BEDFORD BOROUGH COUNCIL

NHS Bedfordshire

Joint Commissioning Strategy for People with Dementia 2011 - 2014

28th June 2011

Transforming Services for People with Dementia

Contents

Foreword

Welcome to the joint commissioning strategy for people with dementia which has been co-produced by Bedford Borough Council and NHS Bedfordshire, incorporates the views of all of our key stakeholders and, most importantly, the views of users and carers collected at stakeholder events prior to completion.

This strategy also includes health and social care needs which have been identified through our joint strategic needs assessment and the views of all of our community expressed through the Bedford Borough Assembly conferences.

This joint commissioning strategy, like all other strategies for Adult Social Services, links directly through the Sustainable Community Strategy for the Borough. One of the key aims in the Sustainable Community Strategy is to ensure that “everybody has access to high-quality health and social care services when they need them and the help they need to lead healthy and independent lives”. The joint commissioning strategy for people with dementia sets out our joint priorities for the next three years.

We have produced this strategy in challenging times with increasingly pressured resources. It is therefore important that we ensure that we do not simply offer a set of reactive services. Bedford Borough Council is determined to achieve our aspiration of delivering services to all of our citizens which are seen as excellent by those who use, depend on or inspect them. With challenge comes opportunity and we will take the opportunity to do things differently with the still significant resources that remain available to us.

We are committed to making changes to transform the way dementia services are delivered over the next three years. This will mean concentrating more on prevention and early intervention. When people need services we will provide them effectively and efficiently and in a more personalised way with all our partners in care provision.

Good mental health is a basic foundation to the wellbeing of individuals, families and communities. It affects our quality of life, our relationships and aspirations. The consequences of dementia on sufferers and their families can be devastating. Stigma and prejudice can add barriers and prevent people from opportunities that most of us take for granted – such as family life, decent homes and having everyday choices respected.

Supporting people with dementia to be fully included in our community and have choice and control in their lives is a major objective for Bedford Borough Council and NHS Bedfordshire. This strategy is the product of work undertaken in 2010/11 to review services and plan for the future.

We are grateful for the support of all the local people with an interest in dementia and particularly Carers, who helped create this strategy through their involvement in the Bedford Borough Dementia Action Group, Mental Health Partnership Board and Learning Disability Partnership Board.

They helped us understand what is really important to people with dementia and Carers in Bedford Borough.

We hope that you find the contents of this document both helpful and informative. This strategy will be updated annually to reflect changing needs, legislative and regulatory requirements and NHS Bedfordshire and Bedford Borough Council priorities. We are confident that by working together we can go from strength to strength, whatever challenges we face.

We are absolutely committed to providing the best possible services to people with dementia and working in partnership to provide safe, sound and supportive services based on an accurate assessment of the needs of our community.

Frank Toner
Executive Director for Adult Services
Bedford Borough Council

Angela McNab
Chief Executive
NHS Bedfordshire

Executive Summary

This is the first joint commissioning strategy for people with Dementia from Bedford Borough Council and NHS Bedfordshire. It complements the Borough's Sustainable Community Strategy, Healthier Bedford Borough Strategy, the Bedford Borough Adults Services Plan and the Joint Commissioning Strategies for different groups of vulnerable adults in Bedford Borough. It sets the strategic direction for the Borough Council, NHS Bedfordshire and partners to improve the health and well-being of people with dementia in the Borough.

The beginning of this strategy was the 2010 Bedford Borough Dementia Conference and the series of 6 stakeholder workshops which followed it. Those workshops included one specifically for service users and carers that was attended by over 50 delegates. The views of people with dementia and their carers will continue to drive our strategy and implementation plans in the context of national policy and guidance.

This joint strategy demonstrates our continuing commitment to enable people with dementia to have maximum independence, choice and control in how they live their lives.

Bedford Borough Council's vision for adult social care for people with dementia is:

> 'To provide excellent, safe, sound, supportive, cost effective and transformational services for people with dementia that promote independence, well being, and choice and are shaped by accurate assessment of community needs.'

The joint vision of Bedford Borough Council and NHS Bedfordshire for the positive transformation of dementia services is to create a system where

> 'All people with dementia have access to the care and support they need, where the public and professionals alike are well informed, where the fear and stigma associated with dementia have been allayed, and where the false beliefs that dementia is a normal part of ageing and nothing can be done have been corrected. In this system families affected by dementia would know where to go for help, what services to expect, and where the quality of care is high and equal wherever they might live.'

We will bring this vision closer by improving outcomes for people with dementia in line with the key principles underpinning the National Dementia Strategy (DOH, 2008) and Quality outcomes for living with dementia (DOH, 2010).

1. Improve public and professional awareness and understanding of dementia.
2. Earlier diagnosis and Intervention.

3. Improve quality of care in general hospitals.
4. Improve quality of care in care homes.
5. Reduce the use of anti-psychotic medication.
6. Improve community support services.

Most people with dementia are older people and the Bedford Borough Older People's Joint Commissioning Strategy addresses strategic domains for older people in general which also benefit older people with dementia. Similarly the Learning Disabilities Joint Commissioning Strategy addresses strategic domains for people with Learning Disabilities (who are especially vulnerable to early onset dementia) in general.

Local Strategic Priorities

These are the combined strategic priorities of commissioners and local people and carers who use dementia services, identified through our consultative processes. They are interconnected and woven through the whole strategy.

- Strong local partnerships between health and social care, housing, culture and leisure services, the third sector and private providers, to address dementia and its effects.
- Joined up services linked more explicitly to levels of need including re-ablement and specialist care teams and a better co-ordinated primary care network.
- A proactive approach to prevention with screening and early intervention to prevent crisis.
- Personalised support with more choice and control for people with dementia and their carers about how support is delivered, using personal budgets (with support as required) to make the most of all resources available.

These strategic priorities are driving our partnership approach to supporting people with dementia in the Borough and maintaining the best possible quality of life for them and their families.

Introduction

This is the first joint commissioning strategy for people with dementia from Bedford Borough Council and NHS Bedfordshire. It demonstrates our continuing commitment to supporting people with dementia to live their lives the way they want to. It will drive commissioning, planning and decision making processes for people with dementia in both Bedford Borough Council and NHS Bedfordshire.

The strategy will be delivered through annual action plans. We are committed to service user and carer engagement and during the life of the strategy we will continue to consult and invite feedback to ensure the annual action plans reflect any changes to local or national priorities.

Vision

Bedford Borough Council's vision for adult social care for people with dementia is:

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The joint vision of Bedford Borough Council and NHS Bedfordshire for the positive transformation of dementia services is to create a system where:

> 'All people with dementia have access to the care and support they need, where the public and professionals alike are well informed, where the fear and stigma associated with dementia have been allayed, and where the false beliefs that dementia is a normal part of ageing and nothing can be done have been corrected. In this system families affected by dementia would know where to go for help, what services to expect, and where the quality of care is high and equal wherever they might live. '

We will bring this vision closer by addressing the combined priorities of the National Dementia Strategy and 'Quality Outcomes for living with dementia'.

1. Improve public and professional awareness and understanding of dementia.
2. Earlier diagnosis and Intervention.
3. Improve quality of care in general hospitals.
4. Improve quality of care in care homes.
5. Reduce the use of anti-psychotic medication.
6. Improve community support services.

