

Sustainability/ Next Steps	• A Berkshire East Joint Commissioning Dementia Strategy is being produced which will demonstrate a clearer understanding of the current local needs analysis. • Clinical staff who missed the session at their surgery have been given the opportunity to receive the training at GP Protected Learning Time forum events. • A training session was included as part of a Study Day for Practice Nurses across Berkshire East. • Additional sessions for any other staff i.e. District Nurses and Therapists will be held in various locations at the end of the project. • See comment on capacity building for the Alzheimer's Society under Transferable Learning. • The Alzheimer's Society and local services will maintain their links with the surgeries.

Key contact/Locality	Ros Middleton, Project Lead, NHS Berkshire East ros.middleton@berkshire.nhs.uk 01753 635573 Mobile: 07776 245087 Gill Major, Project Manager, NHS Berkshire East gill.major@berkshire.nhs.uk 01753 636167 Mobile: 07879 605426

Dementia Strategy Objectives	• **Objective 1:** Improving public and professional awareness and understanding of dementia. • **Objective 2:** Good quality early diagnosis and intervention for all. • **Objective 3:** Good quality information for those with diagnosed dementia and their carers. • **Objective 7:** Implementing the Carers' Strategy.

HAMPSHIRE

6. Memory Matters course

KEYWORDS: Training and education / Memory service / Carers

Aims	1) to improve knowledge & skills of those caring for people with dementia 2) to optimise cognitive functioning of people with dementia
Local Context for Initiative	A psycho educational course had been offered for some years by Hampshire Partnership Foundation Trust. However, attendees were requesting a more diverse & high quality learning experience. They had also felt inhibited from attending by needing to make alternative "sitting" arrangements for the person they were caring for. Those who could not attend, had no alternative available to them. The new Memory Matters course was designed to bring together professionals from a wide variety of backgrounds to deliver seminars, with carers attending only those sections of the course most relevant to them. Simultaneously patients are offered a cognitive rehabilitation group within the same venue. A DVD showing edited highlights of the course is offered to all attendees, as well as to those who have been unable to attend.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Innovations: 1) course personalised for each carer's needs 2) patient groups stratified according to ability 3) Cognitive Stimulation Therapy carried out in patient groups 4) DVD available to all attendees illustrating "highlights" from the course
Challenges **- How these were addressed**	1) coordinating a rolling programme using outside speakers - overcome by planning the courses 1 year in advance 2) finding appropriate venues - local community centres approached

Resources/ Capability/ Capacity **- What does it take to make this happen?**	0.3 WTE Band 6 clinician to plan, coordinate and host 2 course per week. 0.2 WTE band 5/6 clinician and 0.2 WTE Band 3 support worker to manage patient groups. Appropriate venues.

Transferable Learning	

Validation/ Evaluation	Each session is evaluated by carers and feedback is reviewed annually.

Sustainability/ Next Steps	Sufficient throughput of referrals required to justify offering courses regularly through the year.

Key contact/Locality	Julia Lury Julia.lury@hantspt-sw.nhs.uk Hampshire Partnership Foundation Trust Memory Service Moorgreen Hospital Botley Rd Southampton SO30 3JB

Dementia Strategy Objectives	Early diagnosis & support

HAMPSHIRE

7. The Solent Project - piloting of working with People with Dementia using a Recovery Focused Approach

KEYWORDS: Models of care - approaches / In-patient / Research

Aims	The three aims of this service development project are to: 1. To bring specialist care for people with dementia into alliance with models of care for people with other long term conditions and with other users of specailist mental health services 2. To determine the effectiveness of using a recovery approach in working with people with dementia in a specialist older person's mental health unit. 3. To determine whether such an approach might result in cost savings for the service and where these savings might be made.
Local Context for Initiative	This one year project is supported by South Central Strategic Health Authority through the Regional Innovation fund. Recovery is both a key strategic objective for Hampshire Partnership NHS Foundation Trust and a dominant theme underpinning service development in a number of sectors of mental health care in the UK. According to the report, Recovery for Action (2009), The Mental Health Foundation and Strategic Network for Mental Health says recovery needs to be embedded in all mental health services. In recent years there has been much focus on developing recovery focused service, both in terms of service development and academic work, for people with mental health problems, other than dementia. This project aims to evaluate whether people with dementia can benefit from recovery focused approaches and thus to ensure their inclusion. Particularly given the provisions of the Mental Capacity Act 2005 it seems essential the recovery approach should be applied to people with dementia as it has the potential to make significant improvements to the quality of life of a venerable group of people. Two recent publications have argued for the adoption of such an approach (Adams 2009, Martin 2009). A successful conclusion to this project would provide the impetus to create a "market" for the adoption of this philosophy and delivery of care across the region and the wider NHS.
Achievements/ Benefits **To Include:** - **Quality**	Projected benefits of project / outputs: • Improved quality of experience by patients, relatives and staff members

Improvements - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	• Reduction in drug cost • Reduced Adverse incidents • Contribution towards body of knowledge • Reduced staffing cost

Challenges **- How these were addressed**	Part of the original project plan was to recruit a Band 7 nurse prescriber in order to free up medical time. As we were unable to appoint a suitable person a Recovery Worker (Band 3) was appointed to support the development of the project, ensure that staff have a role model and to work with the project lead and the service Matron to keep the proposed changes are on track.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	The project involved the patients, staff and relatives of people in Solent Ward at the Becton Centre in the New Forest. The Becton Centre also has a ward for people with functional mental illness, and a day therapy unit, both of which have recently introduced a similar philosophy of care. It is within the scope of the project to make use of the knowledge, skill and experience that their staff, patients and relatives have gained during this process. The project ran for 12 months, beginning on 1st April 2010. This is the amount of time that the project has received funding for and it is important therefore to keep within this time period.

Transferable Learning	Data analysis is still ongoing, but shows that people with dementia are concerned with four main areas of care on the ward: The physical environment Reducing boredom / providing more activity More control needed over own care More information These four areas fit well with Recovery principles, especially information and control. Carers were generally satisfied with the care provided, while staff saw and addressed several areas in need of improvement, mainly the physical environment and activity. Initially only people with dementia felt that information and control was important, revealing interesting differences between what people with dementia wanted, and what others thought was best for them. Data at the end of the project shows that staff perception has notably moved in this respect

Validation/ Evaluation	Information on outcomes such as length of stay, cost of psychotropic medication, readmission rates and staff sickness were collected at the beginning of the project and are being repeated again at the end of the project. Already data shows reduced medication cost, improved staff morale, increased recovery focus, 60% reduction in incidence involving violence, reduced falls. Patient satisfaction is explored during a series of semi-structured interviews. Early results suggest progress with more work yet to do

Sustainability/ Next Steps	Staff training on Recovery has emphasised the need for all staff to take responsibility for an aspect of the project. Staff have been assisted in creating their own action plans detailing how they are going to make their practice more Recovery focused and how they will assist with improving the ward environment/systems (e.g. evaluating mealtimes / creating new menus with patients.) This has also been linked with staff appraisal and personal development plans. Results show significant changes in practice at mealtimes. Other improvements include the ability of housekeeping staff to work with people with dementia in deciding when to perform certain tasks – rather than cleaning around them. Staff members are working with people with dementia in developing recovery focused care plan. The process of weekly ward round has changed to ensure that people with dementia lead discussion, either through their named nurse, or in person.

Key contact/Locality	**Project Board** The core project team consists of the following members: • Dr Gwyn Grout – Consultant Nurse • Julie Redman – Modern Matron • Jane Winson –Consultant Nurse Trainee • Dr Trevor Adams – Academic Advisor – University of Surrey • Dr Brady McFarlane – Consultant Psychiatrist • Michelle Edwards – Locality Manager For further information on the project please contact: Julie Redman: julie.redman@hantspt-sw.nhs.uk Dr Gwyn Grout: gwyngrout@btinternet.com

Dementia Strategy Objectives	Objective 17

HAMPSHIRE

8. Medicines management and improving anti-psychotic prescribing

KEYWORDS: Anti-psychotic prescribing / Partnership / Models of care - approaches

Aims	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). The medicines management objectives of the Hampshire Strategy are: ○ to support older people with mental health problems and their carers in understanding and taking their medication; ○ 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; ○ to explore opportunities for community pharmacists' medicines use reviews to identify and support older people with mental health needs and their carers; and ○ to review implementation of National Institute for Health and Clinical Excellence guidance across Hampshire and develop methods to monitor and audit their implementation.
Local Context for Initiative	During development and consultation on the Hampshire Strategy, professionals and carers wished to include explicit action on medicines management. 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. 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.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The Hampshire medicines management programme is 'work in progress' and is structured around: 1. Identification and awareness raising with target groups: care homes, GPs and other prescribing practitioners, specialist clinicians, pharmacists, people with dementia and carers; 2. Development and application of prescribing guidelines and supporting interventions; also implementation of measures of progress and evaluation; 3. Engagement programme with all groups through training, education, and professional and peer support. The agreed Hampshire guidelines for anti-psychotic prescribing and managing behaviour problems for people with dementia have been disseminated to GPs, mental health clinicians, pharmacists and managers of care homes. The structured programme to support implementation of the guidelines: o specialist mental health clinicians and pharmacists are using the guidelines in their contacts with GPs and care homes; o through GP medicines management/prescribing fora and audit; o inclusion of the guidelines in the training programme for care home staff and structured engagement through the Hampshire Care Home Forum; o incorporation of the guidelines into local implementation of DH requirements for safety in care homes. 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. 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.

Challenges **- How these were addressed**	1. The multiplicity of stakeholders in this agenda raises challenges in making connections and securing their involvement. 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. 2. GPs' perceptions and questions about the benefits of auditing anti-psychotic prescribing. 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'.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	Local partnerships being in place to enable shared approaches to learning. Clear national direction and guidance that this is an issue that needs to be addressed. Local clinical and medicines management leadership.

Transferable Learning	These Hampshire documents are for sharing: ○ Guidelines for Prescribing and Managing Behaviour Problems in Patients with Dementia. ○ GP audit of anti-psychotic therapy in dementia patients. The learning is in using the guidelines and audit as a starting point for dialogue and challenge with local audiences.  H:\HEALTH.pol\ SOCIAL CARE\Older I  H:\HEALTH.pol\ SOCIAL CARE\Older I

Validation/ Evaluation	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. They will be reviewed and evaluated against the current evidence base and are due for review in November 2010. The GP QOF audit was developed in line with the evidence base and NICE guidelines. It has been piloted with practices before its introduction.

Sustainability/ Next Steps	Next steps will be informed by: ○ audit outcomes and action plans; ○ evaluation of the guidelines; and ○ feedback and challenge from all those engaged. e.g. next steps might include development of targeted training tools. 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.

Key contact/Locality	For further information about the Hampshire medicines management programme: Neil Hardy Head of Medicines Management, NHS Hampshire. neil.hardy2@nhs.net For further information about the Hampshire guidelines for Prescribing and Managing Behaviour Problems in Patients with Dementia: Professor Clive Holmes Professor of Biological Psychiatry at Southampton University and Consultant Psychiatrist, Hampshire Partnership Foundation Trust. clive.holmes@hantspt-sw.nhs.uk

Dementia Strategy Objectives	18. Reduction in anti-psychotic prescribing.

HAMPSHIRE

9. Andover Dementia Advice Service

KEYWORDS: Dementia Adviser / Care Pathway / Carers / Partnership

Aims	The aims of the Dementia Advice service: ○ To enable prompt referral from diagnosis ○ A named point of contact throughout the journey of the illness ○ Tailored information, advice and support ○ Focus on wellbeing rather than illness ○ Increased choice and control to the person and their family network. ○ Information on community activities and resources in maintaining well-being ○ Knowledge to those using services which leads to empowerment. ○ Identified needs informing future service delivery and commissioning. ○ To develop a more efficient approach and use of health and social care services by signposting people appropriately at the time they are needed. ○ The service is key to more effective networking in health, social care and third sector partners and a multi-agency approach, maximising the outcome for the person with dementia. ○ The service will facilitate information sharing as part of the personalisation agenda and give individuals greater control over their assessment, care and support.
Local Context for Initiative	The population of 65+ in Andover is around 10,200 people. This will represent around 510 people with dementia. The current Andover Older Peoples Mental Health Team caseload averages on 400 this includes organic and functional mental health illness. Implementation of the site supports the Joint Hampshire Commissioning strategy for Older Peoples mental health services. In 2009 there was a local review of services in the context of this strategy and the National Dementia strategy reviewing current provision of services and support in Andover for Older People with mental health needs. This generated a high degree of interest in the local community. In addressing some of the gaps identified in the consultation and capitalising on the momentum of change within the local area siting the dementia advice service in the Andover district. Choosing a third sector organisation that has a excellent reputation locally and already works in partnership with health and social care enabled this partnership to go forward with this new service delivery. Working together with a multidisciplinary team the Community Innovations Team that works with those over 65 years that are at risk of going into crisis and promoting well-being. It was identified that those accessing this service there was some degree of mental health need with 16% of people on caseloads being identified with dementia.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	**Quality** **1.** Effective referral pathways through varied wide routes. **2.** Prompt assessment and follow up appointments. **3.** Informed skilled adviser and competent volunteers. **4.** Choice and control over advice and support. **5.** Wide range of information and support to access community activities with the focus on well-being. **Improvements** **1.** Access from the point of diagnosis. **2.** Stronger local partnerships. **3.** More community involvement and awareness of dementia. **4.** Informed local service delivery in focusing on more personalised support and care according to needs. **5.** Better and efficient use of health and social care services. **Innovation** **1.** Fully utilising community activities and engagement. **2.** Forming local village support and befriending for those in need. **3.** Providing information to enable local partners to develop more innovative services. **4.** Forming physical well-being buddies. **5.** Enabling our statutory providers to work in partnership with 3rd sector in delivering a more innovative approach. **Productivity** **1.** Move on from CMHT case load as signposting to more appropriate support and advice with result of better caseload management for professionals. **2.** Referrals to date for one FTE advisor 140 with minimal disengagement. **3.** Signposting and support for those with concerns on symptoms to access a diagnosis. **4.** Local development and consultation on peer support services for those under 65 with a diagnosis of dementia. **Prevention** **1.** Identified safeguarding issues. **2.** Informing those accessing the service on crisis planning and linking carers to local carer organisation for carer support in preventing carer crisis. **3.** Being flexible on access to service with regards to home visits times and linking with carer convenience also. **4.** Raising awareness of access to respite care and planning throughout the year. **5.** Signposting and supporting with home aids. **6.** Attendance at weekly multidisciplinary health meetings to update on progress and report concerns for prompt action. **7.** Attendance at professional and Care Planning reviews to identify concerns and unmet needs. **8.** Reporting concerns to local GPs and updating on action and progress with individual service users.

	9. Having an effective referral pathway with up-to-date risk assessment. **User and Carer Involvement** 1. Consultation through focus group before set up of service to identify unmet and satisfaction of local information and services. Lead by West Hampshire area Service User Involvement Project. At this stage we had service users involved in the promotional material and service user involvement in the recruitment stage of the project. 2. Service user and carer feedback and satisfaction 6 months into service through questionnaire and focus group. More feedback from focus group very poor take up from questionnaire. 3. End of demonstration site evaluation in April with service user and carer feedback. 4. Celebration event and consultation planned in May to inform the progress and achievements of the demonstration site to the local community and consult with service users and carers on satisfaction and unmet need to take the service forward. 5. Service users and carers are involved through an individual level on enabling choice and control and flexibility of the service model and access. Locally through focus groups and consultation. Strategically by taking forward to User and Carer forums in Andover and Hampshire in planning future service delivery. Service users and carers will be invited to join commissioners for feedback on the service.

