Dementia Services Action Plan

December 2010/2014
Report Version 2.2

Essex County Council: Adults Health and Community Wellbeing

Dementia Services Action Plan

Document Purpose	To provide vision for people with dementia in Essex through an action plan that is focused on outcomes. Why we need to make improvements, how we intend to make the changes (and timescales) to meet their aspirations and how we can judge success. The document should be used to drive forward our Commissioning intentions
Target Audience	Commissioners and providers of services for people with dementia and their carer's. People living with dementia and their carer's. District and county councillors.
Delivery	Older People and Older People with Mental Health Difficulties Commissioning Delivery Plan, Older Adult Mental Health Programme Board
Circulation List	Older Adult Mental Health Programme Board, older people's forums, Regional Strategic Health, Commissioning teams in Health and Social Care, Carers Partnerships, Primary care, GP's
Cross referencing	National Dementia Strategy, Quality outcomes for people with dementia: building on the work of the National Dementia Strategy, End of life Strategy, Carers at the Heart of 21st Century, Essex Carers Strategy, My Home Life, Dignity in Care, Older People and Older People with Mental Health Difficulties Commissioning Delivery Plan, Tricordant, Target Operating Model
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Introduction

In Essex, the first phase of National Dementia Strategy (NDS) implementation has been gaining momentum for social care and health partners. As we enter the second year of the strategy, we need to be in a position of being clear what our offer to people with dementia is and supporting, inspiring and driving, the implementation forward, so that developments continue to come on stream in 2010/14. We want to ensure our actions are going to make a real difference to people living with dementia and are 'fit for the future'. While doing this we will be focusing on five key areas that will enable us to significantly enhance the quality of outcomes for people who use services:

- Join up Health, Social care, Independent, Private and Voluntary sectors to provide a seamless equitable service.
- A strong focus on the shift of provision to early intervention and prevention
- Provide personalised support in the community that reduces admission to acute hospitals and residential settings
- The provision of information, advice, and support are consistent and available at the time the person needs it.
- Ensure that those working with people living with dementia and their carers have the appropriate skills and knowledge required to provide a quality service.

These priority areas will always be underpinned by the principles of equality and human rights. This will include a strong focus on differences in access to services, the safety, and effectiveness of care, and people's rights to be treated with dignity and respect. Paying particular attention to ensure that we meet the needs of those people who may have previously fallen through the 'gaps' in the care pathways, which include, people with learning disabilities, physical disabilities or long-term conditions; older people and younger people with dementia

Regionally and locally, critical success factors have been identified to support the delivery of the NDS, which are;

- Strengthened involvement of people with dementia and their carers in planning and development
- Joint commissioning, supported by short and long term project plans, and informed by good practice to speed up change
- Whole system support for the work of the NDS, supported by the development of existing and new networks at both senior and frontline staff levels
- Strong links to other agendas to maximise the benefits of work e.g. on transforming adult social care, Quality Innovation Productivity Prevention, Target Operating Model, Tricordant, carers, My home Life, Dignity in Care, End of life care.
- Build on the focus on workforce development, which is central to delivery on many of the NDS objectives.

The Older Adult Mental Health Programme Board has four work streams that directly relate to the NDS and developments across Essex for people living with dementia

There are clear links that need to be rooted in the action plan with End of Life, Learning Disabilities, Carers and the work that's underway on 'Older People and Older People with Mental Health Difficulties Commissioning Delivery Plan'.

As previously referred to as a priority area, one of the key success factors is ensuring there is a focus on workforce, this will be key to delivering the outcomes in the NDS. There has already been a regional skills gap analysis commissioned and produced which highlights the areas where increased knowledge and skills are required1.

Financial pressures provide the opportunity to work more innovatively. The DH regional team is encouraging organisations to deliver efficiencies through the QIPP programme and work is currently underway to develop additional QIPP projects around acute/intermediate care for people with dementia.

Policy context

In 2007, the Department announced that dementia would now be a national priority and that it would signal this to the NHS through the NHS Operating Framework. It also announced that it would develop a National Dementia Strategy. This five-year Strategy was launched in February 2009. The Department acknowledged that dementia was the biggest challenge it had ever faced, largely due to the complexities of joining up health and social care departments and resources.

National Dementia Strategy.

In February 2009, the Department of Health launched the ambitious and comprehensive five-year National dementia strategy (NDS) aimed at helping people to live well with dementia. The Department estimated that the Strategy would cost £1.9 billion to implement over 10 years, and that this would be funded largely through efficiency savings. National and regional leadership was put in place and initial seed funding of £150 million was allocated to Primary Care Trusts (PCT's) to assist implementation over the first two years.

The vision in the National Dementia Strategy is that services and society should transform their approach and attitudes to enable people with dementia and their carers to live well with dementia. This is in contrast to the current situation, where in many services people with dementia are simply 'managed'. In order to achieve this vision 17 key objectives (*see appendix 1)* were identified specifying improvements of 3 key areas;

· Raising awareness
· Early diagnosis and intervention
· Living well with dementia

The current coalition government has re-iterated its commitment to the needs of people living with dementia and their carers and has identified the implementation of the National Dementia Strategy

[1] http://www.essexcc.gov.uk/vip8/ecc/ECCWebsite/content/binaries/documents/Older_Peoples_Mental_Health_Strategy.pdf