Change and Resources

Addressed by the emerging programmes of Personalisation and Quality, Innovation, Productivity and Prevention (QIPP), the current joint financial model of health and social care is not sustainable. Services need to be redesigned to provide better outcomes within the reduced resources available.

This requires a joined-up approach across all agencies with a role in the health and well being of the Borough. NHS Bedfordshire and Bedford Borough Council have the key leadership roles in driving this forward.

However, neither the Borough Council nor NHS Bedfordshire can improve health outcomes and local quality of life alone. The whole range of public, private and voluntary organisations also need to work more effectively together in order to tackle the challenges facing the Borough, joining-up services where it is sensible to do.

The individual also has a role. Where they can, individuals need to take responsibility for their own health and well-being. For this they need the availability of advice and information that will enable informed lifestyle choices.

Partnership in Bedford Borough

A wide-range of stakeholders are working together as the ***Bedford Borough Partnership*** to implement the Sustainable Community Strategy (2009-2021). This is organised around seven themes for delivery of a step change in people's quality of life[1].

One of the themes is 'A Healthy Borough', with the following goal:

> **"A Borough where everybody has access to high quality health and social care services when they need them and the help they need to lead healthy and independent lives"**

This goal is underpinned by six aims:

> **Aim 1:** Increase healthy life expectancy for all across the Borough.
>
> **Aim 2:** Reduce health inequalities by focussing effort on deprived areas and increasing opportunities for healthier lifestyles.
>
> **Aim 3:** Improve help and advice to vulnerable adults and people with mental health needs to enable them to continue living in their own homes and so maintain their independence for as long as possible
>
> **Aim 4:** Transform adult social care services by improving access, choice, control and advocacy for users and carers through the provision of self directed care.
>
> **Aim 5:** Improve dementia services by raising awareness and understanding and providing earlier diagnosis, intervention and higher quality of care

[1] More details about these goals and aims and the work of the Partnership, can be found at www.bedford.gov.uk[1]

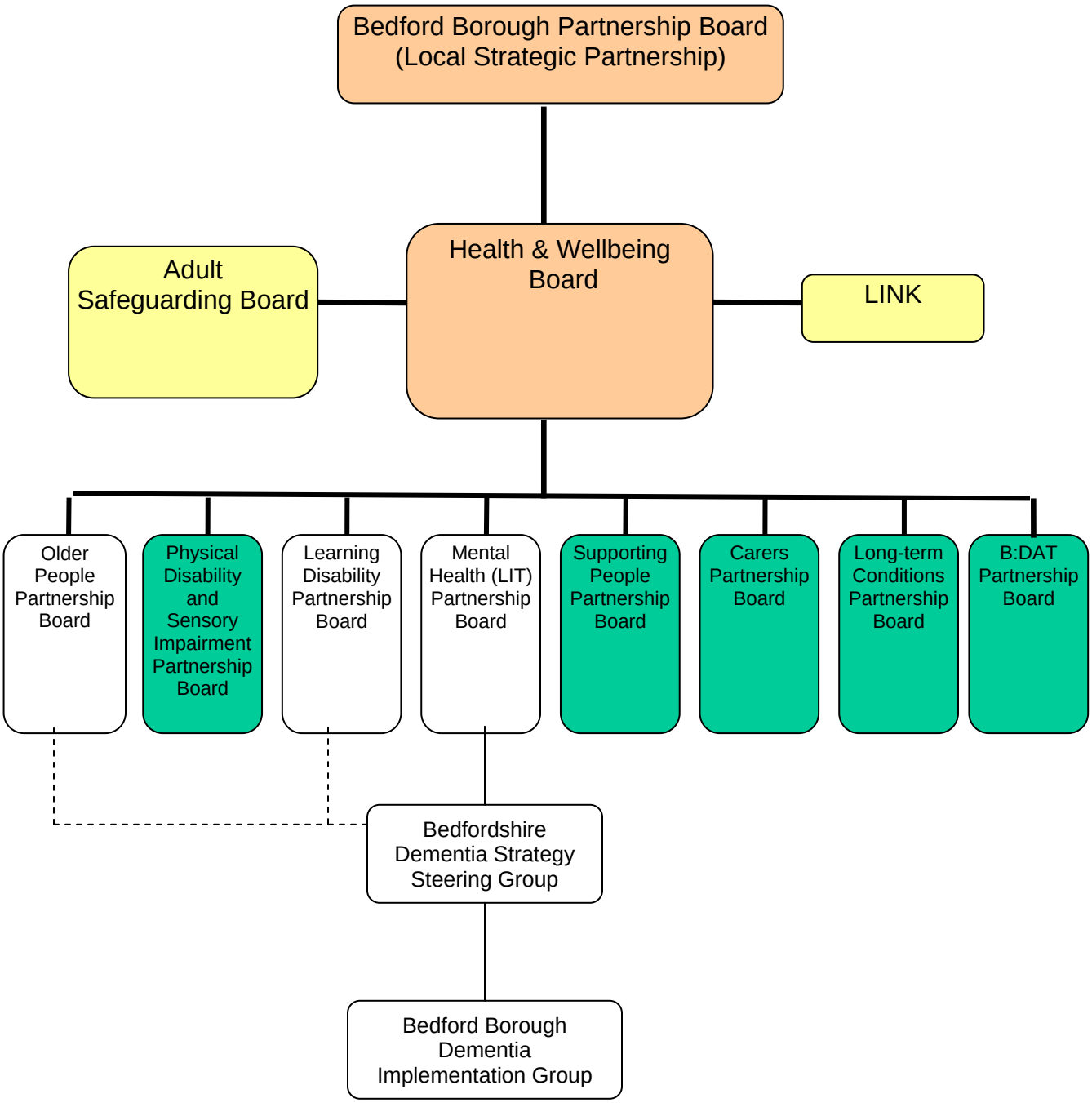
Aim 6: Improve the safeguarding and wellbeing of vulnerable adults and older people.

Implementing this strategy

The Mental Health Partnership Board is one of eight partnership boards in the Borough and it is responsible for the delivery of this strategy. Two partnership groups support the mental health partnership board in this objective. Firstly, the Bedfordshire Dementia Strategy Steering Group takes a whole county view (matching NHS Bedfordshire's role across the county). Secondly, the Bedford Borough Dementia Implementation Group focuses on the particular needs of Bedford Borough.

The Older People's Partnership Board is equally concerned to improve services for people with dementia and this is manifested through a dotted line relationship with the Dementia Strategy Steering Group.

The Bedford Borough Partnership Structure for Dementia.



All lines of communication in this diagram are two way.

Chapter 1

People with dementia in Bedford Borough

1.1 Bedford Borough covers an area of 476 sq. km and is home to approximately 156,000 people living in approximately 64,000 households. Just under two-thirds live in the urban areas of Bedford and Kempston, with almost 36% in the surrounding rural areas. Significant new residential development is planned in the Borough with the population forecast to rise to more than 172,000 by 2021.

1.2 On most social and economic measures the Borough is broadly similar to national averages. The ageing of the Borough's population is set to accelerate in future years with the 75-84 population forecast to rise by 31% and the 85+ population by 61%, from 2008 to 2021.