Challenges **- How these were addressed**	GP engagement referrals are low. This is a slow process the CEO of the host organisation attends locality and strategic meetings where there is a GP presence, linking with Practice based commissioning managers and attending practice managers forums. We also through the organisation work with medical staff who are working on a mental health placement during their GP rotation therefore working with these more junior doctors who are about to embark into general practice in communicating our concerns and current services. Changes within local commissioners – unfortunately we have had several changes with those taking the lead on this site as commissioners. Due to changing circumstances this was unavoidable. However it is key to ensure that there is continuity on leading a steering group through the site life.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	A strong voluntary sector partner who has experience of working in health and social care partnerships. A voluntary sector partner that has an excellent reputation in the local community. Working in an organisation that has a strong team and shares learning and is passionate for this type of service delivery. Good monitoring and outcome collection. Volunteers that are trained and well supported by a volunteer coordinator. Base in a central accessible point for people to access. Strong supervision structures and line management. Organisation that is strong with networking and partnership at senior management level. Access to appropriate training that is specific to train a dementia adviser. Financial control and budget management. Administration support Links to a service user and carer involvement project to ensure involvement at all stages of service delivery.
Transferable Learning	Staffing. For future service delivery the FTE post would be a job share arrangement. It was identified that when having a caseload with vulnerable adults better cover arrangements would be needed. A job share would also enable peer support, sharing of best practice, ideas and innovation. Streamlining of some administration processes. More peer support for volunteers led by volunteer coordinator who is now in post. Develop better working practice with GPs. Develop clear outcome indicators for future service delivery.
Validation/ Evaluation	Service User evaluation carried out throughout site life. Local partners to feedback on services. End of project evaluation to be submitted to local commissioners. Awaiting national evaluation this site was a case study site.
Sustainability/Next Steps	Waiting for final decision on future funding from HCC and NHS Hampshire at time of submitting bid identified 50/50 pick up costs of service. Currently have an under spend to carry forward for 2 months Local commissioners invited to meet and interview team. Costing reviewed by current provider who is able to provide service at lower cost than original funding on demonstration site on one FTE.
Key contact/Locality	• Debra Ramchurn CEO Andover Mind debra.ramchurn@andovermind.org.uk • Gill O'Leary HCC Commissioner gill.oleary@hants.gov.uk • Diane Wilson NHS Hampshire diane.wilson@hampshirepct.nhs.uk

Dementia Strategy Objectives	**Objective 1:** Improving public and professional awareness. **Objective 2:** Good quality diagnosis and intervention for all. **Objective 3:** Good quality information for those with the diagnosis of dementia and their carers. **Objective 4:** Enabling easy access to care, support and advice following diagnosis.

ISLE OF WIGHT

10. Outreach Service – Pilot Project (managing people with dementia in the community)

KEYWORDS: Outreach / Training and education / Information and advice / Challenging behaviour

Aims	To raise the standards and quality of care for people with dementia wherever they may live in the community. On the Isle of Wight a pilot project is being undertaken by specialist staff from the Dementia In-Patient Unit. Staff from this unit will provide support, advice, guidance, and education to other staff/carers in community settings in relation to managing behaviour that challenges.
Local Context for Initiative	Reconfiguration of In-Patient Services. Wide consultation process undertaken with stakeholders to establish their views for future planning and service provision. A need to future proof services so that a range of options can be explored in the future, e.g. purchasing a bed in a variety of settings once skills in those areas have been raised.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	To be realised on completion of project: • Reduce the need for hospital admission for people with dementia. • Keep people in their familiar environments. • Offerchoice. • support carers of people with dementia by working alongside them and providing advice, information and education. • Work with people with dementia and their carers to prevent problems from escalating. • Reduce the inappropriate admission into hospital for people with dementia. • Prevent delayed discharges and will reduce in-patient stay. • Reduce the frequency of inappropriate assessments under the Mental Health Act. • Improve the confidence and skill of staff, carers of people with dementia in residential and community settings. In the longer term, reduce costs of in-patient admission.

Challenges **- How these were addressed**	Making staff available to provide an Outreach Service when the existing in-patient ward needs a full complement of staff. Development of criteria. Working with residential and nursing homes to gain an understanding about the need for change, and work in partnership with them to provide care at a high level of skill.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Dedicated staff who are keen, willing and motivated. Ensuring that staff working to provide the service have the relevant and necessary expertise to share knowledge with others. The opportunity to provide backfill to the ward to release other staff (cost implications).
Transferable Learning	This is based on transferable learning and the objective is to spread good practice widely so that everybody with dementia should expect good quality care wherever they may be.
Validation/ Evaluation	An audit will be undertaken. Questionnaires have been developed to assist in gathering information.
Sustainability/ Next Steps	To monitor and evaluate the effectiveness of this service as a pilot prior to longer term plans to create a designated and sustainable service providing Outreach into the independent sector and a range of community settings.
Key contact/Locality	Sian Bayer, Joint Services Manager Sian.Bayer@iow.nhs.uk Sarah Cooke, Project Manager sarah.cooke@iow.nhs.uk Isle of Wight NHS
Dementia Strategy Objectives	Objective 1, 3, 6, 11, 12, 13.

ISLE OF WIGHT

11. 24 Hour Advice Line

KEYWORDS: Crisis support and rapid response / Information and advice / Residential home

Aims	To provide care for people with dementia in residential and nursing homes with access to advice and support.
Local Context for Initiative	Implementation of the National Dementia Strategy on the Isle of Wight. This was an initiative that was put in place in March 2009 as it was recognised that staff working in care homes needed access to expert advice and support.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Improvement in the quality of intervention provided to people with dementia in residential and nursing home settings. Telephone support provided to manage difficult situations and encourage staff to understand the triggers for different types of behaviour. A solution focussed approach building on the confidence of staff. To prevent difficult situations from developing and escalating, thus preventing the need for more intensive support. Fully involved carers.
Challenges **- How these were addressed**	No additional staff were made available, the existing staff team at the in-patient unit for people with dementia were willing to provide this 24 hour service. The service was widely advertised and care home staff engaged with. Bed pressures have an impact on the ability of staff to respond on occasions.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Willingness and involvement of existing staff team. Good bed management.
Transferable Learning	Transferable learning is core to this initiative. Staff in the independent sector are encouraged to discuss issues and explore options with specialist staff.

Validation/ Evaluation	Positive feedback from care home staff has been reported. All referrals are recorded and outcomes documented.
Sustainability/ Next Steps	To further develop the Advice Line to other groups and carers at home. This initiative is now supporting the new pilot outreach service operating from the in-patient unit.
Key contact/Locality	Sian Bayer, Joint Services Manager Sian.Bayer@iow.nhs.uk Sarah Cooke, Project Manager sarah.cooke@iow.nhs.uk Isle of Wight NHS
Dementia Strategy Objectives	Objectives 1, 3, 4, 11, 12, 13.

ISLE OF WIGHT

12. Sharing/Lending Library of games, activities and equipment	
KEYWORDS: Memory service / Equipment and activities	
Aims	To offer people with dementia and their carers the opportunity to use equipment from the Memory Service so that they can try out different types of equipment/activities at home. Support in using the equipment is offered by members of the team.
Local Context for Initiative	Ongoing development of the Memory Service. Recognising the need to support people with dementia and carers in a range of settings.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	To be realised as project progresses. Improve quality of life and help people to live well. Encourage good relationships and sharing of activities between people with dementia and their carers (including those in residential and nursing homes, and on in-patient wards). Focus on activities that concentrate on positive feelings and outcomes for those taking part (i.e. a focus on what people enjoy and are able to be successful at). This is a new idea and includes Snoezelun type equipment as well as activities to share. Potentially this could reduce problems escalating at home resulting in the need for professional intervention. Very much involves carers. Equipment is loaned out for a specified period and then returned. Benefits many people.
Challenges **- How these were addressed**	Financial challenge of developing the service with no extra funding. A bid applied for and was successful.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Funding and the ideas and enthusiasm of staff to take this forward.

Transferable Learning	Transferable learning is a core feature of this initiative. A wide range of carers, both professional and those caring at home, are able to learn new techniques and experiment with different equipment.

Validation/ Evaluation	This is a very new initiative and audit will be undertaken when the practice is well established.

Sustainability/ Next Steps	Ensuring that money is set aside to procure new equipment as and when required.

Key contact/Locality	Sian Bayer, Joint Services Manager Sian.Bayer@iow.nhs.uk Sarah Cooke, Project Manager sarah.cooke@iow.nhs.uk Isle of Wight NHS

Dementia Strategy Objectives	Objective 4, 5, 6, 8, 11.

ISLE OF WIGHT

13. Psychiatric Liaison (Dementia Liaison Service)	
KEYWORDS:	Awareness and understanding / General hospital / Crisis support and rapid response / Nurse led

Aims	To provide close links between the Memory Service and the in-patient general wards. Work alongside staff on general wards to promote good understanding and practice in relation to people with dementia on general ward settings.
Local Context for Initiative	Implementation of the National Dementia Strategy on the Isle of Wight. World Class Commissioning funding was made available and two staff were recruited; a Psychiatric Liaison Nurse (Band 6), and a Dementia Support Worker (Band 3).
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Share knowledge, practice and skills. Daily visits to general wards. Same day response to referrals wherever possible. Raising of awareness of the needs of people with dementia in general hospital settings. Practical advice and support provided. Strong links with staff in the general hospital have been developed. To build on skills and knowledge and improve confidence. Reduce the stigma often associated with patients with dementia. Support for relatives and carers. Input into discharge planning where appropriate. Problem solving. Improvements to patient experience. A 'befriending' service has also been developed as part of this initiative. A reduction in inappropriate referrals has been observed over time.
Challenges **- How these were addressed**	Establishing good working relationships and links with staff on the general wards – to encourage positive attitudes towards people with dementia. Freeing up time for general ward staff to attend training sessions – to consider providing training within ward team meetings.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	New roles for staff to develop the service. Recruitment of staff with the correct knowledge and skill set, and an ability to transfer these skills to other staff.

Transferable Learning	This is key to the liaison service. Learning is transferred practically and by training.
Validation/ Evaluation	Questionnaires are being distributed to aid evaluation of the service.
Sustainability/ Next Steps	A befriending service has been developed which will complement the liaison service. Equipment and activities are shared where appropriate and are of benefit to people with dementia on general wards. This will be developed further.
Key contact/Locality	Sian Bayer, Joint Services Manager Sian.Bayer@iow.nhs.uk Sarah Cooke, Project Manager sarah.cooke@iow.nhs.uk Isle of Wight NHS
Dementia Strategy Objectives	Objectives 1, 3, 5, 8, 13, 14.

ISLE OF WIGHT

14. Prison In-Reach	
KEYWORDS: Prison / Diagnosis and assessment	
Aims	To ensure that prisoners with dementia are identified at the earliest opportunity so that treatments and services are available to them.
Local Context for Initiative	The Isle of Wight has 3 Prisons. Links have been established with the prison's hospital teams.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Early diagnosis and intervention. Innovative working practices. Enhanced support prior to release from prison and follow up. Prison Team involved in the process of assessment. Training of prison team and raising of awareness, knowledge and skills.
Challenges **- How these were addressed**	Engagement with prison staff has been a challenge due to their work pressures. Need for this initiative to be professionally led (Psychologist from the Memory Service). Ensuring that all staff are aware of the aims of this initiative, and the importance of using the correct assessment tools (e.g. the Addenbrookes tool).
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Successful engagement with the prison team. Ability to release staff from the Memory Service to be involved in this project.
Transferable Learning	Training of prison staff to undertake assessments for people with early signs of dementia. Raising awareness. Supporting care plans.

Validation/Evaluation	This will be audited by the Psychologist.

Sustainability/ Next Steps	Ongoing.

Key contact/Locality	Sian Bayer, Joint Services Manager Sian.Bayer@iow.nhs.uk Sarah Cooke, Project Manager sarah.cooke@iow.nhs.uk Isle of Wight NHS

Dementia Strategy Objectives	Objectives 2, 4, 5, 13.

MILTON KEYNES

15. Peer Support Network
KEYWORDS: Peer support / Awareness and understanding

Aims	The aim of the project is to reach out to a wider population of people with dementia and their carers so that we can continue to strengthen and improve the existing integrated pathway for those with dementia, especially from the point of diagnosis. A key feature of this project will be extending the current links with primary care to provide those professionals with a referral pathway for people with a diagnosis of dementia who do not require secondary specialist services. The principal service aims are: • The facilitation of structured group sessions for people with dementia and/or their carers to discuss the key elements of the illness and its consequences in an informal setting, in the presence of, and supported by peers • The facilitation of experiential learning from peers and information sharing around key areas of concern, experienced symptoms, and coping mechanisms • The prevention of social isolation • The development of social networks outside the groups which will empower people with dementia and their carers to access other community venues and leisure activities
Local Context for Initiative	The local branch of the Alzheimer's Society was founded in1997. The organisation provides support and advice for people with dementia and their carers via a number of platforms that include home visits, phone calls and one to one counselling. In addition, they currently run a number of peer support groups for people suffering from dementia, their carers and former carers. These peer support groups are highly valued by both the users and carers including the statutory OPMH teams. The groups are delivered jointly by both the service and Mental Health Services.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The peer support groups will have become integral to the local dementia care pathway and will: • Continue to link closely with the statutory teams in providing a service to those who would benefit from a peer support group • Increase partnerships with primary care, building on existing practice • Provide needs based groups using a number of models, including - closed support groups - small support groups - general support groups • Operate across a 6-day week, offering a weekend and evening

	service if this meets the needs of both people with dementia and their carers. The groups vary according to need, and are held for: • people who are unaccompanied and in the early stages of dementia • People with dementia and their carer / family member • Carers • Former carers. 16 new groups have been established, including a music group, reminiscent book group, art/craft group, 'singing for the brain' (which should be starting within the next few months) and a coffee morning with a view to this turning into a Memory Café. Service quality has been maintained as we have implemented a Peer Support service specification, which addresses the core product and product surround. Service costs have been minimised by employing one member of staff to run the groups, supported by volunteers. In many cases the venues have been provided at minimal cost. The project had a financial allocation of £58,244, spread over an eighteen month period. Staff costs constituted around 60% of the expenditure. The balance, being allocated to venue hires, publicity, staff recruitment and ongoing operational costs.