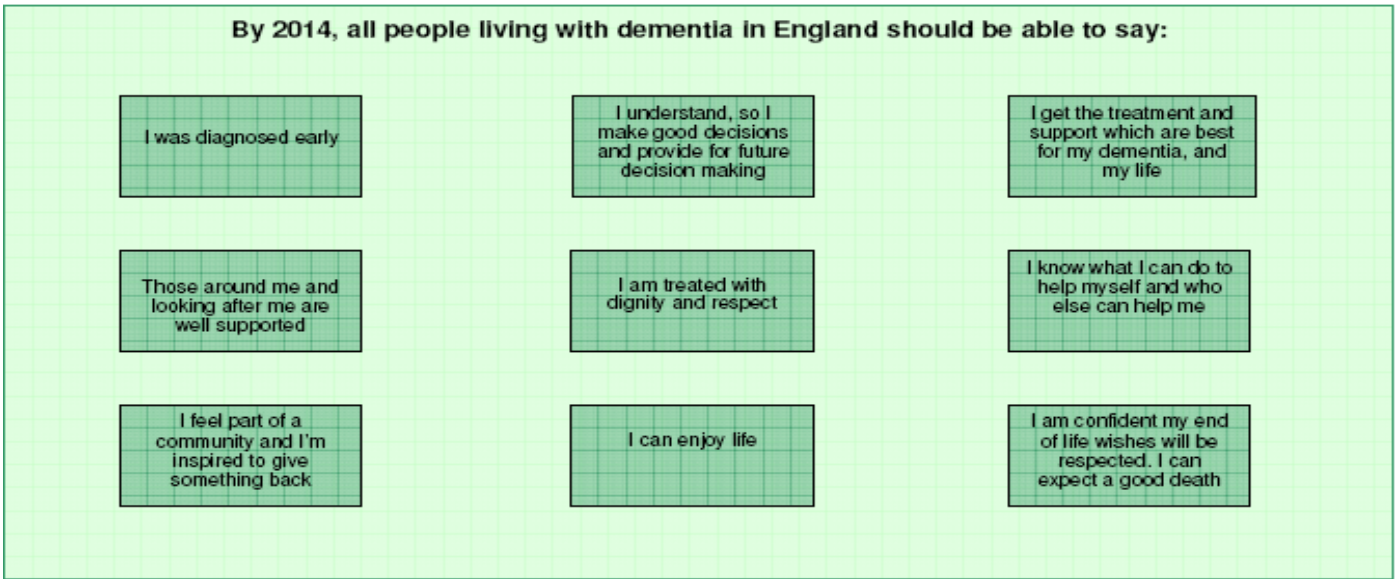
as one of its priorities. This has been reflected in a number of announcements and initiatives with the four priorities for dementia in 2010 being:

Early diagnosis and support - Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia; only a third of GPs feel they have adequate training in diagnosis of dementia.
Improving the quality of acute hospital care - 40% of people in hospital have dementia; the excess cost is estimated to be £6m per annum in the average General Hospital; co morbidity with general medical conditions is high, people with dementia stay longer in hospital.
Improving care home quality - Two thirds of people in care homes have dementia; dependency is increasing; over half are poorly occupied; behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.
Reducing the use of antipsychotic drugs - There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription.

All of these are to be underpinned by personalisation and personal support in the community.[2] Improved community support services, are integral to the each of the four priorities as they support early intervention; present premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

The government has also stated its commitment to ensuring there is a greater focus on accelerating the pace of improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them. A key element of the outcomes-focused approach is ensuring greater transparency and provision of information to individuals. The following nine statements have been proposed by the department, which capture what people with dementia have said they aspire to in terms of their health and social care systems.

Figure 1. Draft synthesis of outcomes desired by people with dementia and their carers



[2] *Quality outcomes for people with dementia*: building on the work of the National Dementia Strategy, DH Sept 2010

Dementia Action Alliance Declaration

Public and political commitment to dementia has grown significantly in recent years to a position where dementia is now a major strand of public policy discussion. To continue and progress the momentum the Dementia Action Alliance[3] was launched on 26 October 2010. The Alliance is a coalition of 45 organisations committed to improving quality of life for people with dementia and their carers in England by 2014 (the date when the National Dementia Strategy comes to an end). On launch, the Alliance published a National Dementia Declaration explaining the outcomes they seek to deliver for people with dementia and their carers. In addition, each signatory organisation has published an action plan setting out what their role is in delivering better quality of life for people with dementia, their carers, and the actions they intend to take in order to help deliver those outcomes. The seven agreed outcomes come under the following headings:

1. I have personal choice and control or influence over decisions about me

2. I know that services are designed around me and my needs

3. I have support that helps me live my life

4. I have the knowledge and know-how to get what I need

5. I live in an enabling and supportive environment where I feel valued and understood

6. I have a sense of belonging and of being a valued part of family, community, and civic life

7. I know there is research going on which delivers a better life for me now and hope for the future

NOTE: For further detail on these outcomes see *appendix 2*

There is a noticeable similarity with the outcomes identified in the revised NDS implementation document. In Essex, we will be using the NDS draft outcomes to steer our action plan and measure how we are meeting the needs of people living with dementia. We will also be ensuring that the synergy with the National Dementia Declaration (NDD) and the Nice Dementia quality standards (NICE QS) is transparent.

The Strategy fits with the new vision for the future of health and social care as set out in the White Paper Equity and Excellence: Liberating the NHS; and with the consultation document Liberating the NHS: Transparency in outcomes – a framework for the NHS

NICE Dementia Quality Standard

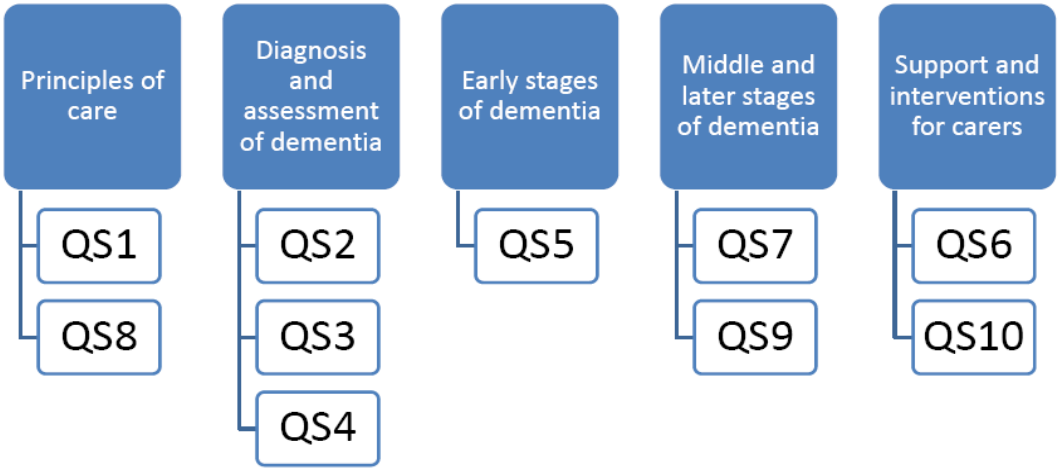
The NICE Dementia Quality Standard provides clinicians, managers, and service users with a description of what a high-quality dementia service should look like, identifying the following key priorities for implementation