1.3 The major difference between the Borough and the national and regional profiles is in its ethnic makeup. Bedford has one of the most ethnically diverse communities in the region and is home to people from an estimated 60 countries, including large Italian and Asian populations. Black and ethnic minority (BME) groups formed 19% of the Borough's population in 2001 and the figure is estimated to be 22% now. Nearly two thirds of this BME population growth has arisen from migration from EU Accession countries, especially Poland and Lithuania.

1.4 The BME population is concentrated in the urban areas, 58% of Queens Park and 44% of Cauldwell residents are from BME groups.

1.5 Health in Bedford Borough is generally close to the England average. The average life expectancy is 80.2 years however life expectancy in the most deprived parts of Bedford town is estimated to be 11 years less than in the most affluent wards – for women the difference is almost 5 years. The urban areas of the borough also have a greater proportion of people suffering a limiting long term illness or disability.

1.6 Using 2007 deprivation measures, Bedford Borough is in the mid-range of English local authorities, but parts of Bedford and Kempston experience considerable deprivation where a higher proportion of people from minority ethnic groups live. Areas in Castle, Harpur and Cauldwell wards are amongst the 10% most deprived areas in England.

What is Dementia?

1.7 The term ‘dementia’ is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness. (Source - Living well with dementia: A National Dementia Strategy, DOH 2009)

1.8 Dementia can affect adults of any age, but is most common in older people. One in 14 people over 65 years have a form of dementia, rising to one in 6 people over 80 years. Dementia is a terminal condition but people often live with it for 7–12 years after diagnosis.

1.9 Carers of people with dementia are often old and frail themselves. They experience high levels of depression and physical illness and a diminished quality of life.

Key Findings for Dementia in Bedford Borough

1.10 The number of people with dementia is going to rise significantly with the aging population, estimated to increase by 16% between 2010 and 2016 in Bedford Borough. Today we estimate 1,670 people are living with dementia and 722 people develop dementia each year in Bedford Borough. Not everybody with dementia is properly diagnosed or known to services. In fact we estimate that only 37% of people with dementia in the Borough are known to service providers. See table 1 below for detailed breakdown.

Table 1: Estimated cases of dementia in Bedford Borough

Age	**Prevalence (total)**		**Incidence (new each year)**	
	Males	Females	Males	Females
65 - 69 yrs	51	36	34	30
70 - 74 yrs	84	74	59	24
75 - 79 yrs	112	176	61	56
80 - 85 yrs	163	279	60	97
85+	184	511	73	227
TOTAL	**594**	**1076**	**287**	**435**

Source: Dementia Executive toolkit using 2008 ONS mid year population estimates

1.11 Dementia is an illness that affects the person in different ways at different stages. Without diminishing the person behind the numbers, an estimate of numbers at each stage is a helpful indicator of where investment in services should occur. The Dementia Executive Toolkit proposes a seven stage model with 'levels' relating to the nature of support needed at that time. Level 1 indicates low levels of support required while level 7 is the highest.

1.12 Nationally it is estimated that 63.5% of people with severe dementia live in private households and 36.5% live in care homes, the proportion of those living in care homes rising with age. This allows us to estimate numbers in the borough who require support at each level (table 2 below).

1.13 Unsurprisingly, people are more likely to be known to services as their support levels increase.

Table 2: Estimated number of people requiring each level of care in Bedford Borough

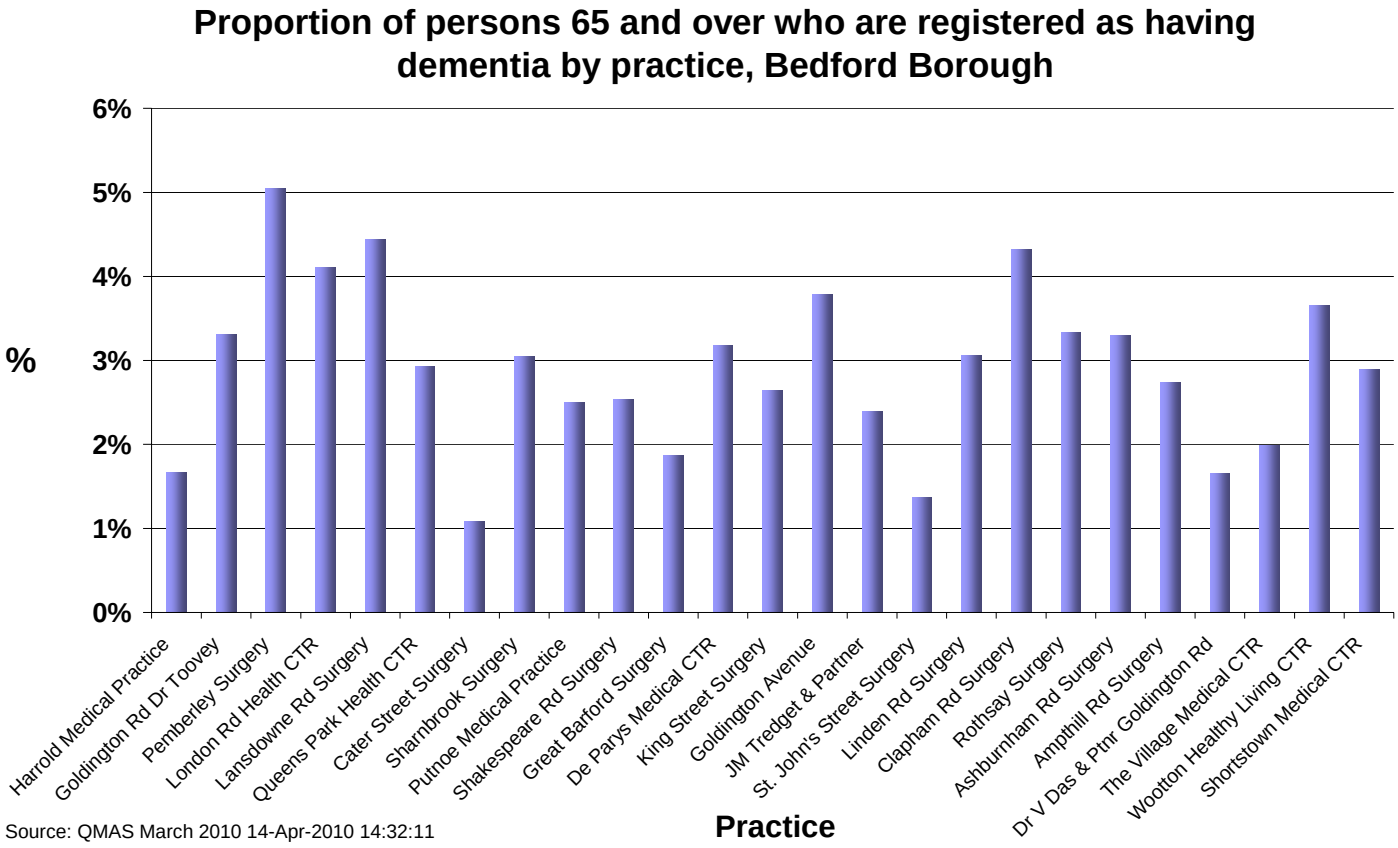
Known to services?	Males				Females			
	Level 1	Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4
Known	14	20	41	128	21	31	82	263
Unknown	129	81	95	85	187	126	191	175
Total	143	101	136	213	208	157	273	438

Source: Dementia Executive toolkit using 2008 ONS mid year population estimates

1.14 Dementia rises with age and affects men and women in all social and ethnic groups. On this basis the wards with the highest proportion of older people will be those with higher numbers of people with dementia. These include Brickhill and Carlton in particular, followed by Great Barford, Putnoe, Bromham, Clapham, Goldington, Harrold, Sharnbrook and Turvey.