Challenges **- How these were addressed**	The groups have been targeted where there are a higher proportion of older people and numbers on QoF dementia registers. This established the roll out of new groups with the aim of attracting early adopters. Recruitment of suitable new support group facilitators proved to be a problem. Word of mouth turned out to be the best route to the labour market. One member of staff found the in-house training/post did not meet their expectations of what was required of them and chose to leave the project. Some of the hours were taken up by the remaining project staff member – this type of training was critical as it was important to maintain a consistent high standard of care.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	The following steps were identified in order to deliver the project: • Product /Project definition • Project Management / Project team/Project Plan • Financial Allocation • Staff Recruitment • Staff Training • Identification of suitable venues • Publicity/Awareness

	• Project Review • Service recording • Service Review
Transferable Learning	Key points both positive and negative can be used to help guide groups being set up in the future in this and other areas Joint working with statutory bodies has allowed service users a clearer picture of services available locally. A lower level of funding is needed to allow groups to continue due to ground work being completed during the pilot. Feed back into groups such as Carers Partnership groups allows statutory and voluntary services to both understand services offered via Peer Support and to signpost service users to the groups.
Validation/ Evaluation	Feedback from users and carers clearly show benefits from attending groups as it empowered them to live well with dementia. The attendees received information, support and understanding which enabled them to gain more control over their lives and decision making for their future. Feedback from other sites at the end of the project will be valuable in looking at good practice enabling a high standard of delivery to be consistent.
Sustainability/ Next Steps	Funding applied for continuation of groups and support to allow them to be an integral part of the service offered. A lower level of funding is needed to allow groups to continue due to ground work being completed during the pilot.
Key contact/Locality	Lynne Stoodley Support Service Manager Alzheimer's Society Milton Keynes 01908 261750 Lynne.stoodley@alzheimers.org.uk

Dementia Strategy Objectives	• **Objective 5:** Development of structured peer support and learning networks. The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services. • **Objective 6:** Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services. • **Objective 7:** Implementing the Carers' Strategy. Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

OXFORDSHIRE

16. Memory Assessment Service: The development of a unified approach and care pathway

KEYWORDS: Memory service / Diagnosis and assessment / Outpatients

Aims	1. Increase in the numbers of people in Oxfordshire with dementia who receive a diagnosis. 2. Establishment of a Memory Assessment Service and clear pathway for diagnosis, including an agreed point of access for the service. 3. Provision of tailored information for people with dementia and / or their carers around the point of diagnosis.
Local Context for Initiative	There have been 2 providers of memory assessment services in Oxfordshire, with no clear pathway or referral criteria for either service. In Oxfordshire, Quality and Outcomes Framework (QOF) data shows that in 2008, 34% of people against prevalence received a diagnosis of dementia. Memory clinics exist, provided by both Oxford Radcliffe Hospitals Trust (ORHT) and Oxfordshire and Buckinghamshire Mental Health Trust (OBMHT). There has been no clear pathway and no agreed service specification, leading to uneven levels of service and post diagnostic support. There has also been confusion among GPs around where to refer a patient with suspected dementia, due to this lack of a clear pathway and duality of providers.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The solution to the above problems in Oxfordshire is the establishment of a single Memory Assessment Service within the county, providing an integrated service between the providers with a clear pathway and a single point of access for Memory assessment services in Oxfordshire. The single Memory Assessment Service builds on existing good practice within Memory Clinics in Oxfordshire. The single point of access for both providers will, once established, receive referrals from GPs, removing current confusion around where to refer, building on recommendations from the National Dementia Strategy that "such services would need to provide a simple single focus for referrals from primary care, and would work locally to stimulate understanding of dementia and referrals to the service." Triage will be provided at this point, with referrals assigned according to clinical criteria. Domiciliary visits will take place as required at this point (as currently happens within Community Mental Health Teams), to assist in triage. Access to a structural imaging appointment to assist in assessment is to be based on clinically requirement. Following this, an appointment will

	then take place in a diagnostic memory clinic; this will be at the closest clinic geographically, unless the patient has requested otherwise. Home visits for diagnosis are available if necessary. The change is that there will be 5 memory clinics for diagnosis occurring within the county on a weekly basis, in suitable locations around the county. If a diagnosis is given, this will be communicated according to NICE guidance at the clinic. A letter detailing this diagnosis will be sent to the patient's GP, with a copy sent to the patient if requested. Post diagnosis follow up and ongoing monitoring will take place in the community; either at GP surgeries or another suitable location. Initial follow up will include information provision and referral to appropriate services. Given the current capacity issues, the need to increase levels of diagnosis and future demand for the service, it is anticipated that Consultant Psychiatrists would no longer be involved in all follow up appointments. This work will be undertaken by a registered mental health nurse (memory clinic nurse), operating in a community setting such as a local GP surgery. Referral to the CMHT for more complex cases will then be based on clinical criteria.

Challenges **- How these were addressed**	Challenges have included ensuring buy-in from clinicians and staff, obtaining suitably robust baseline data around current practice and ensuring that current providers agreed to the changes. The first has been addressed through the membership of the project team, ensuring it has suitable clinical and management representation from all providers and GPs. We also made sure clinicians were given an opportunity to comment through the consultation process. Obtaining the baseline data is having to form part of the contract variation in year one; not ideal but if we don't have robust data, we have to obtain it. Reasonable estimates of activity levels based on the known data have been used in the interim. Providers were involved in the project team responsible for creating the new pathway; as such, there were no surprises for them in the service specification.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	£116,000 of additional funding has been allocated to employ 3 additional Mental Health Nurses to undertake routine follow up of dementia patients in community settings, freeing up consultant time to concentrate on increasing diagnosis. Additionally, some of the funding is provided to roll out a programme of training and awareness for allied professionals such as GPs, to raise awareness of the new pathway and ensure that pre assessments are carried out.

Transferable Learning	The service specification is available to interested parties.

Validation/ Evaluation	The service will be evaluated after 3 months and then annually. The initial period of implementation will be used to confirm baseline activity data. KPIs are included within the service specification, including increased diagnostic activity and information provision to those receiving a diagnosis.

Sustainability/ Next Steps	Full Implementation is the next step.

Key contact/Locality	Duncan Saunders Service Development Manager, Older Peoples Mental Health, NHS Oxfordshire duncan.saunders@oxfordshirepct.nhs.uk

Dementia Strategy Objectives	Objectives 2 and 3.

OXFORDSHIRE

17. Dementia Advisers in GP Practices

KEYWORDS: Information and advice / Dementia Adviser / Homes and housing

Aims	The aim of the Dementia Advisor (DA) project is to deliver personalised tailored information for people with dementia and their carers to enable them to live an independent and successful life.
Local Context for Initiative	In Oxfordshire there are an estimated 7,000 people over the age of 65 and 155 people of working age living with the impact of dementia. This is predicted to increase by 19.3% over the next 10 years The health needs assessment completed in 2007 identified a total of 2,406 people with a definitive diagnosis of dementia. This means that approximately 35% of the expected population of people with dementia has actually been diagnosed. Oxfordshire is therefore in line with the national picture. Consultation with Service Users and their carers identified information as an area needing development and improvement. Three DAs were appointed and trained to provide the service and four GP practices agreed to participate in the learning exercise. The three DAs were appointed by Oxfordshire County Council and linked to and located within the identified GP practices.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The approach identified the following benefits/improvements for people with dementia and their carers: • Much improved communication between the DAs with a caseload of people with dementia and their GP • The project provided opportunities for case reviews to be undertaken • Partnership working with other organisations AGE UK, Alzheimer's Society Dementia Advisors within Memory Clinics • Reduction in time spent by GPs providing information to patients • Provision of link person through the patient pathway, enabling ongoing access to up to date information • Web based information assessment and provision through the development of an Information Prescription Tool specifically designed to assist the DAs to provide quality information to PWD and their carers • 387 clients/carers have received a service so far with 4 weekly and 6 monthly reviews • The ability to reach greater numbers of people with dementia • Provision of personalised tailored information described above

	provides people with dementia and their carers increased opportunities to exercise choice and control over their lives • Location of DAs within GP practices has led to better communication between primary care and other services caring for people with dementia, leading to a seamless experience for service users and their carers.
Challenges **- How these were addressed**	* Reluctance of GPs to make a diagnoss of dementia * Gaining commitment from GP Practices to be involved in the project • Lack of referrals coming through from GP Practices The above challenges were addressed over a number of months by GPs recognising the value of the DA service. This was achieved by key personnel attending GP Practice meetings and providing information about the service, and promoting the role of the DA. The lack of referrals increased as a result, and this issue was also address by changing the criteria from newly diagnosed to diagnosed in the last twelve months. The services was also offered to a further 17 surgeries increasing the number of participating surgeries to 21.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	• Essential to the success of the project is a Dementia Lead/Coordinator who oversees the project. • Dedicated Dementia Advisors with experience/skills and competencies not only to be able to deal with PWD, but also other professionals e.g. GP, Mental Health Teams • Constant monitoring/reviewing with a high degree of flexibility from staff • Effective working relationship with PCT colleagues
Transferable Learning	• The importance of access to personalised information after Diagnosis • Provision of support that is flexible and provided by staff who have the knowledge and expertise to understand the impact dementia can have on a person, and those around them * Provision of consistent information and advice at the time it is needed * Early diagnosis so that there is more time for person centred plans can be put in place • Enabling carers and others to play an active role in the care of the person
Validation/Evaluation	The OCC Dementia Advisers have, in under a year, created a highly valued service which is continuing to expand. There are now plans to expand the service to cover all 83 GP practices. Feedback from

service users is of a consistently positive nature. The only negative feedback has been from those service users who wished they had received the service sooner.
The following recommendations are proposed:

I. The Dementia Advisers' knowledge and expertise should be incorporated into a training manual for future Dementia Advisers.

II. The Dementia Advisers should be supported in developing a more consistent, standardised approach to Information Prescription.

III. Administrative support would help the Dementia Advisers to deal with paperwork and would therefore enable them to provide a service to more service users.

IV. Consideration should be given to ways in which the service could be expanded, to include the provision of a referral pathway countywide, which has GP referrers at its core, but which also creates a route for referrals from other professionals and for self-referrals.

V. Consideration should be given to whether there is adequate provision of the DA service in GP practices in the City area, to ensure that the needs of people from the BME communities are appropriately met.

VI. Consideration should be given to how the information and advice needs of people who live alone, and do not have a carer, might be addressed.

VII. Consideration should be given to whether the OCC Dementia Adviser model could possibly be further enhanced by the OCC Dementia Adviser attending a forum such as a Dementia Cafe.

VIII. All of the above are predicated upon the pilot project continuing. What the pilot has demonstrated is: how much need there is out there for a Dementia Adviser service and how well-located such a service is in GP practices; the value service users place upon the service and the knowledge, expertise and skills of the Dementia Advisers; the ways in which the service can be of benefit to GPs. A weighing of cost-benefits needs to take into account research identified at the beginning of the report which has demonstrated the clear financial benefits to local authorities of preventing or delaying admission to residential care, as well as the human benefits to the person with dementia and their carer(s) and loved ones. The final words go to one of the Dementia Adviser service users:

'[The Dementia Adviser] fully understood the condition and the effects on family and carers. The practical everyday tips and suggestions [the DA] has given us have been really useful, in addition to all the information about the services available. I do hope there will be an ongoing role.'

Sustainability/ Next Steps	Evaluation is taking place locally to evaluate the economic impact of the service to support future sustainability. A business case is being developed to secure funding on an ongoing basis.

Key contact/Locality	Mary Barrett Oxfordshire County Council County Hall New Road Oxford OX1 1DN Mary.Barrett@oxfordshire.gov.uk

Dementia Strategy Objectives	Objective 4. One element aims to ensure that people with dementia and their carers receive appropriate information and advice at the point of, or soon after, diagnosis. Research suggests that early intervention enables informal carers to care for longer, with less carer stress. This can, in turn, delay/prevent the admission of the person with dementia into residential/nursing care.

PORTSMOUTH

18. Nurse-led outpatient clinics for OPMH
KEYWORDS: Outpatients / Diagnosis and assessment / Nurse-led

Aims	Maximum wait of 4 weeks for an initial outpatient assessment. Delivery of 18 week referral to treatment time. Increased patient satisfaction due to shorter waiting times for assessment.
Local Context for Initiative	To support existing outpatient clinics run by OPMH medical staff.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Nurse-led patient assessment, both initial and ongoing, to assess and plan care for mental health issues. This has provided an opportunity for patients to have a longer 1 to1 assessment. The commencement of the clinic has resulted in fewer breaches to waiting times. It has also resulted in more early diagnosis of mental health problems, including different types of dementia. Patients are often seen with relatives and carers, and this has enabled them to have correct information about support services available in the community. Earlier diagnosis has on occasions resulted in earlier prescribing of medication, which has helped with preventative approaches.
Challenges **- How these were addressed**	Nurses not being able to prescribe. This has been resolved by nurse clinics running alongside consultant clinics, and consultants being able to make themselves available, either between patients in their clinics, or by arranging a joint follow-up appointment with nurse and consultant together.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Training needs being met. Appropriate supervision and support, from consultant and managers. Allocated time to run a clinic, and to arrange GP letters, referrals to other agencies, and completion of assessment documentation. Clinic rooms in order to see patients, with access to computer equipment.

Transferable Learning	Shared learning experiences between all of senior nurses that run nurse-led clinics. This has also been shared with band 6 Nurse colleagues who cover clinics in absence of senior nurses.

Validation/ Evaluation	This can take place on a 1 to 1 with the consultant, or discussed, where appropriate, at multi-disciplinary team meetings. There are also occasional meetings organised by the OPMH service manager, to discuss and evaluate nurse-led outpatient clinics.

Sustainability/ Next Steps	Sustainability is fine providing all current resources remain in place. The next steps have yet to be decided.

Key contact/Locality	Maggie Vilkas, service manager for OPMH. maggie.vilkas@solent.nhs.uk

Dementia Strategy Objectives	Recommendation 3 – Good quality early diagnosis and intervention for all. Recommendation 4 – Good quality information for those with dementia and their carers. Recommendation 5 – Enabling continuity of support and advice.

PORTSMOUTH

19. Memory Assessment Clinic for mild cognitive decline
KEYWORDS: Mild cognitive decline/early onset / Diagnosis and assessment / Outpatients

Aims	Enable accurate early assessment and diagnosis of cognitive problems in patients of any age referred with mild cognitive changes.
Local Context for Initiative	Historically this cohort has been assessed in a variety of settings including neurology, primary care, adult mental health and the private sector, as well as in different sections of older persons mental health services. A single assessment pathway for all new patients with mild cognitive changes providing specialist assessment and diagnosis followed by involvement of or diversion to appropriate primary or secondary care services is thus in the interest of the patient and the health system.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Rapid and competent specialist assessment by Consultant Psychiatrist. Accurate neuropsychological diagnosis and input provided by psychologist (Dr Fielder) with an interest in neuropsychology. Early and accurate diagnosis delivered sensitively to patient and family/carer. Early recognition with potential to instigate preventative measures and forward planning. Continuity in support and information offered at time of diagnosis. Early referral to Memory groups providing information and support to patients and carers. Rapid facilitation of treatment, care and support by other aspects of primary and secondary care as appropriate. Rapid facilitation of input by early onset dementia team in patients under 65.
Challenges **- How these were addressed**	Main challenge was to create clinical time. This was done through the creation of a session (one half-day outpatient clinic per week) in the job description of a new consultant post. It also requires the clinical time of an experienced neuropsychologist. The use of Dr Fielders time for this purpose was agreed as a priority (together with CBT) with the other consultants. Finally ensuring that suitable ongoing care and support pathways identified and available post-diagnosis. For example the service reconfigured use of the Day Treatment centre one day a week to provide an eight week programme for newly people and family/carers newly diagnosed with dementia.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	Clinical time as well as other resources i.e. secretarial time, providing information (booklets and leaflets). Also adequate support pathways for ongoing care and support after diagnosis. Currently only capacity, in terms of Consultant and Psychologist time, to run one clinic per week. Therefore service does not have capacity to see every new referral received with mild memory changes. When this clinic reaches capacity patients are seen in ordinary OPC setting which is not ideal. Adequate funding needed.