[3] http://www.dementiaaction.org.uk/

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

The quality standards for dementia are based on the understanding that dementia services are commissioned from and coordinated across all relevant agencies encompassing the whole dementia care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with dementia.[4] This can be viewed clearly in the diagram below

Figure 2 Dementia, areas of care map



[4] http://www.nice.org.uk/aboutnice/qualitystandards/dementia/dementiaqualitystandard.jsp

Age Equality and the Equality Act 2010

We are also committed to ensuring that central to the delivery of the action plan is a focus on equality.

The Equality Act[5] became law in October 2010 and will eventually impact on the way public services are delivered by creating a single new Equality Duty on public bodies to tackle discrimination, promote equality of opportunity and encourage good community relations

The new duty will cover race, disability, and gender, as now, but also include age, sexual orientation, gender reassignment and religion or belief, replacing the three existing, separate duties with a single, more effective framework. Banning age discrimination in the provision of goods, facilities, or services and tackling unjustifiable age discrimination where it has negative consequences. There will be further consultation on this and a transition period before it is implemented, but we need to ensure that services for people with dementia in Essex are age inclusive, providing equity of available resources to achieve identified outcomes. The aim of the age equality agenda is for services to be of equivalent good quality for people of all ages.

A national study of older people's mental health services highlighted likely age discrimination within services. It found: older people's services were falling behind those for working age adults; clear evidence of age discrimination in access to services; and a lack of age appropriateness[6].

The NHS Operating Frameworks for 2009/10 and 2010-11[7] identified dementia as an area for local prioritisation. Getting dementia care right should be a priority for local services from an efficiency as well as quality perspective.

- There are over 570,000 people in England with dementia – and numbers are expected to double in the next thirty years
- Direct costs of dementia to the NHS and social care are in the region of £8.2bn annually
- 40% of people admitted to hospital have dementia
- 40% of the work of community matrons is focused on people with dementia as a co-morbid condition
- At least 50% of long term care residents have dementia

While the numbers and the costs are daunting, the impact on those with the illness and on their families is also profound.

End of Life Care Strategy

The End of Life (EoL) Care Quality Markers[8] provide detailed structure and process markers and measures which will be relevant for end of life care for people with dementia. Within these, there

[5] http://www.equalities.gov.uk/equality_act_2010.aspx
[6] New Horizons/Healthcare Commission (2009) *Equality in Later Life: A National Study of Older People's Mental Health Services.*
[7] Department of Health, *Revision to the Operating Framework for the NHS in England* 2010/11, June 2010.
[8] End of Life Care Strategy: *quality markers and measures for end of life care* (DH, 2009)

are particular points of consideration for end of life care for people affected by dementia. Directly linking in with many of the NDS objectives but particularly objective 12 of the NDS – *Improved end of life care for people with dementia.* The following are the seven EOL markers:

- Public awareness
- Strategic Planning
- Identification, communication and care planning
- Co-ordination of care across organisational boundaries
- Availability of services
- Care in the last days of life
- Care in the days after death
- Workforce planning
- Monitoring

Quality, Innovation, Productivity and Prevention

The tool to drive through this transformation change is the **QIPP** - (QIPP) programme. The key objectives of the QIPP programme, set out in 'Inspiring Change in the NHS' are:

- To improve quality and productivity
- To engage, inspire and empower staff
- To create a legacy of change leaders and a quality culture.

Led by the NHS Management Board the implementation of QIPP has become a priority for SHAs and PCTs and establishes the context for the future development and planning of service providers. Therefore, when we look at transforming support for people with dementia in Essex we need to ensure the QIPP objectives are central to implementing the strategy.

New Horizons

New Horizons9 recognises the potential for reducing the burden and long-term consequences of mental health problems by setting out a framework for early intervention and promoting well-being across society. The Operating Framework 2010/ 11 (and associated revision) reinforces such a vision for mental health and provides clear descriptions of the characteristics for NHS commissioners for the forthcoming year as QIPP is progressed.
It includes:

• Care close to home.
• Fewer acute beds.
• Reduced variations.
• Standardisation of Pathways.
• Early Intervention.
• Productivity.

[9] *New Horizons: a shared vision for mental health*, DH Dec 2009

Summary

This document sets out our approach to ensuring that in Essex, services for people living with dementia and their carers meet the outcomes that people with dementia have identified are important to them. It sets out some priority actions for Essex to take forward to ensure that, working with others; we can make a real difference to people living with dementia and their carer's. We have use the NDS draft outcomes to steer our action plan and measure progress. We will also be ensuring that the synergy with the National Dementia Declaration (NDD) and the Nice Dementia quality standards (NICE QS) is transparent. The same underlining key messages keep coming through from government and the public, which are training, integration, clear pathways, information, and equality. Now need to be sure, we know how we are going to implement them to make a difference.

Delivery Method

Delivery of the action plan will be through the Older peoples programme board and will be interlinked with the Older People and Older People with Mental Health Difficulties Commissioning Delivery Plan. In conjunction with the Dementia Services Action plan, there will sit a Pan Essex Dementia Strategy detailing the demographics and needs of people living in Essex affected by dementia in addition to outlining Pan Essex priorities.

A key delivery mechanism for many of the actions below will be via the Older Adult Mental Health Programme Board (*see appendix 3),* but this will need to be supported by ensuring there is capacity and leadership in place for the overall delivery and reviewing of the plan.