1.15 General Practitioners hold registers of the number of people with dementia known to their practice (see figure 1 below). These are very likely to be an underestimate of actual numbers (because not everyone presents for diagnosis) but they give a starting point to build on.

Figure 1



1.16 The mean survival time following diagnosis is 4.5 years but this can be significantly improved by access to good quality early diagnosis.

1.17 The idea that dementia is significantly under-diagnosed in Bedford Borough is supported by comparing the estimate of 1,760 cases of dementia in Bedford Borough in 2008 with the Quality and Outcomes Framework (QOF) data for NHS Bedfordshire in 2008/09 which reported only 1,442 dementia cases on GP registers for *the combined* Bedford Borough and Central Bedfordshire council areas.

1.18 In 2007, the National Audit Office concluded that dementia services were not providing value for money. Despite significant spending, too few people are ever diagnosed or diagnosed early enough. Early interventions that are cost-effective, and which would improve quality of life, are not widely available. This results in spending at a later stage on more expensive services.

Dementia and Ethnicity

1.19 The Alzheimer's Society's analysis of dementia in the UK reported that 6.1% of all cases of dementia among BME groups are early onset compared with only 2.2% for the UK population as a whole. This may be due in part to the younger age profile of BME groups, which was not considered in the Society's report. Further research is needed to understand the significance of the finding in full.

Service Baseline and Gaps

1.20 A series of workshops were held in November/December 2009 to map services and gaps in provision within Bedford Borough against the key objectives of the national dementia strategy. The workshops included service users, carers and third sector representatives as active participants in the process of rating local performance. Each National Dementia Strategy objective was rated red, amber or green as follows:

Table 3: RAG Rating against national dementia strategy objectives

Objectives	RAG rating (December 2009)	Key Gaps	RAG rating (March 2011)
Raise awareness of dementia and encourage people to seek help	Red/Amber	Lack of awareness and information about early identification.	Amber
Good quality early diagnosis, support and treatment for people with dementia and their carers, explained in a sensitive way.	Amber	Access to memory clinic improved. Directory of services completed. More information and support to families once diagnosed.	Green
Good-quality information for people with dementia and their carers	Red/Amber	Lack of information if not attending memory clinic	Green
Easy access to care, support and advice after diagnosis	Red	Dementia support workers in post – ensure close working with memory clinics.	Amber
Develop structured peer support and learning networks	Amber		Amber
Improve community	Red	Inconsistent	Amber

personal support services for people living at home		quality of homecare. Access to support out of hours.	
Implement the New Deal for Carers	Red		Amber
Improve the quality of care for people with dementia in general hospitals	Red	Awareness of and care of dementia on general wards	Amber
Improve intermediate care for people with dementia	Red		Red
Consider how housing support, housing-related services, technology and telecare can help support people with dementia and their carers	Red	Access to extra care housing and assisted technology	Amber
Improve the quality of care for people with dementia in care homes	Red	Lack of training for staff, poor staffing, limited provision for younger people.	Amber
Improve end of life care for people with dementia	Red	Specialist end of life provision	Amber
An informed and effective workforce for people with dementia	Red	No recognised training or accreditation, lack of dementia champions	Amber
A joint commissioning strategy for dementia	Red	Detailed joint needs analysis to inform joint strategy	Green
Improve assessment and regulation of health and care services and of how systems are working	Red	Develop agreed competencies. Support residential and care homes with access to training and education	Amber
Provide a clear picture of research about the causes and possible future treatments of dementia	Red	Local co-ordination of research	Amber
Effective national and	Red	Establish a	Green

regional support for local services to help them develop and carry out the Strategy		countywide cross agency Dementia Steering group and engage with regional Dementia Lead regularly on progress	

Workforce Development:

1.21 During the stakeholder consultation workshops it was identified that a range of key professionals require additional training and workforce development to support an increased awareness of dementia care in the community. The key professionals identified are:

- GPs
- Social Workers
- Primary Care Practice Staff
- Nursing & Residential Care Home Staff
- Dementia Care Providers
- Emergency Services
- Acute Hospitals

1.22 To support this priority area NHS Bedfordshire has secured SWIFT funding from the Strategic Health Authority which is being used to target these priorities.

1) Dementia Awareness Training
2) Support to GP's on Dementia pathway
3) Prescribing in primary care

1.23 The changes required to deliver enhanced community based services will require an agreed workforce development strategy across the Social Care, Health, Private Provider and Third Sector workforce. Specific development programmes will be developed and commissioned in partnership with all key stakeholders.

DEMENTIA TRAINING LEVELS
(Informed by National Dementia Strategy)

Level	Target Group
1	Staff who work in a service frequently used by those who suffer from

	Dementia eg cleaners caretakers porters administrative staff etc
2a	Those who will work with people with dementia while carrying out some other specialist task eg Dentists, District Nurses, Occupational Therapists Ambulance drivers
2b	Those who will provide care type services to people who have dementia as a significant part of their job role eg Home, Residential, Day or Intermediate carers
2c	Those who have a role in assessing or allocating services and monitoring and reviewing personal care plans who, while not needing to provide specialist services themselves, will need to understand the range of services available and be able to make judgements of their quality and their appropriateness to individual clients/patients eg Social Workers, Community Care Practitioners
3a	Those who will provide specialist services to people with dementia and who need to develop technical or clinical expertise and knowledge to perform effectively eg staff in memory clinics
3b	Those who manage services for people with dementia who need to have a range of knowledge about managing person centred approaches, the service environment and the development of staff skills and knowledge so as to provide a high quality service

Chapter 2 General Context

Legal Basis

Local Authority's duties are set out in:

- **NHS & Community Care Act 1990 - Section 47(1)**
  The Local Authority has a duty to carry out an assessment of need for community care services where a person appears to be someone for whom community care services could be provided, AND a person's circumstances may need the provision of some community care services

- **Section 47(2)**
  If the Section 47(1) assessment identifies a person as being disabled, that person has additional rights as set out in Section 47(2) which requires local authorities to decide as to the services required under the following act:
- **Disabled Persons (Services and Consultation and Representation) Act 1986 - Section 4:**

We must decide whether the needs of a disabled person require any services provided under the following act:

- **Chronically Sick & Disabled Persons Act 1970 Section 2(1):** We must assess the needs of people who fall within the following act:

- **National Assistance Act 1948 - Section 29(1)** Which defines a 'disabled person'.

Safeguarding from abuse, maltreatment and neglect:

2.1 Safeguarding vulnerable adults from abuse, maltreatment and neglect is our number one priority. It is a vital part of the council's core responsibilities and also an essential function of health services.