Transferable Learning	The identification and management of a group of patients who fall between the "gaps" of service provision and criteria. Importance of early diagnosis leading to early support which can have significant impacts upon a persons quality of life.

Validation/ Evaluation	Feedback from primary care and service users. Feedback from fellow clinicians. Epidemiological data and monitoring. Service user experience survey to be carried out soon.

Sustainability/ Next Steps	Needs ongoing education within primary care to refer people early. Liaison with other secondary care services to ensure patients transferred appropriately between services if necessary. The next step would be to expand the capacity of this clinic so see all new referrals with mild cognitive changes. Also in the future this clinic would sit alongside joint clinics in neurology and elderly medicine but funding and resources would be needed across different Trusts to provide this level of input.

Key contact/Locality	Dr Karla Greenberg Consultant Old Age Psychiatrist Langstone Centre St James Hospital karla.greenberg@solent.nhs.uk (form completed by Dr D Cotterell and Dr Greenberg)

Dementia Strategy Objectives	**Objectives 2:** Good quality early diagnosis and intervention for all. **Objective 3:** Good quality information for those with diagnosed dementia and their carers.

PORTSMOUTH

20. Older Persons Mental Health liaison service
KEYWORDS: Liaison / In-patient / General hospital

Aims	To act as a triage service for all referrals to the Older Persons Integrated Community Mental Health Service received from Portsmouth Hospitals NHS Trust (the local General Hospital) and signpost on if appropriate. To provide assessment, advice, follow-up and education on patients suffering from organic and functional older persons mental health issues within the general hospitals. Consultant member of the Team to take the Responsible Clinician role, if appropriate, for patients over 65 detained in the General Hospital under the Mental Health Act 1983 (as amended by the MHA 2007). To provide advice on capacity and the Mental Capacity Act 2005 but only to carry out mental capacity assessments in complex cases where there is dispute or uncertainty. Raise awareness of dementia and other mental health issues within Portsmouth Hospitals NHS Trust, providing advice and education on the most effective approaches to management.
Local Context for Initiative	There is no permanent liaison presence in these general hospital and thus input has historically been provided inconsistently and on an "ad hoc" basis. This has resulted in an unsatisfactory service for clinicians and service users alike. Thus a role was created for 4 sessions of specialist nurse input and one consultant session for clinical work and one consultant session for managerial/developmental activity to improve previous service provision.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Single point of referral. Triage and telephone contact with all referrers within 24 hours of referral being received. Consistent telephone advice and clinical assessment according to clinical urgency by appropriately skilled and trained staff. Earlier diagnosis and care planning of OPMH clients with clearer and quicker liaison with responsible professionals for clients known to OPMH services. Early communication with primary care from hospital to facilitate adequate care planning on discharge. Quicker involvement in discharge planning to prevent delays in discharge from hospital.

Challenges **- How these were addressed**	Creating sufficient funds to finance these roles. Changing the culture of referral and management of OPMH clients in the general hospital. Creating awareness and providing education on dementia and on the role of OPMH and liaison. The interface with a variety of clinical disciplines and social services is particularly challenging. Reducing elevated expectations of what the service can provide. Prioritising appropriately as Team not have capacity meet all liaison demands.
Resources/ Capability/ Capacity - **What does it take to make this happen?**	Currently 2 sessions of consultant psychiatrist time and 4 sessions band 6 or above nurse time and secretarial support. Provision as it stands is insufficient to meet demands. Ideally there should be a permanent presence of both as a minimum over both general hospitals sitting within a multidisciplinary team. When Liaison Team is at capacity then the community mental health teams carry out assessments. Unfortunately when capacity is reached it is the education role which suffers whereas in the long term this is likely to be the aspect that can trigger long term change.
Transferable Learning	Issues surrounding setting up a service that straddles a large swathe of social and health services.
Validation/ Evaluation	Feedback from secondary care – via survey. Feedback from fellow clinicians. Service user and carer feedback. Statistical data regarding referral rates, morbidity, qualitative data on further care, acceleration of discharge etc.
Sustainability/ Next Steps	Needs investment from future commissioners to provide a dedicated full time liaison service in combination with Hampshire Partnership Trust based upon the evidence that this has financial and clinical benefits.
Key contact/Locality	Dr Karla Greenberg OPMH Consultant Langstone Centre St James Hospital karla.greenberg@solent.nhs.uk (form completed by Dr D Cotterell)

Dementia Strategy Objectives	**Objective 8:** improved quality of care for people with dementia in general hospitals Diagnosis and assessment of needs with care planning by a specialist. Managing the needs of patients with dementia in the general hospital setting. Appropriate admission and discharge planning of clients with dementia.

SOUTHAMPTON

21. Involving Seniors in addressing the issue of Dementia

KEYWORDS: User Led Group / Awareness and understanding

Aims	To monitor progress in addressing dementia issues in the city; To raise awareness and increase understanding; To promote a senior focussed agenda that goes beyond health and care services;
Local Context for Initiative	The Southampton Seniors Council is a 'co-production' network that aims to make Southampton a good city to grow older in. It is a member of the city's Later Years Partnership, working alongside the City Council and other agencies. The Seniors Council decided that it wanted to focus some attention on Dementia, following reports about lack of awareness, quality of dementia care, etc.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	The Seniors council invited speakers to its meeting. These included the Alzheimer's Society and a clinician from a memory clinic. It then decided that it would like to hold a conference about Dementia. It planned the conference as a joint initiative with the PCT, which was looking for an opportunity to launch its local strategy. The agenda was jointly agreed, and over 80 people attended the free event. Lunch was supplied by a commercial sponsor. The agenda included presentations about public health and risk factors; what is dementia and the issues; environmental design for dementia, the launch of the PCT strategy, and Admiral nurses. Workshops included living well with dementia and prevention, living wills, awareness and early diagnosis. The result was a higher awareness amongst seniors, with many of those attending being 'connectors' into local seniors groups etc. Building on the Conference the Later Years team produced a briefing/report about the event: www.southamptonlateryears.org Following the conference a meeting was organised amongst those seniors interested to see what could be taken forward. A reference group was set up involving the PCT, Alzheimer's Society, the Link, and seniors council representatives. With a higher level of awareness, the reference group has an informing role with seniors, and is able to make a positive contribution to taking

	the dementia strategy forward. It has recently undertaken a survey about awareness and attitudes to Dementia, and will be producing a report shortly.

Challenges **- How these were addressed**	

Resources/ Capability/ Capacity **- What does it take to make this happen?**	The Seniors Council members are volunteers, but they receive some support from the Council's Later Years team in organising their affairs, providing background materials etc. which enables them to put their energy into the actual issues and the activities that entails.

Transferable Learning	• The importance of breaking down barriers between professionals and the public, and collaborative working; • Recognising the contribution that seniors can make, and in particular awareness raising, working through networks not available to professionals, etc. • The importance of the non health and care aspects – active ageing and prevention; design; living wills; etc.

Validation/ Evaluation	

Sustainability/ Next Steps	Age Concern aims to focus on dementia in the coming year to continue the reference group's work. This initiative is likely to lose momentum as a result of changes to the health system, loss of personnel etc. It is hard to see how this sort of initiative arises and develops in the future.

Key contact/Locality	Southampton Seniors Council c/o Age Concern Southampton 1 Saxon Gate Back of the Walls Southampton SO14 3HA

WOKINGHAM

22. Housing development for people with dementia at Alexandra Place

KEYWORDS: Homes and housing / Partnership / Models of care - approaches

Aims	Wokingham, like many other parts of the country, has growing older population, it is clear there is a need to provide different housing options for older people that encourages and supports them to retain their independence; and to provide choice for older people who currently are restricted to the options of traditional sheltered housing or institutions such as residential or nursing care. Following a review of the Council's own sheltered housing stock, a site was identified as having the potential to be re-developed into extra care housing. The site was currently occupied by a 1960's traditional sheltered housing scheme, consisting of mainly bed-sit accommodation which was no longer popular with prospective tenants. Overall the built environment provided by the scheme as poor. The fundamental design was misconceived providing long walking distances for most tenants from their accommodation to the communal facilities and those facilities are at a distance from the main entrance and manager's office. The individual flats were too small to provide an adequate environment for active older people or an appropriate context for the delivery of higher levels of care to those who are frailer. In commissioning Alexandra Place, Wokingham was clear that the design must offer a safe and secure environment, which would provide the flexibility to meet the future needs and requirements of an ageing population. The expectation in the provision of extra care housing is for a mixed dependency occupation, with around 1/3rd of occupants having care needs in excess of 12 hrs care per week, 1/3rd medium care needs and 1/3rd with low to no current care needs. Alexandra Place will include appropriate technology and telecare systems capable of supporting individuals in their own home.
Local Context for Initiative	Wokingham's Strategy for Housing for Older People identified the need to reshape the pattern of provision of housing for older people in Wokingham. Many of Wokingham's older people are owner-occupiers who will require a range of options to meet both their housing and care needs. In coming years older people will become an increasingly large and influential group within Wokingham, who will expect a high quality of life and support, as they grow older. Government policy clearly identifies the need to provide different housing options for older people that encourages and supports them to retain their independence; and to provide choice for older people who currently are restricted to the options of traditional sheltered housing or institutions such as residential or nursing care. The Strategy has also identified a growing number of older people living

in the borough. The table below demonstrates the projected increase:

Population projections for those 50+ (000s)

Age	2001 Census	2003	2008	2013	2018	2023	2028
50-64	27.6	27.8	29	29.2	30.5	30.7	28.8
65-74	10.3	10.9	11.6	14	15	14.4	15.4
75+	7.6	8	9.4	11	12.4	15.2	16.8

This translates to a doubling of those of 75 years of age and above by 2023. This together with the rising aspirations of older people in relation to their future accommodation and care; and the shift in tenure amongst older people with currently 79% owner occupation of those 75 years of age and over, means there is an imbalance in provision of specialist older people's accommodation across tenures.

The Council provides a substantial amount of conventional sheltered housing for rent. The requirement for this type of accommodation is reducing and a review of sheltered housing highlighted the gaps in provision both in respect of the standard of accommodation offered and the range of facilities available to older people. The majority of this accommodation is in single bedroom flats whilst some is in bed-sits.

Much of the accommodation is old and some of the design limitations are more evident as the tenant population grows older. Most provide limited facilities for the delivery of care or for the delivery of cultural, educational and leisure programs that will provide tenants with a rich pattern of life. As the tenant population ages increasing frailty makes it more difficult for tenants to find opportunities for cultural, educational and leisure pursuits outside the scheme.

Wokingham had a limited range of housing options for older people and for those with dementia, with a distinct under-provision of extra care housing, and without this being addressed the care and support needs of older people will not be fully addressed.

Achievements/ Benefits

To Include:
- **Quality Improvements**
- **Innovation**
- **Productivity (cost efficiencies)**
- **Prevention**
- **User/Carer Involvement**

The key features of Alexandra Place are:

- A mixed tenure development providing 64 new homes for older people (including 10 apartments specifically for dementia care) The mix will be 46 x 1 bedroom apartments and 18 x 2 bedroom apartments of which 14 are for shared ownership. Most apartments have either a balcony or private patio.
- Imaginatively designed communal areas which promote inclusion but allow privacy. This includes practical, well laid out gardens, a restaurant, hair salon, therapy and exercise suite, IT café and shop.
- An attractive building design that is sympathetic to the surrounding area and incorporates the principles of sustainable development (Code for Sustainable Homes Level 4).

	• A Community Membership Scheme allowing both residents and the local community to benefit from the range of communal facilities and social activities offered on the scheme. This innovative model not only promotes choice and inclusion, but will also ensure that the communal facilities are financially viable. Some key features of the Extra Care & Support and Dementia Care services are: • Care provider has extensive experience in delivering Extra Care services providing on site Management and Care Staff 24 hours a day/365 days a year • Fully trained, registered and qualified staff • Expertise in delivering Dementia Services, including nationally recognised research and innovation • Service user led in design, delivery and development of services • Experience in developing partnership protocols

Challenges **- How these were addressed**	Some of the principal challenges faced in moving this project forward were: • Re-housing of tenants from the existing sheltered housing scheme on the site – this required not only time and funding (for home loss and disturbance payments) but also active communication and location of appropriate alternative housing. • Planning – taking any new development project through the planning process is a challenging task, but particularly for a council led initiative. Working closely with planning officers and involving local residents was key to a smooth transition through the planning process. • Funding – projects such as this require the input of funding from a number of sources. Alexandra Place in particular required the Council to provide the land together with some financial subsidy together with grant funding from the HCA. • Partnership working – the project involves a number of partners e.g. the council, housing development organisation, housing management organisation, care provider. It has been imperative throughout the project that we all work towards a common goal. Effective communication and consistent personnel are a key factor to this being achieved.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	Partnership working is seen as essential to the effective delivery of Extra Care Housing. Key partnerships with health, social care and supported housing (Supporting People) are absolute requirements to ensure the delivery of extra care housing, care and support services that are co-ordinated and responsive to the changing needs and aspirations of older people.

Transferable Learning	• Forging strong partnerships – both externally and internally e.g. adult social care, corporate strategy • Effective project management
Validation/ Evaluation	
Sustainability/ Next Steps	Alexandra Place is scheduled to be complete and open in June 2011. Wokingham has also since commissioned a specialist dementia extra care scheme, which will consist of two clusters of 9 one bedroom ground floor apartments for local residents with dementia together with 8 one bedroom first floor apartments for adults with a learning disability. This is the first such scheme for Wokingham and is due for completion in the Spring of 2012.
Key contact/Locality	Carol Lovell Senior Strategy Officer Carol.lovell@wokingham.gov.uk 0118 974 6082
Dementia Strategy Objectives	

WOKINGHAM

23. Inclusion for people living with dementia: Intermediate Care Rapid Response and Reablement team

KEYWORDS: Admission avoidance / Models of Care / Crisis Support and rapid response

Aims	■ Provide a service in the individuals own home, maximising independence and enabling them to remain there ■ To involve the person's individual social systems, providing support and information to family/carers during this period ■ To provide information to the individual to enable choice ■ To provide a comprehensive, multi-professional assessment of the individual's mental health, physical health, social care and spiritual needs ■ Develop an individualised care plan which is sensitive to the individual's personal circumstances, gender and ethnicity ■ To facilitate individual's engagement during the acute phase of their illness by initially focusing on their perception of overall needs rather than just their 'mental health needs' ■ To provide treatment packages, working jointly with local services From: McNab L (2006) a new service in the intermediate care of older adults with mental health problems. *Nursing older people*, 18 (3) pp.22-26. ■ Identify risk and devise risk enablement plans with the person living with dementia their family/carer's From: Department of Health (2010)'*Nothing Ventured Nothing gained' Risk guidance for people with Dementia* London: The Stationary Office.
Local Context for Initiative	Funding was made available for Community Psychiatric Nurse (CPN) in 2004. This was an agreement between Head of Intermediate Care, Wokingham, Community Services Manager Social Services Wokingham and Locality Manager Old Age Psychiatry in line with Department of Health (2001) *National Service Framework for older people.* London: The Stationary Office also The Nuffield Institute for Health (2002) *Exclusivity or Exclusion? Meeting mental health needs in intermediate care* Leeds: Nuffield Institute for Health. The increase of dementia in the local borough is due to raise significantly. Information from: Joint Strategic Needs Assessment For Berkshire West

	(2008) p. 18 Wokingham Borough Summary Older people Support the increased need for social care services "The number of older people will increase. People over 85 make up around half of all of the adult social care service users. The increasing trend in the population of older people will have a big impact on social care services. The total number aged 75 and over living alone is also projected to rise by 35% (9,200 in 2008 to 13,200 in 2020), although the percentage of people living alone is likely to decrease. In 2006/07 around 1,600 people aged 65+ received social services support from Wokingham council. Of that number just under 200 were in residential or nursing care. **Plan for anticipated rise in health and hospital demand** The increasing older population in Wokingham will impact upon the health service with increases in emergency admissions and mental health contacts. Coronary heart disease and Stroke numbers are likely to rise around 16%, but heart failure might increase 52%, due to increasing older age-groups. The Projecting Older People Population Information System estimates that the number of people aged 65+ with dementia will increase by around 41% from 2008 to 2020 to approximately 1950 people".