To ensure the actions are delivered on target it is suggested that the action plan below is subject to six monthly reviews for the first two years, thereafter annually.

Action Plan

Key: **PCT's** – Primary Care Trusts, **MHT's** – Mental Health Trusts, **SCD** – Social Care direct, **OMT** – Operational Management Teams, **SP&C** – Strategic planning and commissioning, **QSI** – Quality Standards Improvement team, **OAMH ws** – Older Adult Mental Health Programme Board work stream, **WF** - Workforce

Outcome and Descriptor (From the DH, Quality Outcomes for people with Dementia: building on the work of the National Dementia Strategy Sept 2010)	**Benchmarking** (against the NDS objectives, NDD outcomes and the NICE Quality Statements, with a brief descriptor of where Essex is in relation to these outcomes)	**Action**	**Lead**	**Target Time** (date actions will have been implemented by)					**Progress linked to progress and mapping Document**			
				2010	2011	2012	2013	2014	North East	Mid	West	South
1. I was diagnosed early. *People will have the information they need to understand the signs and symptoms of dementia. Those concerned about dementia will know where to go for help. The time between people presenting symptoms to a doctor and being diagnosed*	NDS 1, 2 NDD 1 NICE QS 2, 3 **Where are we now?** The National campaign is raising awareness of dementia to the general population. Locally Alzheimer's Society is funded to provide many services including information and advice to people in	1.1 Provision of a memory service in each locality that is age inclusive.	SP&C/ PCT's	•								
		1.2 Develop preferred outcomes and define delivery needs for memory services within the county, for people with dementia and their carers within the community				•						
		1.3 Support memory services to explore and develop ways to actively identify people at risk of developing dementia	SP&C/ PCT'S			•						
		1.4 Improve recording across organisations to inform progress, future need, unmet need and the Primary care QOF register	SCD/OMT	•								

will be as short as possible for everyone.	Essex. Care Pathways have been developed locally, resulting in differences in access and services	1.5 Work in partnership to develop Essex Wide whole system pathway	PCT/OMT /SP&C				•					
		1.6 Ensure all information is accessible in a variety of formats , is clear and easy to read	SCD/OMT		•							
		1.7 Training available for all staff (health, social care and private, voluntary and independent sectors) to be able to recognise early symptoms of memory problems in order to promote early diagnosis, and to understand options available to support people living with dementia and their carers.	OAMH ws2		•							
2. I understand, so I make good decisions and provide for future decision making. *Everyone affected by dementia will get information and support in the format and at the time that best suits them. They will be supported to interpret and act on the information so that*	NDS 3, 4, 5 NDD 3, 4 NICE QS 3, 5 **Where are we now?** There is a variety of information available from different organisations, but it can be fragmented and difficult to find. GP care advisors are being piloted in NE and Alzheimer's society are	2.1 Explore 'total place', 'virtual ward' thinking for working in partnership with all sectors to establish a 'Dementia hub' of knowledge and resources available to all	SP&C/PC T'S		•							
		2.2 Explore options for one point of contact in Essex with partner organisations. People affected by dementia and those who work with them will know where to get information, advice, and access to resources in their area.	SP&C/ PCT'S		•							
		2.3 Ensure key workers have the skills to support Advance Care Planning (ACP) and	OMT/OA MH 2			•						

they understand their illness and how it will impact on their lives, including any other illnesses they may already have. They will know what treatments are best for them and what the implications are and they will be supported to make good decisions.	linked in with Memory services across the region However many people do not have contact with people who have the knowledge and skills to provide the information to people that will help them to understand the impact of their illness. Currently there is no 'one point of contact' or website for people in Essex (public, providers or professionals) to go to for information and help.	MCA with people living with dementia									
		2.4 Enable Peer Support groups and networks to be involved in the development of the Strategy and Services for people with Dementia and their Carers	SP&C	•							
		2.5 Implement CQC recommendation: 'Ensure that older people and their carers are provided with information and support when they are discharged from hospital'	OMT/QSI		•						
		2.6 Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training that is consistent with their roles and responsibilities	WF/OMT					•			
3. I get the treatment and support which are best for my dementia, and my life. *Everyone living with*	NDS 2, 6, 8, 9, 10, 11, 13,18 NDD 2,3 NICE QS 1, 4, 5, 7, 8 **Where are we now?**	3.1 Develop a joint workforce planning and dementia training strategy	WF		•						
		3.2 Mandatory dementia training for all team managers and senior staff in Adult Social Care and Mental Health Trusts	WF/OMT				•				

dementia will receive the best dementia treatment and support, no matter who they are or where they live. They will feel that their personal needs have been appropriately assessed and that their treatment and potential consequences of treatment have been well planned and delivered in a coordinated way that is appropriate to their individual needs and preferences. They will be able to exercise personal choice in social care and ongoing support will be of a high quality.	There is a good range of innovative services across Essex with real progress being made on implementing the above objectives of the NDS. However, these are fragmented and inconsistent. Assistive technology for people with dementia can promote greater independence and reduce risk, but is currently underused.	3.3 Explore the use of Star Outcome Assessment tool(*See appendix 4)* to measure progress against outcomes	QSI/OMT		•							
		3.4 Work in partnership to agree pathway that encompasses entry into hospital pathway of care throughout stay and discharge planning.	OMT/QSI					•				
		3.5 Explore the market to find ways to Increase the capacity of re-ablement to support the prevention agenda and reach people with dementia potentially at risk in the community before admission to hospital.	SP&C/OMT/CT		•							
		3.6 Work with our partners to stimulate the market to offer more personalised services to people with dementia	SP&C/OMT		•							
		3.7 Explore opportunities for joint commissioning with PCT's, local councils and third sector to provide day opportunities that are responsive to personal budgets	SP&C/OMT/QSI/PCT'S		•							
		3.8 Explore options for night time support services for people with dementia to provide essential carer breaks.	SP&C/OMT/QSI			•						
		3.9. Build on existing liaison services to reduce inappropriate admission and length	SP&C/PCT'S				•					