2.2 Safeguarding is about more than just adult protection, it is about enabling vulnerable people to choose lifestyles and services to support their needs which ensures their independence, health, safety and wellbeing. Services need to deliver flexible support based on the principles of human rights, dignity and independence.

2.3 The definition of safeguarding used in this document is as defined in the national framework of standards for good practice and outcomes in Adult protection work (ADSS, 2005):

> *"all work which enables an adult who is or may be eligible for community care services to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect"*

2.4 Abuse comes in many forms – physical, sexual, psychological, financial, neglect or discriminatory abuse. Institutional abuse happens in services where poor care is delivered. These forms of abuse can be deliberate or the result of ignorance, lack of training, non compliance or management oversight.

2.5 Safeguarding across Bedfordshire is monitored by the multi-agency Safeguarding Adults Board. Membership includes service users and carers alongside key statutory, voluntary and private agencies.

2.6 The Safeguarding Adults Board sets priorities for improvement in policy, practice and performance. It continually strives to reduce the occurrence of abuse by taking a 'lessons learnt' approach to prevention. A detailed

improvement action plan is in place and regular monitoring reports will continue to be provided to the Board.

2.7 Strategic aims of the Safeguarding Board for 2011/12:

1. Prevention / raising awareness
2. Workforce development
3. Partnership working
4. Quality Assurance
5. Involving people in development of safeguarding services
6. Outcomes and improving people's experience

Strategic Framework:

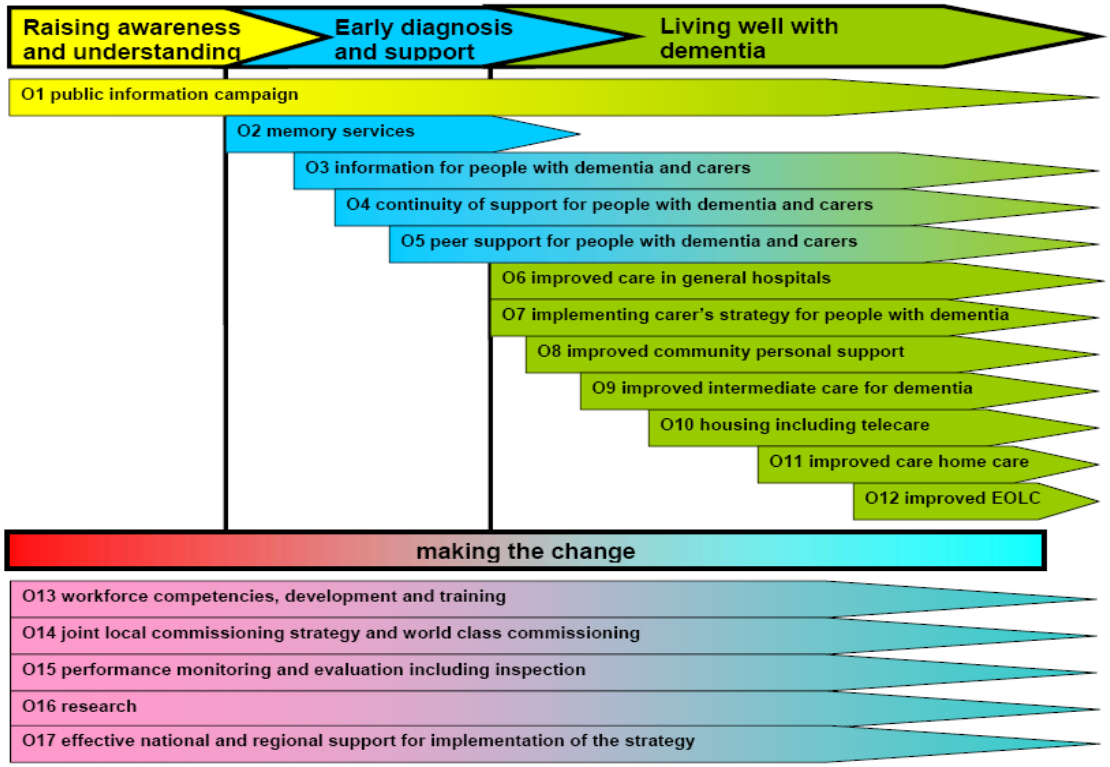
2.8 There is a wide range of government policy, guidance and legislation relevant to people with dementia.

- **Improving services and support for people with dementia, National Audit Office 2007**. In this report the National Audit Office suggested dementia care in the UK today was as poor as cancer care in the 1950's. The National Audit office found significant sums of money wasted on bad care and reported evidence of how better community services responses can shift care out of acute hospitals.

- **'Always a last resort' (All Party Parliamentary Group on Dementia, 2008)** found that many people with dementia are being inappropriately prescribed sedative antipsychotic drugs due to inadequate care and up to a quarter of people in general hospitals at any one time have dementia

- **Living well with dementia: DH A National Dementia Strategy February 2009.**
  This strategy sets out 17 key objectives under 3 main themes (with the 4th being delivery of the other 3). It builds on the on the National Service Framework for Older People, NICE guidelines on the management of dementia (2006) and the Alzheimer's Society Dementia UK report (2007).

  Priority Themes and Objectives of the National Dementia Strategy



Evidence is provided in the National Dementia Strategy that early support at home can decrease institutionalisation by 22% and even in complex cases, case management can reduce admission to care homes by 6%. It is estimated that the increased costs associated with early diagnosis combined with effective support and treatment would be offset within six years due to the subsequent delay, or complete avoidance, of being admitted into care homes.

There is limited evidence regarding the effectiveness of strategies to prevent dementia other than strategies to prevent cardiovascular disease generally i.e. adequate physical activity, healthy eating, avoiding obesity, controlling blood pressure and cholesterol.

<u>The 17 key objectives shown in the chart above have been integrated into the 28 projects and actions of this Bedford Borough Joint Commissioning Strategy.</u>

- **Nothing ventured, nothing gained: risk guidance for people with dementia, DOH November 2010.** 'Nothing ventured, nothing gained' encourages everyone involved in supporting people with dementia to take a proportionate, measured and enabling approach to risk. The National Dementia Strategy focuses on enabling people to live well with dementia. Personalisation is about positioning choice, control and independence with the individual and it is within this context that this guidance is applied.

2.9 Using evidence from research on risk and ideas about current best practice, this guidance aims to help people with dementia, family carers, and practitioners negotiate a shared approach to positive risk taking. It is based on identifying and balancing the positive benefits of taking risks against the risks of an adverse event occurring. In this way, the best results for the person with dementia will be achieved.

Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy, 2010.

This document presents the Department of Health's revised, outcomes focused implementation plan for *'Living Well with Dementia – A National Dementia Strategy'*. It is not prescriptive and recognises the pace of implementation will vary depending on local circumstances and the level and development of services within each NHS and Local Authority area.

The four priority areas identified are:

- **Good quality early diagnosis and intervention for all** - 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.

- **Improved quality of care in general hospitals** - 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.

- **Living well with dementia in care homes** - 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.

- **Reduced use of antipsychotic medication** - 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.