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	

Challenges **- How these were addressed**	Criteria for IC community didn't seem to "fit" for people living with dementia therefore criteria changed to: Eligibility for rapid response: ■ Adults who are unwell but medically stable whose admission to an acute hospital bed can be prevented; ■ Adults who are registered with General Practitioner in Wokingham; ■ Patients must give consent to actively participate in a Rapid Response programme. Eligibility for reablement: ■ Adults who are medically stable and registered with a General Practitioner in Wokingham; ■ The individual referred should have potential to improve and

	benefit from therapeutic intervention within 6 weeks; ■ Patients must consent to actively participate in a reablement programme. The "6 week time frame": it has been identified by the PCT that patients with mental health problems spend longer on the service. The clinical expertise of the MDT are taken into account so people can have longer than the 6 week period to reach their full potential should it be identified that they are likely to progress further. Varying skills and knowledge of staff: some training has been provided by CPN. Coaching is provided on individual cases re: best practice in working with that person. There is still much work to be completed in this area to meet objectives of the strategy. Task orientated culture v person centred care: ongoing challenge getting others to see the "whole picture" and understand the complexities of living with dementia and the impact it has on the person and their families/carer. The organisation has a top down approach: policies and decisions are made by senior managers who have to lead a whole organisation and manage all health conditions. It is difficult as a clinician to initiate new ideas therefore clinicians need to meet senior managers so they can implement from the "top down". Time only 1 CPN to cover wards and community, time dedicated to patients and working with staff therefore service development/ devising training packages for staff on dementia is limited. Unsuitable referrals/referral process to CPN patients often referred for CPN assessment when the patient is delirious, CPN devised a pathway, this has not yet been agreed by senior management therefore not in place at present.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	• Visionary leader passionate about changing/developing services for people living with dementia • CPN based within IC services • CPN supervised by experienced CPN • Skilled CPN with experience of working with older adults in the community • Teamwork/ team support • Determination • Partnership working with Social Services, Mental Health Teams, Voluntary and Private Sector • "Thinking outside the box" • Person-centred/relationship centred care

Transferable Learning	• Change the systems to include the person with dementia • Be flexible regarding time on the service • May take longer to engage the person in services but skilled clinician should led and use expertise to offer appropriate service • Employ skilled CPN to be based with the Intermediate Care team rather than the CPN being employed by mental health trust. • Care plans based on goals and interventions see: Park S (2003) *goal setting in Occupational Therapy: Evaluating Client-centred outcomes* [course handout] London: Harrison Associates.
Validation/ Evaluation	• People living with dementia receive IC services regardless of their disability • Reduce hospital admission • Reduce admission to long term care • People living with dementia who have been reluctant to engage with services in the past have accepted ongoing services at home to maintain their well-being and avoid unnecessary admission to care homes • Ongoing support for person/ families/ carers • Support, consultancy and information is offered to staff in long term care settings when individuals with dementia are transferred to their care. • Direct referral to the community older adult mental health team i.e. memory clinic from Intermediate Care
Sustainability/ Next Steps	Clinician feels next steps could be for clinician to meet senior managers (in line with Department of Health (2010) *Equity and Excellence: liberating the NHS* London: The Stationary Office) to discuss: • Person-centred policy • Clear pathways • A shift from task orientated care to person-centred care • Person centred appraisals • Specialist nurse for dementia to lead change and initiate objectives of the strategy • More CPN's to increase capacity and deliver strategy objectives • Training programmes for all staff • Dementia champions • PCT to consider completing inspiring dementia in the NHS, the 70 point NHS culture and quality of care checklist from: Dementia Care Matters, Sheard D (2010) • CPN to work collaboratively with the older adult liaison team in the acute sector once team established to ensure people with dementia are given the opportunity to return to their home if it is their wish.

Key contact/Locality	Julia Bliss (Head of Intermediate Care Services Berkshire West PCT) Mobile number: 07881788653. Alain Wilkes (Service Manager Commissioning) 0118 9746810 Juliet Millar (CPN) 0118 9495079 Juliet.Millar@berkshire.nhs.uk

Dementia Strategy Objectives	**Objective 1:** Raise awareness of dementia and encourage people to seek help **Objective 2:** Good-quality, early diagnosis, support and treatment for people with dementia and their carers **Objective 3:** Good-quality information for people with dementia and their carers: **Objective 4:** Easy access to care, support and advice after diagnosis: **Objective 9:** Improved Intermediate Care for people with dementia: **Objective 10:** Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers. **Objective 12:** Improved end of life care for people with dementia: **Objective 13:** An informed and effective workforce for people with dementia: NB Although we are meeting parts of the strategy there is still much work to be done as discussed in sustainable next steps.

EAST SUSSEX

24. East Sussex Assessment & Diagnostic Clinics (ADC's)	
KEYWORDS: Diagnosis and assessment / Outpatients / Information and advice	
Aims	To increase diagnostic capacity in East Sussex through service redesign in line with NDS Objective 2 good quality early diagnosis for all. To ensure good quality information for those with diagnosed dementia and their carers in line with NDS Objective 3. Enabling easy access to care, support and advice following diagnosis in line with NDS Objective 4. Improved community personal support services in line with NDS Objective 6. **It is important to state that this is a work in progress with a target start date for the new service configuration in July 2011.**
Local Context for Initiative	East Sussex has higher numbers of older people over the age of 65, 75 and 85 years old, compared to the UK average. It is also expected that there will be increases in the overall number of older people living in East Sussex in the future. Approximate calculations predict there will be 22,350 more people over 65 years of age by 2016, a 19% increase since 2006. What is important about these changes in population however, is that not only are the overall numbers aged over 65 set to increase, but that the highest rises are in the lower age bands, those between 65 and 69, and 70 and 74 potentially highlighting a higher projected Dementia prevalence rate than many other parts of the UK.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Although East Sussex had embarked on a piece of local research, 'Preparing for the National Dementia Strategy' in 2008, it was the publication of the National Dementia Strategy in February 2009 that provided the springboard for action to facilitate complete service redesign and improvement of dementia services in East Sussex. March 2009 – October 2009: Develop and agree multi agency East Sussex Dementia Action Plan. January 2010: Two day facilitated stakeholder event to determine shape of new East Sussex Dementia Care Pathway. 70 stakeholders engaged including service users, carers, third sector, clinicians & key operational staff. Agreement to utilise best practice care pathway model as highlighted in the NDS. February 2010: Review of existing NHS mental health provider day

	hospital provision. May 2010: Project plan provided to existing NHS mental health provider requesting operational and cost model for new Assessment & Diagnostic Clinics (ADC's) in East Sussex October 2010: Cost and operational model agreed with existing NHS mental health provider for new ADC's including circa 750k saving on original contract to re-invest in dementia support services in East Sussex. November 2010: Competitive tender launched to build on successful establishment of Dementia Advisor (DA) Demonstrator Site programme. Provision of pre and post diagnostic intervention, GP single point of referral, DA to be provided to each PBC cluster in East Sussex. **Planned implementation activity:** January 2011: Launch competitive tender for additional dementia support services from third sector providers. April 2011: Award tendered DA contract. June 2011: Award tendered additional dementia support services contract/s July 2011: DA provider goes live. July 2011: New East Sussex ADC's go live. Additional diagnostic capacity operationalised. September 2011: New additional dementia support services provider goes live. October 2011: End of dementia service redesign project new pathway operational. NB. ADC's service, pathway redesign and additional support service provision completed at zero additional cost.

Challenges **- How these were addressed**	**1). Increased service requirement – challenging financial landscape** 1.1) Review of existing service provision arrangements. 1.2) Frank, open discussions with existing NHS mental health provider 1.3) Collaborative & positive approach to service redesign 1.4) Focus on outcomes for service users and carers **2). Complex whole systems service delivery** 2.1) Building on mature working relationships with key stakeholders 2.2) Identifying joint core organisational objectives 2.3) Proactive communication and information share between key stakeholders **3). Liberating the NHS White Paper**3.1) Engage GPs from day 1.3.2) Recruit GPs to key commissioning decision making groups.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	• Senior management buy in to meeting redesign objectives; • Motivated knowledgeable staff with dedicated time in each key agency; • Good track record of trust/partnership working with LA and NHS mental health provider; • Regular communication feed to senior management; • Positive and ongoing focus on engagement with GPs; and • Pragmatic acceptance by existing providers of new world direction.
Transferable Learning	As above. ADC's Service Specification available.
Validation/ Evaluation	As per contract reviews in 2011. Sussex Dementia Partnership evaluation 2011.
Sustainability/ Next Steps	Undertake planned Implementation activity.
Key contact/Locality	nigel.blake-hussey@esdwpct.nhs.uk
Dementia Strategy Objectives	2, 3, 4, 6.

East Sussex

25. East Sussex Dementia Adviser Service

KEYWORDS: Information and Advice / Dementia Adviser

Aims	• Provision of a quality information and signposting service tailored to individual need, supported by an evolving database of activities and services called Guidebook. • A focus on the individual with an aim to empowering people to access the information they need and promoting independence, self-help, well-being, choice and control. • Building partnerships with other health and social care professionals in order to maximise the outcome for the person with dementia. • Seeking out those traditionally hard to reach and making information and signposting accessible to all.
Local Context for Initiative	The East Sussex Living Well With Dementia Adviser Project (ESLWDAP) will provide the opportunity to engage in a national learning programme which will ensure high quality service model development that addresses the aspirations of people living with dementia, in both rural and urban settings. The ESLWDAP will enable those with a dementia diagnosis and their carers to access information and support in a manner that will promote control over their own lives and contribute to their independence and quality of life as time progresses. A need for information and signposting aimed at the person with dementia as a priority in the early stages of the disease was identified through the National Dementia Strategy. People with dementia have said that they could be helped to live well for longer if the had better access to good quality, relevant information supported by a named contact, 'someone to be with us on our journey'. This would enable people with dementia to access information and make choices about their future.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	• Having a total of 760 referrals through the service in a year. Reaching 437 people with dementia and 323 carers, family members and friends of people with dementia. • Providing quality information appropriate to a person's individual need. • Creating a growing database of up to date information about services and activities in the local area that people with dementia, their carers, families and friends can use – Guidebook. • Promoting independence, self-help and control and encouraging people with dementia to make choices regarding their own future. • Early intervention can help towards alleviating stress, preventing

	crisis and promoting the well being of the person with dementia as well as their carers, families and friends. • Establishing successful partnerships with health and social care professionals and other commercial and voluntary sector organisations for the benefit of people with dementia. • Recruiting and training a team of skilled volunteers to support the dementia advisers in their work and provide people with dementia and their families with the additional support required. • In providing a proactive and personalised point of access to information and support services throughout the care journey, the need for crisis point intervention is much reduced. It is too early to measure cost efficiencies, but we can assume that on the basis of the potential benefits of early intervention services that there will savings made later in the dementia pathway.
Implemented Challenges **- How these were addressed**	• Initial reluctance to refer in to service from health and social care professionals, which has been addressed by continual relationship building and awareness raising of the service through talks, presentations and meetings. • There are a limited number of activities and services to signpost people to in the early stages of dementia and also for those living alone. We have addressed this by working together with community groups to help involve people with dementia as well as keeping abreast of services available for people with dementia. We have made full use of services already provided by the Alzheimer's Society. • The ability to support high numbers of people with dementia is dependant on the support of volunteers and the complementary role of Dementia Support Workers and a Befriending Service. In areas where these services do not already exist it has been necessary to adopt a more flexible approach to the service provided to meet these needs. • Volunteer recruitment and retention has been a challenge and uptake of volunteers varies between each of the three areas covered. A Volunteer Officer has been recruited to address these issues and take the lead on volunteer recruitment. • A lack of sufficient work space and equipment limited the service initially as did connectivity and use of secure dongles. All three dementia advisers now have permanent desk space, storage and broadband lines, and use of land line telephones where mobile phone signals are poor. • The early diagnosis of dementia is often not happening so it has been necessary for the Dementia Advisers to be more flexible in terms of the suitability of referrals. Looking to the future the dementia advisers are also involved with a Dementia Awareness Raising Campaign along side East Sussex NHS Community Health Services in order to encourage people to seek an earlier diagnosis. • The care pathway for people with dementia varies between locations within East Sussex. We have been flexible towards our own referral pathway and benefit from an open referral criteria

	which has helped to overcome any obstacles relating to this.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	• Permanent desk and storage space in nominated bases with access to a computer, broadband, a secure network and the use of a telephone. • Access to a full range of marketing materials promoting the service to people with dementia and their carers' friends and family as well as health and social care professionals. • Access to the full range of Alzheimer's Society Resources, including the Dementia Advisers Toolkit, further specialised literature and online resources. • Extensive training provided to Dementia Advisers and all Volunteer roles supporting the dementia advisers. • Successfully delivering the service relies on leadership by the area Locality Manager, line-management by the area Support Services Manager, administrative assistance from the Locality Administrator, and support to recruit and retain volunteers by the Volunteer Officer. With further support from staff at the Central Office. • With the above structure in place we have established a team of three Dementia Advisers, three Dementia Adviser Volunteers, and four Guidebook Volunteers. We have provided a continued service to a total 760 people with dementia, carers, family and friends to date.

Transferable Learning	• The referral pathway is dependant on the area and the availability and structure of health and social care services and other private and voluntary organisations. Relationship building with other professionals is of key importance as is the accessibility of the service to people with dementia due to an open referral criteria. • Diagnosis of dementia often not happening at early stage dementia which has an impact on the service being delivered. • In order to sustain a high level of contacts it is necessary to also have in place the roles of Dementia Support Workers, and Befrienders as well as a team of volunteers to support the dementia adviser in their work. • A change in attitude and culture towards partnership working in mental health services is needed. • Better leadership and communications are needed from partnership organisations in order to integrate the service successfully into services already available for people with dementia to build lasting relationships and drive change.

Validation/ Evaluation	A local evaluation was completed in September 2010 to help determine commissioning intentions. The ongoing evaluation of the impact of the service on the quality of life for people with dementia through the Healthbridge National Evaluation. Also findings from Alzheimer's Society three Dementia Adviser Pathfinder Sites which were also evaluated

	during 2010.

Sustainability/ Next Steps	The current East Sussex Dementia Adviser Service has rollover funding to June 30th 2011. East Sussex Downs and Weald and Hastings & Rother Primary Care Trusts are in the process of tendering for a Dementia Adviser Service to cover nine separate G.P clusters in East Sussex for three years from July 2011.