		of stays in acute hospitals	MHT'S									
		3.10 Assistive technology to be embedded in discharge planning	OMT'S			•						
		3.11 OAMH teams to champion the use of Assistive technology for people with dementia in all settings	MHT'S/OMT'S				•					
		3.12 Engage with primary care in particular GP's to encourage the use of assistive technology for people living with dementia	SP&C/PCT'S/MHT'S/OMT			•						
		3.13 Review the role of Older Adult mental Health Teams in meeting the needs of people living with dementia and their cares	SP&C		•							
		3.14 People with dementia should not be excluded from any services because of their diagnosis, age or coexisting learning disabilities	SP&C/PCT'S/MHT'S/OMT			•						
4. I am treated with dignity and respect. *People living with dementia will report that they are treated with dignity and respect by all those involved*	NDS 1 NDD 1, 2, 5, 6 NICE QS 1, 13 **Where are we now?** There has been a considerable increase nationally in media	4.1 Continue to fund the Alzheimer's society in Essex to raise awareness of dementia across the region and reduce stigma	SP&C	•								
		4.2 In partnership, establish a proactive approach to identifying people with dementia who live alone and may not self	SP&C/PCT'S/MHT'S					•				

throughout their dementia journey. They will also be open about living with dementia without fear of stigma or discrimination. It will be well recognised and understood by the public and professionals that dementia is a condition that increasing numbers of people will live with.	coverage highlighting the needs of people with dementia which is helping to reduce stigma. In Essex there have been various initiatives to raise awareness and reduce stigma including a series of events which have taken place in shopping centres, , GP's practices Stanstead Airport. Recording over 1000 contacts during a week of publicity events inc. 205 BME contacts. However, we know we need to do more and build on the national	present to services.										
		4.3 Promote dignity agenda across dementia services in Essex	OMT/QSI		•							
		4.4 Safeguarding – continue to develop practice and process around Safeguarding, Deprivation of Liberty and Mental Capacity Act, in line with locality Safeguarding actions plans and CQC recommendations.	ASU/OMT /QSI		•							
		4.5 Promote My Home Life in residential settings in Essex	SP&C		•							
		4.6 Ensure staff promote the use of 'This is me' doc. to improve hospital care. http://alzheimers.org.uk/site/scripts/download_info.php?fileID=849	OMT/QSI /MHT/PC T'S		•							
		4.7 Ensure that all staff working with older people and in health, social care and the private, voluntary and independent sector have an understanding of dementia and how to support people living with dementia	WF/OMT					•				

	campaign and raise awareness and understanding of the effects of dementia to reduce stigmatisation.	4.8 Staff in supported housing, residential settings, home care etc know where to go to get the information and advice they need to provide the care that is needed to optimise independence for people with dementia in the community	OMT/QSI					•				
5. I know what I can do to help myself and who else can help me. *People living with dementia will be supported to self-manage the consequences of dementia and its treatment, to the degree they are able/wish to. They will know where to turn to get the clinical,*	NDS 3, 4, 5, 6, 13 NDD 1, 2, 3, 4, NICE QS 1, 3, 4, 5 **Where are we now?** Essex Adult Social Care has been providing Self directed Support and personal budgets(PB'S) to people in Essex since 2008, however take up for people with dementia remains low. We need to ensure that we maximise the use of	5.1 Identify new models of services, particularly focussing on supporting independence • Providing flexible support and treatment that enables service users to remain at home • Providing person centred activities that maximise service users skills • Expand short break opportunities • Ensure crisis management plans are in place	SP&C/OMT/QSI			•						
		5.2 Active promotion of the use of personal budgets for people living with dementia needs. (*Evidence suggests people with dementia are likely to benefit the most yet are least likely to take up the opportunities).*	OMT/MHT		•							

practical, emotional and financial support they need when and where they need it. They will feel confident that they can practice their faith and spirituality and that others will help them when they need support.	(PB'S) to support people to manage the effects of dementia. We also need to ensure people know where to go to get the support they need, at the time they need it	5.3 Explore options of for dementia hubs (locality based) that are able to provide information, advice via telephone, web, email etc to support people to manage the effects of dementia and know when and where to seek help at the time they need it.	SC&P/PCT/MHT		•							
6. Those around me and looking after me are well supported. *People living with dementia will feel confident that their family, friends and carers have the practical, emotional and financial support they need to lead as normal a life as possible throughout the dementia journey. They will know where to get*	NDS 3, 4, 5, 7 NDD 2, 3, 4, 5, 6, NICE QS 3, 4, 6, 10 **Where are we now?** With nearly 1 in 9 of the UK's carers looking after someone with dementia, this is a significant group of carers whose needs should be better catered for. Meeting the needs of carers is a high priority for Essex. To do this we recognise that we need	6.1 Health and social care managers should ensure that the rights of carers to receive an assessment of needs as set out in the *Carers and Disabled Children Act 2000* and the *Carers (Equal Opportunities) Act 2004* are upheld	MHT/OMT		•							
		6.2 Ensure carers assessments are comprehensive and meaningful, focusing on opportunities for cares and that reviews and assessments always explore opportunities for assistive technology to support carers and cared for.	OMT		•							
		6.3 Ensure Carers of people living with dementia are fully included in all areas of the Essex Carers Strategy	Linda Hample		•							

help when they need it.	to ensure carers are provided with quality, consistent, information and support at the right time.	6.4 Support the development of Peer support groups for carers of people living with dementia	SP&C/PCT			•						
		6.5 Increase access to 'Dementia Cafés' in Essex	SP&C/PCT					•				
		6.6 Increase options for promoting the development of breaks that benefit people living with dementia and their carers	OMT/QSI				•					
7. I can enjoy life. *People living with dementia will be well supported in all aspects of living with dementia, leaving them confident to lead as full and active life as possible. They will be able to pursue the activities (including work) that allow them to be happy and feel fulfilled while living with dementia.*	NDS 1, 4, 5, 6 NDD 3, 4, 5, 6 NICE QS 3, 4 **Where are we now?** In Essex there is a focus on increasing access to supported housing for people with dementia to maximise independence and social inclusion For example the recent development of an Extra Care Housing scheme in Witham jointly with District councils, Hanover	7.1 Develop a focus group of people living with dementia and their carers to work in partnership with and inform decisions.	SP&C			•						
		7.2 Support development of good quality advice and information that is consistent, to people with dementia and their carers, at first point of contact that makes the most of informal support and mainstream services	ESCD/OMT/MHT/PCT			•						
		7.3 Improve access to supported housing for people with dementia.	SP&C				•					
		7.4 Staff to receive training to support positive risk taking for people living with dementia.	WF/OMT		•							
		7.5 Ensure the workforce have the skills to support people with dementia and their	MHT/WF/PCT/OMT					•				