  <u>These four areas have been integrated into the 28 key projects and actions of this Bedford Borough Joint Commissioning Strategy.</u>

2.10 More generally the improvement of community personal support services is integral to and underpins each of the four priorities as it supports early

intervention; prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

Local Drivers

2.13 There are a number of local drivers influencing how we commission services for people with dementia.

2.14 Organisational Change. Following the 2010 Comprehensive Spending Review, Bedford Borough Council is bringing together many of its Adult Social Care, Housing and Community Services (such as culture and leisure). We will take this opportunity to further develop joint working for people with dementia in services that should complement each other well.

2.15 Service Re-design and Modernisation. Both the Council and NHS are redesigning services to deliver national policy and improved outcomes for service users. In many instances doing this in partnership will result in more effective use of resources and a more streamlined service for users.

2.16 The Supporting People programme provides housing related support services to help people with dementia live independently for longer. It is a key contributor to promoting and sustaining the independence people with dementia through the range of services it funds including extra care housing and other supported accommodation, community alarms, the housing improvement agency and floating support services.

Consultation

2.17 NHS Bedfordshire carried out six workshops (including one specifically for service users & carers in partnership with the Alzheimer's Society) which had had attendance by over 150 different stakeholders. The objective of the workshops was to self assess against the National Dementia Strategy 17 objectives, mapping current services and highlighting gaps in service provision. Stakeholders were then asked to highlight three priorities relevant to Bedford Borough. Those stakeholder priorities and views have been integrated into this strategy.

2.18 Clinical engagement has been managed through the clinical reference group. The membership of the clinical reference group includes practice base commissioning officers, GP leads and senior clinicians from South Essex Partnership Trust.

2.19 Clinical representation has also been a feature of the Dementia stakeholder workshops, the Dementia Strategy Group and Local Implementation Groups.

Equalities Impact Assessment

2.20 An initial EIA has highlighted that consideration needs to be given to the following patient groups: older people, people with learning difficulties and minority groups. Older people and people with learning difficulties may be disadvantaged if they are unable to retain information and services are not delivered in the home setting. Minority groups often come across language problems and differences in cultural practices. Providers will be asked to address these issues by using interpreting services, recruiting staff from minority backgrounds and adapting the assessment materials to older people and people with learning difficulties. Providers will also be asked to explore the possibility of offering services at home for housebound patients.

Current Services

Bedford Borough Council

Social Care Teams

2.21 Based at Borough Hall, these teams provide assessments of need and organise care packages for older people and people with disabilities. Packages may involve home care, personal care, respite, day care, nursing or residential care, or increasingly direct payments.

Hospital Social Work Team

2.22 Based in the hospital, 6 staff facilitate timely discharge by ensuring support is in place when the person returns home.

Re-ablement Service

2.23 This home care service provides up to 6 weeks assessment and re-ablement. The aim is to improve the person's skills so they can return to a normal life of independent living following trauma such as a fall or stroke. The team will also assess and identify appropriate on-going support if needed beyond their 6 weeks involvement. The concept of re-ablement in Dementia is care is fairly new and its applicability to dementia needs to be established.

Day Centres

2.24 The council runs 2 day centres in Goldington Road and Conduit Road. Conduit Road is attuned to the needs of people from Black and Minority Ethnic Groups. The service is limited to 'office hours'.

Occupational Therapy Team

2.25 This team staff assess people's needs (all ages) and make recommendations for equipment, minor works or major adaptations to homes to increase people's independence and enable them to live in their own home for as long as possible.

Care Standards Review and Welfare Rights Service

2.26 This team carry out annual reviews for all service users including people with dementia. They make sure people are getting their support delivered to a good standard and the person's assessment of need remains current.

2.27 The Welfare Rights Service is available to eligible children and adults from all user groups.

2.28 The council's Blue Badge parking permit and concessionary fares scheme is available for people with dementia to help maintain their independence.

NHS Dementia Services

2.29 NHS Bedfordshire commissions a range of dementia related services from the local specialist mental health provider (South Essex Partnership Trust, SEPT) and the third sector (Alzheimer's Society).

South Essex Partnership Trust (SEPT)

2.30 The NHS contract with SEPT applies across the whole of Bedfordshire and includes a range of services specifically for service users diagnosed with dementia and their carers:

- 2 x Memory Assessment Clinics – One based in Bedford and one in Central Beds localities
- Older People NHS inpatient beds across Bedfordshire 11 beds for Continuing Health Care based at Fountains Court, Bedford
- Older People Community Mental Health Teams in Bedfordshire in Bedford, Houghton Regis and Biggleswade.
- Acute Assessment Units. These offer short term multidisciplinary assessment, treatment and care. 15 beds at Fountains Court and 16 Beds (shared between Bedfordshire and Luton) at Townsend Court, Houghton Regis.

The Alzheimer's Society

2.31 The NHS Bedfordshire contract with The Alzheimer's Society is for the provision of:

- Support services with Alzheimer's Society providing advocacy
- Low level dementia support workers.

2.32 Bedford Borough Council also commissions the Alzheimer's Society for the provision of personal support and Carers Breaks.

Carers in Bedfordshire

2.33 NHS Bedfordshire commissions Carers in Bedfordshire, in partnership with Bedford Borough Council for the provision of:

- Support and advice
- Carer's café
- Carer's breaks.

General NHS Services

2.34 These are available to people with dementia in the Borough but are not Bedford Borough, or people with dementia specific. This list is not exhaustive, but summarises key services which are accessed more by people with dementia.

The Archer Unit

2.35 Provides short term in-patient rehabilitation and support, for patients who meet the service criteria, with the aim of optimising individual level of function. Patients receive a multi-disciplinary assessment and individualised treatment programme, with regular reviews and pro active discharge planning.

Community Nursing Service

2.36 The community nursing service works to provide evidence based nursing care. The key aim of the service is to avoid unnecessary hospital admissions by providing timely care for patients in their own homes and facilitating timely discharge from hospital.

Community Matrons

2.37 Currently, many patients who have complex long term conditions (LTC) and high intensity needs are admitted into an acute hospital on an unplanned basis. The management of these patients is generally reactive rather than proactive. The Community Matron Service offers a community based proactive response to complex Long Term Conditions and high intensity needs. Each

community matron will work within a population size of about 50,000 people, with a caseload of around 50 active Very High Intensity Users aged over 18 years of age.

NHS Rehabilitation and Enablement Service

2.38 A multi-disciplinary service consisting of Physiotherapists, Occupational Therapists, Assistant Practitioners, Rehabilitation Support Workers and Social Workers. The service uses a patient centred approach and works in partnership with patients, and where appropriate their relatives and/or carers, and other community teams or services involved. The service works to prevent unnecessary admission to acute hospital or nursing/residential care, and coordinate with acute and secondary care colleagues to facilitate timely discharge from hospital.

Rapid Intervention Team

2.39 The Rapid Intervention Team work to prevent avoidable hospital admissions, and support appropriate early discharge by providing rapid assessment of patients and access to short term community based nursing, therapy, personal care, medical support and some investigations.

Continence Service

2.40 The key aim of this service is to provide continence services to patients living in their own home or a care home and provide a high quality, cost effective and productive service that enables innovative practice and meets individual patient needs.

Private Care Sector

2.41 A number of private sector care homes provide residential and nursing care at points along the dementia pathway. Some staff teams in this sector have specialist skills to offer particularly when behaviour becomes difficult to manage.