Key contact/Locality	Elisa Vaughan – Sussex Locality Manager Tel: 01403 276649 evaughan@alzheimers.org.uk

Dementia Strategy Objectives	**Objective 3: Good Quality Information** Good quality information should be available for people with dementia and their carers, including the development and distribution of a set of good quality information on dementia and services. Information on local service provision should be tailored to each individual area. **Objective 4: A Dementia Adviser** Following diagnosis, all people with dementia should have access to a dementia adviser who can act as a point of contact for information and signposting to other services. The focus of the work would be to help people with dementia to navigate the health and social care system.

KENT

26. Raising Awareness for the Early Diagnosis of Dementia

KEYWORDS: Awareness and understanding / Diagnosis and assessment / GP surgery

Aims	• To inform 15,000 patients aged 65-75 about memory problems and dementia and if concerned to encourage them to seek help from their GP; • To develop a template for GPs to follow when seeing patients with memory concerns; • To raise awareness among staff at GP surgeries and other health professionals, of dementia and the support services available in the local area; and • To provide support and services to patients and their carers identified by this project.
Local Context for Initiative	Alzheimer's & Dementia Support Services (ADSS) is located in North West Kent (NWK). Covering some 45 square miles, its operational area is Dartford, Gravesham and Swanley serving both urban and rural communities. Lying within the Thames Gateway Development area the population is, and will continue, to experience rapid growth. The numbers of over 85s is 3 times the national average and areas of Dartford and Gravesham have been identified as having the highest proportions of elderly people with additional health risk. The Early Intervention Project (2008-2013) was set up as a result of carers of people with dementia telling us that with hindsight they wished they had known about our services several years earlier. Since most of our service users were aged between 75 and 85 we decided on a five year early intervention project to raise awareness of dementia with a potential outcome of a downward shift in the age profile of our clients. This project is funded by the Big Lottery Reaching Communities Fund and is targeting 15000 patients aged 65-75 from 30 GP practices in North West Kent. In 2007 a pilot project was carried out with a large GP practice in Gravesend and formed the basis of the bid for funding of the current five year project. *Seabrooke & Milne (2009) Quality in Ageing, Vol. 10 pp 29-36.*
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost**	The achievements of the Early Intervention Project have exceeded our expectations. It has been welcomed by GPs in the Practice Based Commissioning (PBC) group and the PCT. A key achievement that had not been anticipated has been the development of a template for GPs to use when patients present with memory concerns. As the project is rolled out, this template will ensure that most, if not all, GPs in North West Kent will be following the same procedures for patients presenting with memory concerns. The template includes a standardised blood screening form

efficiencies) - **Prevention** - **User/Carer Involvement**	and the GPCOG test to screen for cognitive impairment. The GPCOG test was chosen as the screening instrument because of it's suitability for use in primary care. *Milne, A. et al. (2008) Screening for dementia in primary care: a review of the use, efficacy and quality of measures. Int Psychogeriatr. 20(5):911-26* Early indications are that patients within the 65-75 age group are being referred onto the memory clinic for further tests if the GP suspects memory problems. At the end of the second year, the outcomes of this project to date are as follows: • A leaflet on 'Ageing and Memory Matters' has been developed to raise awareness of memory problems among patients aged 65-75 and alert them to take action if they have any concerns. • A template has been developed for GPs and Practice Nurses to follow when assessing patients with memory concerns. The template was developed in collaboration with the local Practice Based Commissioning group. It is being loaded onto the computer systems at each surgery and is being used when seeing patients with memory concerns. Feedback from staff at surgeries reflects the positive value of this template. • More than 4900 patients from 10 surgeries have had the leaflet on memory matters and been invited to make a 20 minute appointment with their GP or Practice Nurse if concerned. • More than 133 patients have had 20 minute appointments with their GP or practice nurse to discuss their concerns about memory problems and at least 18 patients have been referred onto the memory clinic for further tests • Feedback has been received from 5 surgeries and 10 staff members have reported being more knowledgeable about dementia as a result of this project. • 90% of health professionals liked using the GPCOG test. • 25 carers have reported benefits from being referred to ADSS via this project *"Talking to you has been very helpful. It's the first time anyone has acted and I'm impressed with the GP and your follow up". – Carer.* *"Mum loves the day care. It's brilliant and I'm very happy as from a selfish point of view, I have time to myself now". – Carer* • We have seen a downward shift in the age profile of ADSS clients this year with more clients in the 65-75 age group and less in the 76-85 age group.

	• Training sessions on dementia and the Early Intervention Project have been provided to health care professionals including Practice and Community nurses and other nursing staff.

Challenges **- How these were addressed**	Due to their already heavy workload, getting GPs to participate in any additional projects is always challenging and the project had to be made as easy and beneficial as possible for them. It also had to have to backing of the PCT and the PBC groups who were quick to see the benefits of this project in being able to raise awareness of dementia among both patients and staff teams. The PBC group was also keen to have all GPs follow a standard procedure when assessing patients with memory problems, a likely outcome of this project. Highlighting the advantages of the project to the partners at surgeries, and providing them with an easy to use dementia template, usually encouraged them to take part in the project but even then other factors, (e.g. the potential swine flu pandemic) often caused delays in their participation. It is important to secure full funding for the project and leave the surgeries with the minimum amount of work possible.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	The project is fully funded by the Big lottery Reaching Communities fund (£233,000) and the only additional cost incurred to date has been for the production of the template for the GP IT systems. This cost has been picked up by the PBC group. We have been fortunate to have the backup of the GP IT department who have very kindly agreed to load the template at the surgeries as needed. It is also important to ensure there are services available to support people identified by the project and at the start of the project we launched a weekly “Early Stage” club for people experiencing mild cognitive impairment.

Transferable Learning	The leaflet for the project has already been developed and also translated into Punjabi for the local Asian population. The template has been developed for GPs using the Vision system and could also be set up for other systems if required.

Validation/ Evaluation	The project is seeking feedback from carers of people with dementia who have come through from this project and also from staff at participating surgeries

Sustainability/ Next Steps	GPs are being encouraged to search for patients turning 65 once a year and send the memory matters leaflet together with a letter inviting them to make a 20 minute appointment if they have any concerns. Also, they are

	being encouraged to flag patients with concerns and send reminder letters as needed.

Key contact/ Locality	Viniti Seabrooke, Project Manager Alzheimer's & Dementia Support Services Dene Holm House, Dene Holm Road Northfleet Kent DA11 8JY Email: seabrookeviniti@btconnect.com

Dementia Strategy Objectives	Objectives 1 and 2. • Raising Awareness • Good quality early diagnosis and intervention for all.

KENT

27. NHS West Kent Dementia Crisis Support Service

KEYWORDS: Crisis support and rapid response / Outpatients / Admission avoidance / Homes and housing

Aims	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. 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. 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.
Local Context for Initiative	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. 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. 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. 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.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	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. 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. 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.

Challenges **- How these were addressed**	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. 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. 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. 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 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. 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.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	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. 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. Referrals are also being accepted from GPs, Community Nurses, Kent Contact Assessment Service and Kent and Medway Partnership Trust CMHT. 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 UP TO A MAXIMUM PERIOD OF 6 WEEKS for each service user.

Transferable Learning	The key bits of learning from this innovative service are around: 1. Involving users and carers in the service redesign. 2. having a strategy to underpin the changes to the system. 3. involving all partners in the pathway and communicating with them regularly. 4. having regular meetings with the providers during the teething period of the project. 5. contracting with a range of providers to offer greater choice and flexibility for the consumer.
Validation/ Evaluation	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.
Sustainability/ Next Steps	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 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.
Key contact/ Locality	Emma Hanson, Joint Commissioner, West Kent PCT and Kent Adult Social Services emma.hanson@kent.gov.uk 07595 088589
Dementia Strategy Objectives	**O6: Improved community personal support services;** **O7: Implementation of the Carers Strategy;** **O8: Improved quality of care for people with dementia in general hospitals;** **O12: Improved end of life care; and** **014: Joint Commissioning.**

KENT

28. Independent Dementia Advocacy in West Kent
KEYWORDS: Awareness and understanding / Information and advice / Homes and housing / Crisis support and rapid response / Carers

Aims	To represent the interests of people with dementia, to be on their side and to secure their rights by • empowering those who are able to make their own decisions and • safeguarding the rights and services for those people who cannot make specific decisions And to ensure that the person is central to all decisions.
Local Context for Initiative	There was a "gap" in service provision for independent advocacy to have independent support on the side of the person with 'no other agenda'.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Achievements include service users remaining independent whilst accessing more care in their home for longer. Service users accessing benefits/allowances/discounts that they might not have known about to enable them to remain independent longer. Speaking up for the person and ensuring they remain central to all decisions and participate as much as they are able/wish. To be the additional independent support to people going through the safeguarding process which might seem frightening and ensuring they are listened to. Being a voice for someone with communication difficulties. Delivering awareness sessions to professionals in health and social care and other setting; and to carers/service users on the importance of an independent voice, person centred dementia and how to access this service for their clients/cared for. To include reminders around the Mental Capacity Act.
Challenges **- How these were addressed**	Occasionally a carer will find it difficult to understand that an independent person is helpful in finding out the wishes and feelings of the cared for person. This is addressed with the utmost diplomacy – to ensure that the carer knows they are still very important but that it could be helpful for them too, to know what their cared for person wanted. Some people can only speak to an independent person about their wishes and feelings because the advocate has no agenda and is not emotionally involved – and does not advise.

	Occasionally, a professional would feel undermined because they think they are their clients' advocate. This is addressed with training and awareness of the role and a discussion about how helpful it can be to their role as well as to the person, if there is an advocate supporting their client. "We hear what others miss".

Resources/ Capability/ Capacity **- What does it take to make this happen?**	This organisation has the expertise of many years' experience and knowledge of "advocacy" in a mental health setting. We understand that vulnerable people are not always listened to, and the less able they are, sometimes the less of an individual they appear to become. It takes training, awareness, a change of mindset for some to fully understand that an advocate has no obligations to a "service" only to the person with dementia. Advocates have regular formal supervision at which every case is discussed and in a setting where they themselves are supported.

Transferable Learning	The project has been able to raise awareness and provide training for health and social care professionals to help them better understand the concept of person centred dementia and how this can be put into practice, particularly within the Mental Capacity Act. The project is hopefully transferring to the wider community (including the voluntary sector, private sector and statutory) the acknowledgment that having an independent person on the side of a vulnerable person who can speak up and ensure their "voice" is heard in whatever format.

Validation/ Evaluation	Verbal feedback from clients who are able to express it. Feedback from professionals. Evidence of people accessing financial benefit through having advocacy. 3 training events to health and social care professionals – with positive feedback. Good feedback in Formal Review.

Sustainability/ Next Steps	This is fragile as it is dependent on the funding decisions for this forthcoming year. We know that Commissioners and Contracts and others want it to continue but we are the mercy of the decision makers of financial issues within the local authority and NHS. We have attended Formal Review and provided evidence so we are now waiting to find out if the project carries on.

Key contact/ Locality	Our Commissioner is Emma Hanson, Dementia Commissioner for West Kent. emma.hanson@kent.gov.uk

Dementia Strategy Objectives	3, 6 and 12.

MEDWAY

29. Dementia Advisers in Medway
KEYWORDS: Diagnosis and assessment / Information and advice / Dementia adviser

Aims	1. To improve access to and information on care to people living with dementia and their carers, allowing them to exercise greater choice and control over their own lives 2. To improve upon the delivery of care for people living with dementia in Medway 3. To build on the work of the existing Alzheimer's and Dementia Family Support Service 4. To establish a baseline level of service, set key performance indicators and measure progress 5. To undertake a cost benefit analysis of the service to ensure that the project is mainstreamed into core service delivery beyond the lifetime of DH funding. 6. To commission independent evaluation to measure the impact of the project on local dementia care service provision and to feed the lessons learnt into continuous improvement in service delivery. 7. To deliver joined up service delivery between health and social care statutory agencies and the third sector provider of the dementia.
Local Context for Initiative	➢ Medway is UA with 250,000 popn ➢ NHS Medway and Medway Council jointly commission service and part fund pilot ➢ Existing Alzheimer's and Dementia Family Support Service (ADFS) (peer support model) in Medway established for several years ➢ Re-design of Strategic Dementia Care pathway in progress led by NHS Medway ➢ Memory clinic services provided by KMPT (Social Care Partnership NHS Trust) ➢ Sunlight Development Trust successful social enterprise already providing community based advice and information services
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention**	**Quality** 1. All advisors have been provided with accredited, specialist training in dementia 2. A database was established from the project initiation to log all management information on the service and track service users 3. An action plan has been prepared with service users for all those that want them

- **User/Carer Involvement**	**Efficiency** 1. The team logs all calls and automatically has a reminder to call each person within a recommended time frame 2. Each advisor is allocated a specific area of activity in Medway in terms of targeting their efforts on communication and promotion of the service 3. The provider makes use of the ICT and telephone networks provided by Medway Council to share costs **Outcomes** 1. Performance reports from provider give clear indication of who is using the service and a full breakdown of the characteristics of users 2. Local evaluation has provided evidence of impact of the service for users and carers and the advisory team 3. The service has assisted over 300 people in its first 12 months of operation **Experience** 1. Operational lead for new service seconded from existing peer support service at outset rather than recruiting specific new member of staff to lead on the DA pilot 2. Set DA pay levels based on comparable job profiles- submit for grading before appointment 3. Provide more resources up front for communication to key stakeholders **Integration** 1. The DA team now have a regular weekly presence in the memory clinic 2. The service is now well publicised throughout Medway within health and social care and wider community settings 3. The service is embedded within the community networks available to the provider **Other** 1. Dementia Advisors trained in Certificate in dementia care at NVQ Level 3 2. Project Board has had representation from a past carer and person living with dementia 3. Close links have been made between Admiral nursing service, memory clinic and DA service

Challenges **- How these were addressed**	1. Integration with health and social care system coming from the voluntary sector was hard work This has been a major barrier to the development of the service and after a lot of hard work and persuasion the advisors now have a regular presence at the memory clinic. 2. Obtaining referrals from GPs Again, this has been very slow to progress despite initial enthusiasm amongst some GPs at Locality Boards. We have made some progress on this issue but there is still much to do. 3. Short term nature of pilot meant running to catch up from day 1 High expectations, somewhat unrealistic at the outset were that the service would pick up significant referrals from its first few months. Evidence of costs and benefits difficult to prove due to short term nature of pilot.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	We have 4 full time Dementia Advisors and one 0.5FTE operational lead employed to deliver the service plus some administrative time. There has also been an investment in project management time from Medway Council.
Transferable Learning	We have printed materials e.g. leaflets, support plans, newsletters that we are willing to share with anyone who would like them.
Validation/ Evaluation	We commissioned the Dementia Centre South East (part of Canterbury Christ Church University) to undertake external evaluation. Copies of all reports are available to anyone who is interested.
Sustainability/ Next Steps	We are looking at a new model of service as a hybrid with elements of peer support and advice and guidance services. The current model is not sustainable in a time of significant budget cuts. NHS Medway will be leading the commissioning of the new model and will identify resources to fund this service.
Key contact/Locality	Wendy Alleway, Joint Commissioning Manager for Older People, NHS Medway, Wendy.Alleway@medwaypct.nhs.uk Ben Gladstone, Commissioning Portfolio Manager, Medway Council, Ben.Gladstone@medway.gov.uk

Dementia Strategy Objectives	**Objective 2:** Good-quality early diagnosis and intervention for all. **Objective 3:** Good-quality information for those with diagnosed dementia and their carers. **Objective 4:** Enabling easy access to care, support and advice following diagnosis.