	Housing and ECC.	carers through the difficult phases of their illness to reduce reliance on antipsychotic medication										
8. I feel part of a community and I'm inspired to give something back. *People who have been affected by dementia and others will feel inspired to contribute to the life of their community, including action to improve the lives of others living with dementia. This includes having the opportunity to participate in high quality research.*	NDS 1, 5, 16 NDD 5, 6, 7 **Where are we now?** We need to actively focus on research to inform practice and models of service delivery for people affected by dementia. We also need to change the perception of people with dementia being dependent, to one of maximising skills to engage in meaningful activities in the community.	8.1 Actively promote volunteering for people with dementia	SP&C/OMT					•				
		8.2 Promote and support research in Dementia, look at options for psychosocial research projects to inform practice	SP&C/PCT/MHT					•				
		8.3 Increase and support the uptake of intergenerational projects, including 'My Home Life'	SP&C				•					
		8.4 Support communities to explore opportunities to increase social inclusion for people with dementia and their carers	SP&C				•					
9. I am confident my end of life wishes will be respected. I can expect a good death. *People who are nearing*	NDS 12, 13 NDD 1, 2, NICE QS 5, 9 **Where are we now?** In Essex there is an End of Life Action Plan that	9.1 Ensure all providers have the 'End of Life resource pack'	SP&C/OMT			•						
		9.2 Look at opportunities for multiagency EoL training for staff working with people living with dementia	WF		•							

the end of their life will be supported to make decisions that allow them and their families/carers to be prepared for their death. Their care will be well co-ordinated and planned so that they die in the place and in the way that they have chosen.	is being developed to ensure that we are in a position to deliver the EoL care quality markers. EoL plan links closely with the dementia action plan to ensure that people with dementia are treated with dignity and have their needs met	9.3 Work with our partners to improve quality of End of Life interventions in preferred location.	OMT					•				
		9.4 Commissioners to ensure that there are mechanisms in place to coordinate individuals' care across dementia and end of life care services. These must include health (including mental health), social care and housing services.	SP&C/OMT					•				
		9.5 Encourage more accurate recording of diagnoses of dementia, particularly where dementia is a contributing factor at the end of life. To improve understanding of access to end of life care services by people with dementia.	OMT/PCT/MHT		•							
		9.6 Work with our partners to take an active role in encouraging end of life care services to address the needs of people affected by dementia.	SP&C/PCT/MHT		•							
		9.7 Ensure End of Life champions understand the needs of People with dementia	OMT/wf			•						
		9.8 Needs of people living with dementia to be evident in the Essex EoL plan.	Tes Smith	•								

10. Outcomes for Essex Essex is clear what it's priorities and actions are which will improve outcomes for people living with dementia and their carers in Essex and how this will be achieved.	**Where are we now?** The draft Pan Essex strategy has been written and is presently out for consultation. Progress is being made with the Mapping and progress report but it is recognised that this will be an ongoing piece of work as services develop. More work needs to be done to ensure we do not let people with dementia 'slip through the net' and that all people with dementia in Essex receive a good service that is joined up.	10.1 Produce a Pan Essex Dementia Strategy to inform and support the delivery plan.	April Lawlor/ Sheila Davis	•					
		10.2 Form an Older Adult Mental Health Programme Board to support joint delivery of the Dementia Plan	Chris Martin	•					
		10.3 Produce a 'progress and mapping' document to measure progress against the delivery plan and NDS outcomes/objectives.	SP&C	•					
		10.4 Review Older Adult Community mental Health Teams role, in meeting the needs of people living with dementia	SP&C/MHT/PCT/OMT		•				
		10.5 Reduce duplication and 'hand off's' between services and teams.	OMT/QSI			•			
		10.6 Commissioning of services will be needs led i.e. open access, LD services that may meet the needs of Younger people with dementia and vice versa.	SP&C	•					
		10.7 There will be capacity and leadership in place to deliver the Dementia Plan	ECC	•					

Appendix

Appendix 1

National Dementia Strategy Objectives

The key objectives of the Strategy, addressed in more detail in the full document, are as follows:

Objective 1: Improving public and professional awareness and understanding of dementia. Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

Objective 2: Good-quality early diagnosis and intervention for all. All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Objective 3: Good-quality information for those with diagnosed dementia and their carers. Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

Objective 4: Enabling easy access to care, support and advice following diagnosis. A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

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.

Objective 8: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

Objective 9: Improved intermediate care for people with dementia. Intermediate care which is accessible to people with dementia and which meets their needs.

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

Objective 11: Living well with dementia in care homes. Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes

Objective 12: Improved end of life care for people with dementia. People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

Objective 13: An informed and effective workforce for people with dementia.

Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

Objective 14: A joint commissioning strategy for dementia. Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy.

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers. Inspection regimes for care homes and other services that better assure the quality of dementia care provided.

Objective 16: A clear picture of research evidence and needs. Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.

Objective 17: Effective national and regional support for implementation of the Strategy. Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Objective 18: Reduction in the use of antipsychotic drugs for people with Dementia.

Appendix 2

National Dementia Declaration Outcomes

1. I have personal choice and control or influence over decisions about me

- I have control over my life and support to do the things that matter to me.
- I have received an early diagnosis which was sensitively communicated.
- I have access to adequate resources (private and public) that enable me to choose where and how I live.
- I can make decisions now about the care I want in my later life.
- I will die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care.