A Dementia Pathway

2.42 Bedford Borough's social care, NHS and third sector services for dementia are not yet part of an integrated care pathway across the whole health and social care system. The result for some service users and carers is:

- difficulty in accessing services,
- confusion on what services are available,
- being caught between health and social services,
- at times service users and carers receiving no support at all.

2.43 An important outcome of this Dementia Strategy will be the development of a whole system, care pathway approach.

Chapter 3 Strategic Priorities for People with Dementia

3.1 Dementia can affect anybody regardless of any other disability or impairment so the priorities for people with dementia identified in this chapter should be read in conjunction with those identified for adult service users in the Borough's Joint Commissioning Strategies for Older People, Learning Disability, Mental Health, Physical Disability, Sensory Disability and Carers.

3.2 In line with our policy of inclusion and the use of universal services by all members of the community, where we say 'people' it includes 'people with dementia'.

3.3 The 6 strategic priorities identified here and the 28 key actions and projects in the following action plan combine to meet all the requirements of:

- The National Dementia Strategy, 2009 (17 objectives)
- Quality outcomes for people with dementia, 2010 (4 priority areas)
- The views of Bedford Borough Service Users and Carers expressed in consultation
- The views of Bedford Borough service providers (statutory, private and community sector) expressed in consultation.

Strategic Priority 1: Improve public and professional awareness and understanding of dementia

3.4 There are many false beliefs about dementia amongst the public and within the workforce including professional groups. Chief amongst these are that dementia is a 'normal' part of ageing and nothing can be done about it. Together with the stigma that dementia carries, these false beliefs stop people talking about signs and symptoms or presenting for support at an early stage.

3.5 Consultations in the Borough frequently raise the issue of improving information, advice and guidance. People with dementia, should have easy access to advice and information about health and wellbeing, local programmes and activities. Information should be available in large print, different languages and in a range of innovative formats.

3.6 When there is a lack of clear information available about care services, individuals can easily become disempowered. Providing improved information, that informs, assists and support people with dementia to access universal and specialist services and to enable them to increasingly participate in the life of their communities, is therefore a 'must do'. This applies not only to people with

eligible needs for support from statutory services but also to people who fund their own support privately.

3.7 At the commissioning level we know we need to increase knowledge about dementia across the health and social care system and work in better partnership. Getting the basic facts and figures right is an important part of the foundations for doing this. Various methods are available and following evaluation we will implement the most appropriate for Bedford Borough.

3.8 We will:

1. Provide good quality information for people diagnosed with dementia and carers. This will be available in a range of formats and languages to match the needs of the Borough population.
2. Complete a Dementia Commissioning Tool such as the Dementia Executive or the Norfolk model applied to Bedford Borough local facts and figures.
3. Maintain an up to date Dementia webpage with links to local and national information about dementia and services that can help people and their carers.
4. Design and implement a workforce development programme for all staff in health and social care, and related fields such as housing and leisure, setting out the facts about dementia, the benefits of early diagnosis and how people can be helped.
5. Participate and contribute to the proposed Dementia Community of Practice. An open network of people interested in dementia who commit to share ideas, good practice and evidence.

Strategic Priority 2: Earlier diagnosis and Intervention

3.9 Only a third at most of people with dementia receive any specialist health care assessment or diagnosis. When they do it is often at a time of crisis or late in the illness when choice is more limited and preventable harm has been done.

3.10 We know from work elsewhere in the country that early diagnosis and intervention is both possible and beneficial. Tackling the stigma of dementia is essential to encourage people to seek help at an early stage and present themselves for referral to specialist services.

3.11 Diagnostic services need to be able to cope with the number of people coming forward for assessment and their carers. Sensitivity to the needs of BME groups is essential as is tailoring services to meet the needs of people suffering early onset, including those with learning disabilities.

3.12 Referring services have an important role to refer intelligently, emphasise to people the benefits of early diagnosis and reassure them against the fear of diagnosis.

3.13 In all parts of the system, communication about the diagnosis to individuals and carers needs to be done well and with access to immediate care and support as required in each individual case.

3.14 We will:

1. Develop early diagnosis and intervention services that work for the whole population and have the capacity to see all new cases of dementia in the Borough. They will complement existing services and arrange relevant support and care immediately from diagnosis according to each individual's circumstances.

2. Enable easy access to care, support and advice on personalized terms, giving information and advice at a pace, in a format and level of details that suits each individuals needs.

3. Develop structured peer support and learning networks for service users, carers and professionals.

Strategic Priority 3: Improve quality of care in general hospitals

The Dignity Challenge

3.15 The Dignity Challenge is a national initiative to improve dignity in health and social care services. It applies across all care settings and provides a clear statement of what people should expect from a service that respects their dignity, backed up by a series of 'dignity tests'. These dignity tests will be implemented in Bedford Borough by providers, commissioners and people who use services to see how their local services are performing.

3.16 Dementia co-exists with other health problems that people generally experience. Many people admitted to hospital for investigations or treatment have dementia, although in most cases it will not have been diagnosed.

3.17 For those people the experience of hospital admission can be particularly disorientating and /or upsetting.

3.18 We will (focusing on Bedford Hospital):

1. Identify clinical leads for dementia with an advisory role to clinicians across the hospital.

2. Appoint an acute dementia liaison nurse to provide an early detection function in the wards, and liaise with different agencies on discharge, to ensure health outcomes, patient dignity and overall experience do not suffer through lack of insight by clinical teams.

3 Increase early recognition of people with cognitive impairment at time of admission to hospital and implement early treatment plans which acknowledge the complications dementia and delirium can bring.

4. Improve discharge planning to take account of dementia related factors.

5. Improve end of life care for people with dementia across all settings including hospital.

6. Implement a Bedford Hospital Dementia Group with clear terms of reference to improve health outcomes for dementia patients.

Strategic Priority 4: Improve quality of care in care homes.

3.19 The Dignity Challenge (see priority 3 above) applies equally to care homes. Two thirds of people in care homes are thought to have dementia. Levels of dependency are increasing and behavioural disturbances are increasingly prevalent. These are often associated with poor occupational programmes and inappropriately treated with antipsychotic drugs.

3.20 Care Homes need to register compliance with basic standards under the Care Quality Commission. We will work with care homes in Bedford Borough to achieve standards well beyond basic and to foster excellence in dementia care across the sector.

3.21 We will:

1. Ensure regular specialist input into care homes and workforce development of care home staff on the same terms as NHS and Social Care staff.
2. Review behavioural management guidance and ensure people with dementia are properly safeguarded form abuse, neglect and maltreatment.
3. Improve end of life care for people with dementia across all settings including care homes.
4. Improve assessment of local care home standards and support providers to meet their own development needs.

Strategic Priority 5: Reducing the use of anti-psychotic medication.

3.22 In 2008 the All Party Parliamentary Group on Dementia published their inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes ‘Always a last resort’.

3.23 The Group heard that over-prescribing is a significant problem in many care homes. Evidence on the use of antipsychotics included behavioural and psychological symptoms of dementia but also issues external to the persons condition such as:

- inadequate dementia care training for care home staff
- Inadequate leadership in care homes
- lack of support from external services (including inadequate monitoring and review of prescriptions)
- exclusion of family and friends from decision-making.