SURREY

30. Surrey NHS South East Coast Regional Transformation Fund (RTF) Bid

KEYWORDS: Care pathway / Partnership / Models of care - approaches

Aims	The programme will transform the care pathway for people with Dementia in Surrey and pilot an approach whose results will inform further development in Dementia Care pathways throughout the South East Coast SHA.
Local Context for Initiative	Initially conceived and developed entirely by clinical specialists who sought general management and financial expertise to support them to model through the financial impact of doing the right thing clinically, it clearly demonstrates the power of focussed strategic clinical leadership in achieving both quality improvement and greater financial sustainability.
Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	Anticipated benefits across all of these areas. The programme has six project activity areas of: 1. Dementia friendly & built environments 2. Develop well-being centres, dementia cafes & services 3. Comprehensive memory services 4. Carers support 5. Integrated approach to community dementia care 6. Develop gold standard acute hospital liaison & admission avoidance.
Challenges **- How these were addressed**	The bid identifies eight key challenge areas e.g. 1. Disinvestment in secondary care 2. Professional and public confidence in the changes and new service 3. Skilling and equipping the workforce 4. Identifying funding for community development 5. Funding 6. Joint commissioning 7. 3rd sector players 8. System leadership ……. and how it anticipates meeting these challenges

Resources/ Capability/ Capacity **- What does it take to make this happen?**	Related to previous point.

Transferable Learning	Whilst the bid is directed at transforming services within Surrey, the indicative savings identified already include an element (unidentified in their scale as yet) that relate to Sussex within the SHA region and inevitably an element of benefit for those areas that border Surrey including a number of London Boroughs and Hampshire.

Validation/ Evaluation	We plan to run the implementation as an Action Research project and to this end will seek to engage with other project teams already working on improving care for people with dementia in Surrey, Sussex and Kent to share what works well and ensure effort is not wasted in redoing work already further advanced in one area. The bid also outlines a number of other areas for validation /evaluation.

Sustainability/ Next Steps	1. Developing Partnership Board 2. Programme Planning 3. Outline programme plan

Key contact/Locality	Jayne Reynolds, Associate Director OPMHS, Surrey & Borders Partnership NHS Foundation Trust Jayne.Reynolds@sabp.nhs.uk 07825927931

Dementia Strategy Objectives	Meets all 7+ national priorities.

SURREY

31. Friends with Dementia, Woking

KEYWORDS: BME / Homes and housing / Peer Support / Information and Advice

Aims	**Friends with Dementia** is a Demonstrator Site Pilot project that is funded by the Department of Health and working in partnership with Surrey County Council and Surrey PCT. **Aims** ▪ Increase access to dementia services in Woking ▪ Increase knowledge of dementia within the local British Asian community ▪ Enable people with dementia and their carers to access information and practical support on dementia care This service is based in the Friends of the Elderly Bradbury Resource Centre and provides simple and accessible information about dementia and the services available locally to people with dementia and their carers. This is aimed at both those who have not yet received a formal diagnosis and those who require support after diagnosis. There is an outreach worker whose remit is to support the British Asian community. The project aims to establish peer support groups for those with dementia and for their carers. These include local groups for members of the local British Asian community. The service has been set up to address the importance of users' and carers' cultural needs. There is a website that hosts 3 forums which enables 24 hour peer support. One forum is for people with dementia, one for carers and one for care professionals. People with dementia and their carers are signposted to support services already available in the area, including Friends of the Elderly Home Support Service, (Friends at Home Woking) the Alzheimer's Society day care, café style social events and Advocacy. There is a strong emphasis on user involvement in the design and delivery of the information and groups The Bradbury Resource Centre is open to the public, providing a lending library to include books, activities, DVDs, written and internet information and access to the Friends with Dementia Internet Forums. **British Asian Outreach Service** The Friends with Dementia British Asian Outreach Service commenced in April 2010. An outreach worker was recruited from a relevant cultural background and facilitates the Asian British element of the project.

	The Friends with Dementia outreach worker speaks the relevant Asian Languages including Urdu, Bengali and Hindi. Appropriate literature is available and culturally acceptable premises are used to support engagement with the British Asian population.

Local Context for Initiative	Woking Borough has a population of 89,840 with 13,101 people over 65. This includes over 4,700 residents from a Pakistani, Indian, or Bangladeshi background, and the majority of whom live in the Maybury district of Woking. ▪ The local British Asian population is now in its 4th generation and has a significant number of elders. This community is known not to be accessing dementia services. The estimated prevalence of people with dementia in Woking aged over 65 is 1,028 with 130 under 65. ▪ There is a need in the community for accessible information on dementia both to raise awareness, so encouraging diagnosis and to enable people with dementia to live successfully at home.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	**Quality improvements** ▪ Flexible individual and group support given to people with dementia and their carers ▪ Access to the Friends of the Elderly Resource Centre for all service users ▪ Access to British Asian Outreach Worker **Innovation** ▪ The Friends with Dementia resource centre is a 'one stop shop' for dementia information, support and guidance. ▪ Positive relationships with other local organisations that is encouraging a two way referral system. ▪ Working closely with other local British Asian services. ▪ Building relationships with local religious and community leaders at two of the main Mosques. ▪ Carrying out research on the community to enable a good understanding of religious and cultural needs. ▪ Establishing contacts with other organisations, which are doing similar work and adopting good practice. ▪ Delivering dementia awareness raising talks to various local groups. ▪ Partnership working with Woking Borough Council to deliver peer support groups within their community centres. ▪ A dementia awareness day was held in Woking town centre for the general public with a varied range of topics delivered by local professionals (GP, Consultant Physician in Care of the Elderly, service providers and an Admiral Nurse). ▪ Opened the Friends of the Elderly Resource Centre and lending library. Guests included local service providers, Surrey County

	Council, Surrey Primary Care Trust, Surrey and Borders partnership, health professionals, the Imans from two Woking mosques and some members of the local British Asian community. ▪ Successful networking across the local borough that encourages referrals and helps raise awareness of the service. **Productivity** ▪ Working in partnership with local community centres to deliver peer support groups. ▪ Building a team of dedicated volunteers to assist in the delivery of the service. ▪ Friends of the Elderly Resource Centre for all service users including professionals. **Prevention** ▪ Prevent crisis in the home, necessitating access to NHS services. ▪ Dementia awareness raising amongst the British Asian population in the Woking Borough. ▪ Decreased social isolation for people with dementia and their carers through regular peer support groups. ▪ Increased choice and control by providing information on other services within the local area. **User / Carer Involvement** ▪ Service users are involved in the planning and delivery of each element of the service. ▪ Carer representatives and local health professionals attend the Friends with Dementia partnership board. ▪ Attending the local community hospital on a regular basis is encouraging further referrals. ▪ Facilitating flexible peer support groups that encourage people with dementia and carers to attend on their own or together. ▪ Dementia awareness raising sessions within the British Asian community are being successfully delivered through existing community support groups. Due to the cultural complexity of this community, working closely with these groups has helped build confidence and trust with the Friends with Dementia British Asian Outreach Worker.

Challenges **- How these were addressed**	**Clear and effective referral pathway –** there is not a ready source of referrals to the project, as it is not embedded within current mental health provision. This is being addressed by direct engagement with the general public and through networking with both statutory and voluntary service providers. ▪ Currently working closely with Surrey County Council, local health professionals and other agencies to develop a referral system. **Partnership working -** building effective working relationships with all professionals in this field. ▪ Developing positive relationships with other local support services such as Alzheimer's Society, Carers support and local health

professionals including CMHT, GPs, community matrons and district nurses.

Difficulties of establishing a new service and building links within the local community both with service users and professionals.

- Mapping existing services and looking at gaps in provision.
- Working in partnership with local community centres to launch support groups.
- Communicating with community workers and local health professionals to encourage involvement.

British Asian community engagement due to the stigma around dementia, this includes - cultural, religious, social, language and educational constraints.

- The local population consists mostly of people who have migrated to the UK from Mirpur, North East Pakistan.
- This community in Woking is very closely knit and could be described as 'insular'.
- There is no word for Dementia in Urdu or Punjabi. If translated literally it means 'mad or madness'.
- The concept of deference for the elders is very strong in the Asian community.
- Daughters in law are usually the caregivers and they are unable to challenge the male authority in the family.
- As well as not recognising themselves as carers, the concept of taking a break from caring is nearly non-existent in the local community.
- The stigma associated with Dementia is very strong.
- Polygamy is quite prevalent.
- Social segregation of the two sexes is strictly followed in the community.
- Many British Asian men do not share the domestic responsibility in their families as it is considered a 'woman's job'.

Addressing challenges with the British Asian community

- Raising awareness of dementia within the local British Asian population by strengthening links with existing groups.
- Deliver talks to local groups.
- Encourage British Asian women's groups to visit the Resource Centre.
- Further engagement activity will need to be carried out with religious and education leaders at the local mosque(s).
- Develop ways to target male members of the community.
- Encourage better partnership working through community leaders and other British Asian support workers.
- Encourage involvement and referrals from British Asian GPs and other health professionals.
- Hold a dementia information day (as per those carried out for cancer and stroke awareness.) These events have been delivered in partnership with other health/voluntary organisations, including the use of British Asian health professionals as guest speakers.
- Work directly with specific GP surgeries (those serving the highest

	ratios of British Asians) to raise awareness of dementia in the local community. ▪ Expand awareness of dementia to other community targets such as local schools with a high population of British Asian children.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	**Staff** ▪ Service Manager = 37.5 hours per week ▪ British Asian Outreach Worker = 21 hours per week **Resources** ▪ Funding ▪ Lending library and resource centre ▪ Venues and refreshments ▪ ICT equipment ▪ Website and forums ▪ Internet access ▪ Marketing materials **Capability** ▪ Agreed purpose from the beginning ▪ Professional facilitation and governance i.e. Friends of the Elderly and Surrey County Council i.e. steering group • Project Management ▪ Investment ▪ Working in partnership across the borough ▪ Involving community volunteers ▪ Training staff and volunteers ▪ Enabling groups to be community and peer led ▪ Applying professional standards i.e. CRB checks and adopting good practice ▪ Community working, with a 'grass roots' approach **Capacity** ▪ Flexibility to adapt service based upon the needs of people with dementia and their carers (individually or together).

Transferable Learning	1. Shared locally within the community 2. Shared across the County 3. Shared regionally 4. Shared nationally ▪ Agree the concept for delivering peer support i.e. who is it for? ▪ Start slowly, building community links and involvement, particularly when working with BME groups. ▪ Build relationships with other professionals i.e. CHMT. ▪ Develop a referral pathway prior to the start of the service i.e. through the memory clinic. ▪ Design the service with the help of other local professionals or parties, including any local religious leaders. ▪ Provide opportunities for other service providers to share information, training and resources.

	▪ Engage people with dementia and their carers in service design. ▪ Recognise and understand the complex cultural and religious needs of BME groups.

Validation/ Evaluation	**Project monitoring -** Against the project aims and objectives ▪ Project partnership board meet bi-monthly ▪ Friends of the Elderly monthly report produced ▪ Department of Health quarterly monitoring report ▪ A report has been prepared for Surrey County Council **British Asian Outreach service** It will take some time before the Friends with Dementia Project can be trusted and well accepted by the local British Asian community. Key to the success of this project will be the Friends with Dementia Outreach Worker's ability to challenge existing beliefs and the stigma surrounding dementia. The challenge will be educating people about dementia and encouraging them to seek diagnosis and support from local services.

Sustainability/ Next Steps	It is anticipated that the expected outcomes will interface with the design of the Surrey Dementia and Older Peoples Mental Health Joint Commissioning Strategy 2010-15. Next steps and sustainability will be strongly influenced by the direction of the final strategy. This will include a continuation of the work already in progress working in partnership with Surrey County Council – ▪ Confirming referral pathways for people with dementia and their carers ▪ British Asian community engagement activities ▪ Launching new peer support groups ▪ Friends with Dementia promotional leaflet ▪ Carers information seminars

Key contact/Locality	**Linda Cornelia** **Service Manager** **Friends with Dementia** The Bradbury Centre Smiles Place Lavender Road Woking Surrey GU22 8BJ **Tel:** 01483 753 652 / 07738 579 401 **Email:** linda.cornelia@fote.org.uk **Web:** www.friendswithdementia.org.uk **Friends of the Elderly:** www.fote.org.uk

Dementia Strategy Objectives	This project meets the following NDS objectives: ▪ **Objective 1:** Improving public and professional awareness and understanding of dementia. ▪ **Objective 2:** Good-quality early diagnosis and intervention for all. ▪ **Objective 3:** Good-quality information for those with diagnosed dementia and their carers. ▪ **Objective 4:** Enabling easy access to care, support and advice following diagnosis. ▪ **Object 5:** Development of structured peer support and learning networks. ▪ **Objective 6:** Improved community personal support services.

SUSSEX

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

KEYWORDS: Partnership / Models of care - approaches

Aims	• To Improve dementia services across the whole county in line with the National Dementia Strategy (NDS); • To ensure the development of new care pathways for dementia care; • To strengthen collaboration between various organisations and agencies involved in dementia care and sharing learning; and • To reduce unexplained variation in service across the county.
Local Context for Initiative	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. The SDP comprises 12 statutory health and social care organisations plus representation of Dept of Health South East (DHSE) and Alzheimer's Society. The current and projected financial pressures on health and social care economies create the need to reappraise the investment profile for dementia services. There are well established partnership relationships between health and social care commissioners in each of the three localities: East Sussex, West Sussex and Brighton & Hove. There is also a commitment to working with the third sector and people with dementia and their carers and families. Sussex has two national demonstrator sites: Dementia Advisor in East Sussex and Peer Learning Networks in Brighton & Hove.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	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. 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 crisis support at home. One of the measures of quality has been the very powerful reminder by people 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 West Sussex has appointed a project manager to implement far reaching changes to dementia services. 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.

Challenges **- How these were addressed**	• To agree a framework which recognises **both** the benefit of a pan Sussex perspective **and** 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. • 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.

Resources/ Capability/ Capacity **- What does it take to make this happen?**	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. A Project Manager supports the ongoing development of the Partnership's work. As mentioned previously, West Sussex has also appointed a project manager to help the implementation of the NDS on the ground.

	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.

Transferable Learning	• Lay the foundation and agree principles for collaborative working. The SDP contains providers and third sector as well as commissioners. • Involve people with dementia and carers in design of new pathways as their views can be powerful and challenging to the current practice. • Use metrics and system modelling (hard evidence) to support the process of change. • Focussing on rapid access to memory assessment and the roles of dementia advisers.

Validation/ Evaluation	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.

Sustainability/ Next Steps	The SDP will sustain itself through the continuing priority accorded to dementia services across Sussex. Next steps will include continuing to address issues on a pan-Sussex basis such as research, anti-psychotics, workforce skills and learning. Additionally the three localities will continue with their own specific service remodelling strategies. The successful bid for Regional Transformation Funding will enable a series of projects to identify sustainable models of care and releasing savings.