2. I know that services are designed around me and my needs

- I feel supported and understood by my GP and get a physical check-up regularly without asking for it.
- There are a range of services that support me with any aspect of daily living and enable me to stay at home and in my community, enjoying the best quality of life for as long as possible.
- I am treated with dignity and respect whenever I need support from services.
- I only go into hospital when I need to and when I get there staff understand how I can receive the best treatment so that I can leave as soon as possible.
- Care home staff understand a lot about me and my disability and know what helps me cope and enjoy the best quality of life every day.
- My carer can access respite care if and when they want it, along with other services that can help support them in their role.

3. I have support that helps me live my life

- I can choose what support suits me best, so that I don't feel a burden.
- I can access a wide range of options and opportunities for support that suits me and my needs.
- I know how to get this support and I am confident it will help me.
- I have information and support and I can have fun with a network of others, including people in a similar position to me.
- My carer also has their own support network that suits their own needs.

4. I have the knowledge and know-how to get what I need

- It's not a problem getting information and advice, including information about the range of benefits
- I can access to help me afford and cope with living at home.
- I know where I can get the information I need when I need it, and I can digest and re-digest it in a way that suits me.

- I have enough information and advice to make decisions about managing, now and in the future, as my dementia progresses.
- My carer has access to further information relevant to them, and understands which benefits they are also entitled to.

5. I live in an enabling and supportive environment where I feel valued and understood

- I had a diagnosis very early on and, if I work, an understanding employer which means I can still work and stay connected to people in my life.
- I am making a contribution which makes me feel valued and valuable.
- My neighbours, friends, family and GP keep in touch and are pleased to see me.
- I am listened to and have my views considered, from the point I was first worried about my memory.
- The importance of helping me to sustain relationships with others is well recognised.
- If I develop behaviour that challenges others, people will take time to understand why I am acting in this way and help me to try to avoid it.
- My carer's role is respected and supported. They also feel valued and valuable, and neither of us feel alone.

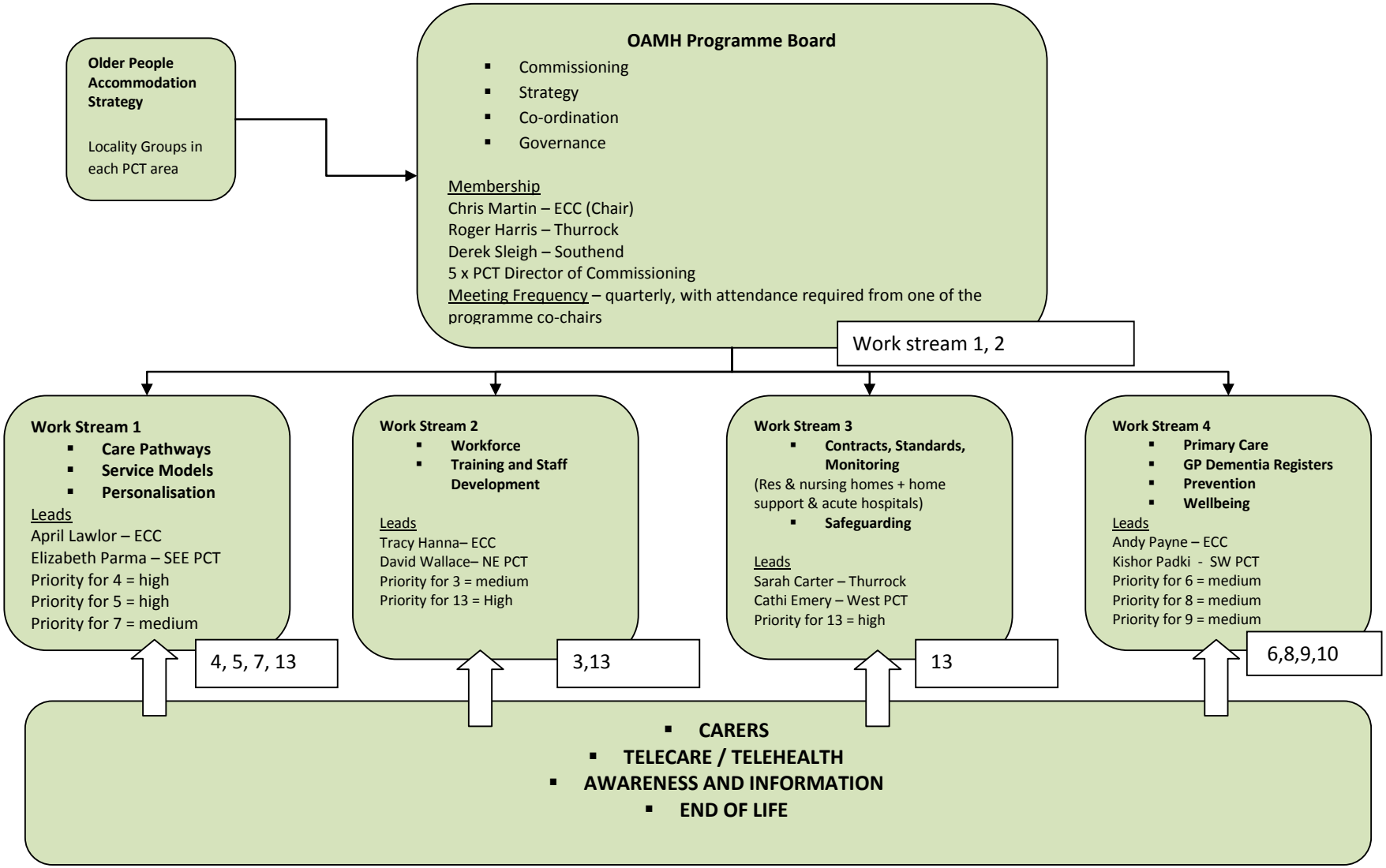
6. I have a sense of belonging and of being a valued part of family, community and civic life

- I feel safe and supported in my home and in my community, which includes shops and pubs, sporting and cultural opportunities.
- Neither I nor my family feel ashamed or discriminated against because I have dementia. People with whom we come into contact are helpful and supportive.
- My carer and I continue to have the opportunity to develop new interests and new social networks.
- It is easy for me to continue to live in my own home and I and my carer will both have the support needed for me to do this.