Key contact/Locality	The Project Manager for the Sussex Dementia Partnership is Charlotte Clow. Her contact details are: charlotte.clow@sussexpartnership.nhs.uk Telephone: 01273 778383 ext 2191 The DHSE contact is Richard Hayes, a member of the Older People and Dementia team. His contact details are: richard_hayes169@hotmail.com Telephone: 07768 751901

Dementia Strategy Objectives	Whilst the NDS will in time address all of the 17+1 objectives, at this early stage it is particularly focussing on: • Memory services; early diagnosis and intervention; • Improved community personal support services; • Improved care in general hospitals; • Joint local commissioning strategy; and • Living well with dementia in care homes.

WEST SUSSEX

33. Dementia crisis team

KEYWORDS: Admission avoidance / Crisis support and rapid response / Outpatients / Carers

Aims	To provide a service which can allow people in a crisis to remain at home. The service aims to provide person centred care for both the person with dementia and their carer, minimising the risk of hospital admission. The team provides urgent assessment, up to 72 hours of intensive nursing and social care as well as up to six weeks follow up care before referral onwards to appropriate care management teams. The team aim to reduce the number of admissions to acute hospital and acute mental health beds in the South of West Sussex area.
Local Context for Initiative	The prevalence of dementia doubles with every 5 year increase in age. The cost to the economy is estimated as £17- £18 billion. The population is aging and over the next 30 years the number of people is expected double. The improvement of dementia services has received increasing attention over the past 10 years, starting with the inclusion of a standard relating to mental health services in the *National Service Framework for Older People, DH, 2000*, the development of a set of clinical guidelines for effective and efficient dementia care produced by The National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE), *Dementia, Supporting people with dementia and their carers, NICE/SCIE, 2006* and culminating in the publication of the National Dementia Strategy, *Living Well with Dementia: A National Dementia Strategy, DH, 2009.* West Sussex has a larger than average population over the age of 65, with approximately 13000 people diagnosed with dementia. Information from the strategic health authority showed that the county has an above emergency average admission rate to acute hospitals. The incidence of dementia in West Sussex is expected to grow over the next ten years, currently the county diagnoses approximately 31% of the people that are predicted to have dementia in the county. A public consultation told us that we needed to concentrate on ensuring the best care for people who are experiencing a crisis, and that the service should be responsive to the needs of carers as well as the person with dementia. We were also told that people with dementia and their carers often find the disconnect between health services and social care difficult to navigate, and that a crisis team that worked across these boundaries would be the most effective.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	It is anticipated that the team will: - Reduce the number of unscheduled admissions to acute care prompted by a dementia crisis; - Provide a unique service in which the carers needs are of equal importance as those of the person with dementia; - Facilitate early discharge from inpatient care; - Allow people experiencing a crisis to remain home, avoiding the emotional trauma of a hospital admission; - Minimise the probability of a crisis occurring again by onward referral to community teams and relevant case managers; - Immediate access to social care input for people referred to the team; - Reduction in admission to long term care home placements in residential and nursing homes; and - Reduction in admission to short term care home placements in residential and nursing homes.
Challenges **- How these were addressed**	**Aligning health and social care to ensure seamless care for the person with dementia and their carer.** This challenge was met by regular project meetings hosted by the provider and involving the local authority, third sector provider and the PCT. These meetings ensured that all agencies were fully supportive and in a position to implement their parts of the initiative in the timeframes required. This model will be replicated around the county with support and input from all agencies involved in the South Crisis Team.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	- Agreement for joint funding from PCT and Local Authority - A third sector organisation who are in a position to take on a large contract - Dedicated nursing and social care professionals who are co-located to ensure that they are one team, rather than two separate organisations. - Clear referral pathways via CMHTs and Adult Social Care teams.
Transferable Learning	Partnership working – the team is working together across health and social care boundaries due to close working between NHS provider trust, Local Authority and third sector organisation.
Validation/ Evaluation	- **Number of acute OPMH in-patient admissions are reduced** – baseline occupancy taken to monitor change. - **Reduction in the number of EMI residential/nursing home admissions** – baseline occupancy taken to monitor change.

	- **Reduction in number of admissions to general hospital for people with dementia** – baseline taken to monitor change. - **Number of discharges facilitated by Dementia Crisis service** – General hospital/ OPMH acute. - **Response within 4 hours of receipt of referral, when referral is received before 5pm** – audit of referrals. - **All admissions to Organic In patient ward will be via this team, during operational hours** – 95% of referrals to be assessed by crisis team prior to admission – audit of admissions. - **Patients and carers value the service** – patient and carer survey. - **Better patient and carer experience** – patient and carer survey. - **Response within 4 hours of receipt of referral, when referral is received before 5pm** – audit of referrals.

Sustainability/ Next Steps	The service is sustainable due to funds released by service redesign.

Key contact/Locality	Jo Robertson – Dementia Project Manager , NHS West Sussex Joanna.Robertson@westsussexpct.nhs.uk

Dementia Strategy Objectives	**Objective 3** – Good quality information for those diagnosed with dementia and their carers. **Objective 6** – Community personal support services. **Objective 7** – Services within the carers strategy. **Objective 13** – An informed and effective workforce across all services.

BRIGHTON & HOVE

34. You Me and all of Us Living with Dementia Together	
KEYWORDS: Information and advice / Peer support / Awareness and understanding	
Aims	To set up a Peer Support Network for people living with dementia i.e. people with dementia and their carers and supporters
Local Context for Initiative	Brighton and Hove's 'peer support' model includes two parts: **Part 1** 'All of Us, Living with Dementia Together' – Large scale hub events and spoke Model Principle of the events are to bring together as many sections of the community as possible. The 'spoke' community groups, either those in existence (as seen below) or those set up as part of the project, to work with communities of interest to offer peer support and to encourage attendance at the larger hub style events. The events provide a structured but yet informal and relaxed learning environment for people with dementia and their supporters to come together to receive support, to discuss concerns, to talk to professionals and to learn about help and services that exist in the city. Existing groups including: • Friendship café • Carers support group • Former carers support • Monthly outings • Drop in sessions • Monthly coffee mornings • Summer and Winter socials **Part 2 -** 'You and Me, Living with Dementia Together' To repeat and adapt the model of the You and Me Group previously operated by SPFT (Sussex Partnership Foundation Trust) and the Alzheimer's Society, which focused on the needs of couples 'living with dementia, together' and to have their needs for support, information and advice addressed within the context of their relationship. It was anticipated that the larger events and the running of smaller spoke groups could identify community groups which would be interested in taking part in such groups.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	**Quality Improvements** Our peer support model has improved the quality of life experienced by those with dementia and those who support and care for them by: • Providing a forum which is open to a wider network of supporters, therefore enabling friends and family to develop their awareness in order for them to provide better understanding and support • Introducing them to services available locally therefore empowering them to be able to seek out relevant services independently. • Providing people with the opportunity to meet others in a similar situation therefore reducing a feeling of isolation. • Providing an environment where people can both receive emotional support and find support avenues they can utilise outside of the event. • Introducing people to innovative methods of support available in the city, including, alternative therapies and activities which can be used to benefit those with dementia and their supporters i.e. reflexology, yoga, mindfulness, singing, dancing (listed below). **Innovative methods of support** • Singing groups – proved to increase wellbeing and social inclusion, enabling people to leave their worries behind, to help with communication, learning and to reduce stress. These have been held as part of the large events and as spoke groups running alongside the events. • Interactive theatre provided by Ladder to the Moon – offering much of the same benefits as singing. Sessions offered as part of the large hub events. • MBCT (Mindfulness based Cognitive Therapy) 8 week course for carers, facilitated by a local tutor and currently running as a spoke group. An introductory session will be offered at our next (and last) hub event. These courses are also commissioned by Brighton and Hove County Council • Creative writing – thought to increase: mental stimulation, reminiscence and reflection on one's life story and a therapeutic release of life's stressors. Session offered as part of the large events • Therapies including – Shiatsu, massage, Cranial Sacral, Reiki, offered as part of the event. • Gentle movement and dancing – enjoyed as part of the larger events. Benefits like those offered by singing. **Productivity** • Use of local, reasonably priced community centre for the hub events • Using local facilitators to facilitate workshops, therefore reducing travel costs incurred • Using internal resources where available, i.e. stationary, printing etc.

	Prevention Inviting people to the hub events who may have concerns about their memory will help to raise their awareness of dementia and the services that are available in the city. It is hoped therefore that they will not feel so inhibited to seek diagnosis and therefore help earlier. This early intervention will therefore go towards preventing the need for crisis support later on. **User/Carer Involvement** Evaluation and feedback given by service users through the planning committee, groups and large scale events have enabled commissioners and service providers to find out the needs and requirements of people with dementia and their carers and will therefore in turn be used in the development of services moving forward.

Challenges
 	
- How these were addressed
	Challenges
	• **Locating those with dementia or carers for people with dementia within harder to reach groups**
	• Addressed by:
	  • Holding general awareness raising sessions, linking with key people within BME, LGBT communities
	  • Working with key people within these communities to spread the word of our events in order to encourage attendance
	• **Lower number of people at events than expected**
	• Addressed by:
	  • Advertising within local publications, newspapers, weekly bulletins, magazines, PCT website, local organisations, GP surgeries, dentists, pharmacies, local mental health trust etc.
	  • Through local Alzheimer's Society
	  • Attending GP/Practice Manager Meetings to raise awareness
	  • Sending updates to previous attendees
	• **Numbers of those identifying themselves as being a member of a BME, LGBT communities at the events very low**
	• Addressed by:
	  • Registration form designed to capture this information with accompanying note to state why collecting the information and that it will be kept confidential

Resources/ Capability/ Capacity **- What does it take to make this happen?**	• Dedicated outreach workers • Mental Health Professionals • Commissioners • Nurses • Specialist nurses and GPs within hospitals and surgeries • Dementia trainers to train health professionals • Better carer training • Dementia advisors

Transferable Learning	• Feedback obtained from the events have confirmed the need for carers and people with dementia to be able to attend separate support/discussion sessions in order for them to feel at liberty to talk openly about the issues they are experiencing. This has been trialled at our events however a great deal of trust needs to be obtained prior to either side being comfortable in leaving their loved one with people unknown to them. • For a carer to attend a carer session there needs to be a trusted respite service in place in order for the carer to be able to attend • Reaching harder to reach communities requires dedicated outreach worker as building relationships and trust is a gradual process. Cultures and points of views regarding mental health issues are often seen in a negative light and help is mostly preferably sought within the confines of the family unit.

Validation/Evaluation	**Evaluation methods include:** • Post event feedback form completed by participant • Post event email sent to workshop and stand facilitators and volunteers • All feedback from each event collated in form of post event report, including qualitative and quantitative data. • Live action plan written from feedback/learning gathered from events and continuously reviewed by planning committee • Spoke groups - Feedback form completed by participant and evaluated by lead facilitator • You and me group - Feedback form completed by participant and evaluated by lead facilitator • National Evaluation – Via Wellbeing Questionnaire and MDS

Sustainability/ Next Steps	Health care commissioners are in the process of developing a new memory assessment service and care pathway including a dementia advisor service. The Sussex Dementia Partnership will shortly lead a dementia awareness campaign to raise awareness of the new memory assessment service and the value of early diagnosis amongst the general public and GPs. The Dementia Demonstrator site planning team are currently discussing ways in which the learning from the pilot can be used to continue with the most successful interventions and sessions to complement and run along side services that exist already within Brighton and Hove. Ideas for sessions have been gathered from participants attending hub event, Alzheimer's Society, Sussex Partnership Trust and planning committee, these include: • Gardening Sessions • Creative Writing

	• Meditation with instructors who loud enough to hear by the deaf • Key skills for carers to interact with someone with dementia • Sitting exercises, no fast music or footwork • Coffee mornings • Help with concentration • Ballroom dancing • Mindfulness with alternative practitioner • Singing for those with memory and mental health problems but not diagnosed with dementia • Singing groups • Reflexology and complementary therapies • Massage • Space to talk • You and Me type sessions • Dementia and Carer specific support groups • Yearly/twice yearly large scale hub events

Key contact/Locality	Emily Watts – NHS Brighton and Hove Emily.Watts@BHCPCT.nhs.uk 01273 574779

Dementia Strategy Objectives	• Objective 1 - Improving public and professional awareness and understanding of dementia • Objective 3 – Good-quality information for those with diagnosed dementia and their carers • Objective 5 – Development of structured peer support and learning networks

SOUTH EAST - GENERAL

35. Dementia Metrics

KEYWORDS: Metrics and knowledge - information

Aims	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: **O2: Good-quality early diagnosis and intervention for all;** **O6: Improved community personal support services;** **O8: Improved quality of care for people with dementia in general hospitals;** **O11: Living well with dementia in care homes.** The purpose of these dementia metrics is to: • inform a baseline measure against priority objectives in the Strategy; • provide a starting point to inform discussion about local, whole system organisation and effectiveness of dementia services; • highlight where there are gaps in current data sets; and • stimulate joint planning to have a direct result in improved outcomes. The full data set of dementia metrics is now available on the DH Dementia Information Portal www.dementia.dh.gov.uk.
Local Context for Initiative	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. 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. A summary of the indicators is given below: • Dementia diagnosis level • Hospital admissions in relation to prevalence • Length of stay in relation to prevalence;

	• Expenditure on organic mental disorders per 100,000 population • Assessments, reviews and packages of care for people with dementia in relation to: - prevalence - overall mental health chart type - all charts in the older age group South East Coast SHA has taken this work further and created primary and secondary care dashboards to understand progress. The dashboards are updated regularly so that staff can track progress.

Achievements/ Benefits **To Include:** - **Quality Improvements** - **Innovation** - **Productivity (cost efficiencies)** - **Prevention** - **User/Carer Involvement**	In Kent this has led to an increase in the diagnosis rate of people with dementia. 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. 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. 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.

Challenges **- How these were addressed**	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: • 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; • classification of dementia in the RAP is by professional judgement and not based on a diagnosis; • there are significant gaps in the collection of dementia specific data, for example, in relation to carers; and • future work is required for the development of metrics which reflect the dynamics of Council placements as well as the quality of care homes.

	Some local areas have used the national indicators to build their own dementia specific metrics.
Resources/ Capability/ Capacity **- What does it take to make this happen?**	Dementia metrics are fully available on the DH Dementia Information Portal at www.dementia.dh.gov.uk 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.
Transferable Learning	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. Dementia metrics form part of an overall approach used by SE Coast SHA.
Validation/ Evaluation	Dementia metrics have been developed in conjunction with SE Coast SHA and the NHS Information Centre. They provide a whole system view, although it is important to note that improvements to data quality are required to strengthen their usefulness.
Sustainability/ Next Steps	Improvements to data quality are required to enable a move towards benchmarking as a means of understanding and raising performance.
Key contact/ Locality	Alison Blight, Special Projects Lead, DHSE alison.blight@hscpartnership.org.uk Emma Hanson, West Kent Commissioner emma.hanson@kent.gov.uk Adam Cook Quality Observatory, NHS SEC adam.cook@southeastcoast.nhs.uk

Dementia Strategy Objectives	These metrics provide a partial view of progress with implementation of the Strategy in relation to 4/7 of the following priority objectives: **O2: Good-quality early diagnosis and intervention for all;** **O6: Improved community personal support services;** **O8: Improved quality of care for people with dementia in general hospitals;** **O11: Living well with dementia in care homes.**