7. I know there is research going on which delivers a better life for me now and hope for the future

- I regularly read and hear about new developments in research.
- I am confident that there is an increasing investment in dementia research in the UK.
- I understand the growing evidence about prevention and risk reduction of dementia.
- As a person living with dementia, I am asked if I want to take part in suitable clinical trials or participate in research in other ways.
- I believe that research is key to improving the care I'm receiving now.
- I believe that more research will mean that my children and I can look forward to a range of treatments when I need it and there will be more treatments available for their generation.
- I know that with a diagnosis of dementia comes support to live well through assistive technologies as well as more traditional treatment

Appendix 3

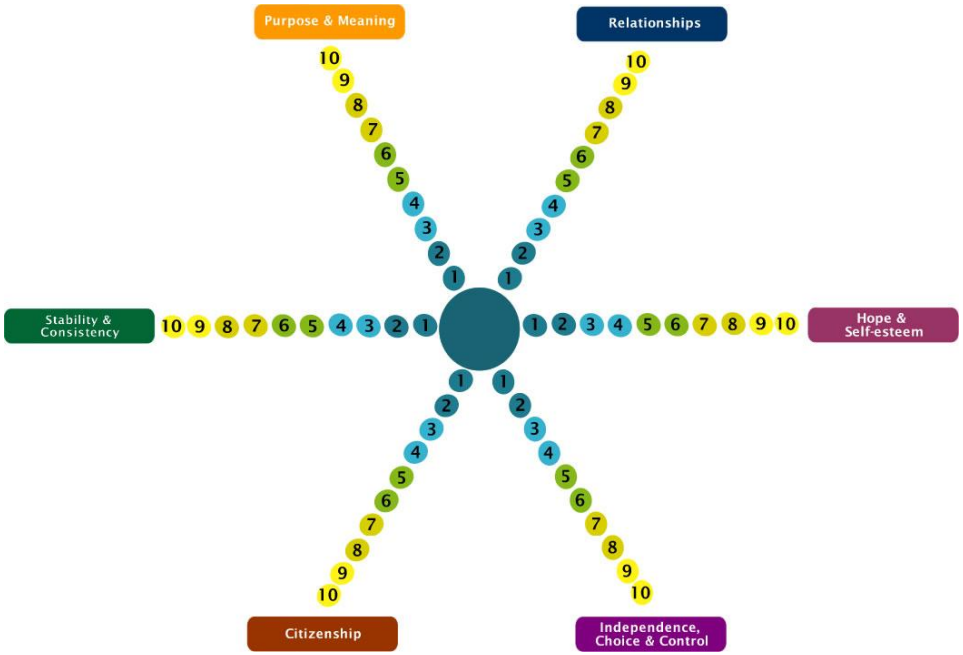

Older People Accommodation Strategy
Locality Groups in each PCT area
OAMH Programme Board
Commissioning
Strategy
Co-ordination
Governance
Membership
Chris Martin – ECC (Chair)
Roger Harris – Thurrock
Derek Sleigh – Southend
5 x PCT Director of Commissioning
Meeting Frequency – quarterly, with attendance required from one of the programme co-chairs
Work stream 1, 2
Work Stream 1
Care Pathways
Service Models
Personalisation
Leads
April Lawlor – ECC
Elizabeth Parma – SEE PCT
Priority for 4 = high
Priority for 5 = high
Priority for 7 = medium
4, 5, 7, 13
Work Stream 2
Workforce
Training and Staff Development
Leads
Tracy Hanna– ECC
David Wallace– NE PCT
Priority for 3 = medium
Priority for 13 = High
3,13
Work Stream 3
Contracts, Standards, Monitoring
(Res & nursing homes + home support & acute hospitals)
Safeguarding
Leads
Sarah Carter – Thurrock
Cathi Emery – West PCT
Priority for 13 = high
13
Work Stream 4
Primary Care
GP Dementia Registers
Prevention
Wellbeing
Leads
Andy Payne – ECC
Kishor Padki - SW PCT
Priority for 6 = medium
Priority for 8 = medium
Priority for 9 = medium
6,8,9,10
CARERS
TELECARE / TELEHEALTH
AWARENESS AND INFORMATION
END OF LIFE

Appendix 4

Mental Health Concern – Recovery Star

http://www.mentalhealthconcern.org

Dementia Services – A Person Centred Outcomes Framework:



Meaning & Purpose

- Promoting Independence
- Meaningful Activities
- Preserving life roles
- Education – improving people's future expectations
- Life story work

NDS Key Objectives: 3, 4, 6, 7, 8, 9, 10, 11, 13

Relationships

- Preserving Roles
- Carer Support
- Psycho Education
- Respite Care
- Dementia Advisor Role
- Life Story Work

NDS Key Objectives: 3, 5, 7

Hope & Self-Esteem

- Education
- Stigma
- Early Diagnosis
- Education – improving people's future expectations

NDS Key Objectives: 1, 2, 3, 4, 5, 6, 7, 11, 12

Independence, Choice & Control

- Positive Risk Taking
- Good diagnoses
- Good information
- Tele-care
- Housing & Support
- Advocacy
- Dementia Advisors

NDS Key Objectives: 2, 3, 4, 6, 8, 10, 11

Citizenship

- Stigma & Discrimination
- Public health education
- Public engagement
- Community activities

NDS Key Objectives: 2, 3, 4, 6, 8, 10, 11

Stability & Consistency

- Good respite care
- Consistency of long term support (Dementia Advisor)
- Housing support (Promoting Independence)
- Good access to primary care in nursing homes

NDS Key Objectives: 3, 4, 6, 9, 10, 11