3.24 Serious concerns were raised about widespread inappropriate prescribing with unjustified exposure to harmful side effects including:

- excessive sedation,
- dizziness and unsteadiness leading to falls,
- body rigidity and tremors
- a doubling in the risk of mortality
- an increase the risk of stroke by up to three times.

3.25 The Group found that in specific circumstances the use of antipsychotic drugs can be appropriate but recommended that the use of antipsychotics should always be a last resort, used at times of severe distress or for critical need only.

3.26 Good practice guidelines have been produced by the National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (NICE-SCIE, 2007), that set out effective and appropriate guidance on pharmacological and non-pharmacological solutions. However, there is an urgent need to address the barriers to this good practice being implemented.

3.27 Quality Outcomes for People with Dementia (DOH, 2010) confirmed the priority given to the report and its findings (Anti-psychotics had not featured heavily in the original National Dementia Strategy) and reducing the use of antipsychotics in dementia is now a major workstream.

3.28 We will:

1. Ensure availability of ‘best practice’ dementia training for all care home staff and domiciliary care agencies.
2. Ensure care homes and domiciliary care agencies receive effective support from external services, including GPs, community psychiatric nurses, pharmacists, psychologists and psychiatrists, making regular, pro-active visits to care homes.
3. Include the use of antipsychotics for people with dementia in Mental Capacity Act training for care home staff.
4. Introduce protocols for the prescribing, monitoring and review of antipsychotic medication for people with dementia utilising pharmacists to check compliance through integrated pathways.
5. Undertake regular audit of antipsychotic drugs for people with dementia both through GPs and the care homes.

Strategic Priority 6: Improving community support services.

Personalisation

3.29 People with dementia must have greater choice and control over how their needs are met. Personalisation is the approach to make this happen across health and social care.

3.30 Everyone who is eligible for social support services will know what resource they have to meet their needs and be able to receive it as a direct payment. They will have the opportunity, with support if they want it, to direct how their personal budget is used to meet their needs. People who do not wish to receive the direct payment will still be supported to direct how they want their personal budget to support them.

3.31 NHS Bedfordshire, working in partnership with Bedford Borough Council, has been chosen as one of 20 sites to participate in a national in-depth pilot of Personal Health Budgets and the development of Personal Health Plans. People with dementia are not a target group for the pilot but it is expected the approach will spread to them in the next couple of years.

Advocacy

3.32 For many people with dementia, their first contact with a local authority service may be at a time of considerable stress or crisis. Advocacy services (where an advocate communicates and supports the service user's wishes) are invaluable at this time. Advocacy supports people in making their own decisions and ensures that their views were properly represented. Good advocacy services for older people with dementia are available locally commissioned via the voluntary and community sector.

3.33 The Mental Capacity Act introduced statutory independent advocacy for the first time in 2007. This independent advocacy, for people without capacity in certain clearly defined situations, is available in the Borough and needs to be well publicised to make sure it is used effectively.

Service Redesign

3.34 Most people with dementia live in the community, in their own homes and want to carry on living there as long as they can. The whole thrust of this strategy (and the related Joint Commissioning Strategies for Bedford Borough) is to support people in their own homes for as long as possible. For this to be achieved within available resources there will need to be a shift in how resources are deployed.

3.35 Inpatient beds are expensive and not the best way of delivering support to most people with dementia. They consume a disproportionate amount of resources and for as long as that continues will prevent the development of more appropriate community supports.

3.36 For this reason we need to redesign the dementia care pathway in Bedford Borough so that the highest number of people benefit to the greatest overall effect.

3.37 In our redesign we will ensure these key features are present.

- Increased choice in the type of support available and where it is provided
- Increased access to early detection so more people can make informed choices about their future support requirements
- Provide care at home for longer
- Provide more support to carers

3.38 Delivering these key features will have co-dependencies with our strategies for Personalisation, Carers, Re-ablement and Intermediate Care, Long Term Conditions, Avoiding Hospital Admissions, Telecare and Telehealth, Community Equipment, Housing Related Support including Extra Care, and End of Life.

3.39 Separate to, but connected with, this overall Dementia Strategy we have begun consultation on changes to inpatient beds and will continue with service redesign until we can demonstrate all resources are deployed to the best effect.

Extra Care Housing

3.40 The role of Extra Care housing in providing an effective alternative to residential care is a major part of our vision for the future. Extra Care housing can be owned, rented, part owned and part rented or leased by the person living there. Extra Care schemes come in a range of models and are often designed with on-site services like shops, library, health workers and social activities.

3.41 There are different models of Extra Care housing with various features to promote independent living and help people with dementia and their Carers to self-manage for longer. They can provide a base for intermediate care, rehabilitation services, day activities, keep fit, floating support for people with dementia living nearby who need help and support, and for community based teams of domiciliary care and health workers providing therapy and nursing.

3.42 A typical scheme could be 40-60 one or two bed-roomed apartments with a range of supported communal facilities including communal rooms, library, fitness suite, and restaurant all of which can, by arrangement, be accessed by the local community.

3.43 We will:

1. Commission the minimum necessary amount of in-patient hospital care for people with Dementia.
2. Develop specialist community mental health services to enable and support patients with dementia and their carers to live in their own homes and local communities for longer.

3. Implement and evaluate the roles of dementia support workers & dementia advisors to support the person with dementia and their carers through the patient journey.
4. Manage system redesign through the Mental Health QIPP (Quality, Innovation, Productivity and Prevention) Plan and in full consultation with all stakeholders.
5. Develop Extra Care Housing to reduce the number of people who need to be admitted to residential or nursing care homes.
6. Ensure implementation of Personalisation and all related Joint Commissioning Strategies is consistent with the goals of this Dementia Strategy.

Glossary

Advocacy	Support for people in making their own decisions and ensuring that their views are properly represented.
Commissioning	Planning, buying and reviewing of health and social care services.
Direct payments	Money paid to you by your local Council so that you can buy your own care and support.
Fuel poverty	This is a where a household cannot afford to keep adequately warm at a reasonable cost. A fuel poor household is one that needs to spend more than 10% of its income on fuel use in order to heat the home to an adequate standard of warmth.
Health Inequalities	Refer to gaps in the quality of health and health care across, racial, ethic, sexual orientation and socio-economic groups. Despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. These inequalities mean poorer health, reduced quality of life and early death for many people.
Joint Strategic Needs Assessment (JSNA)	NHS Bedfordshire and Bedford Borough Council working together to understand the future health, care and well-being needs of the community.
Mental Capacity Act	Provides important safeguards to protect families, carers, health and social care staff, and other people who act and make decisions on

	behalf of people who lack the mental capacity to make the decision for themselves.
PCT	Primary Care Trust, known locally as NHS Bedfordshire and responsible for the health of all people living in Bedfordshire. NHS Bedfordshire assess needs, plan services, fund care, deliver patient satisfaction and assure quality. Overall aim is to secure a real improvement in the health of local people.
Person centred planning	Putting you at the centre of planning for your life. Family, friends, professionals and services listening to and learning about what you want from your life and working together with you to make this happen.
Personal budget	This is the money you get from Bedford Borough Council, Adult Services.
Personal health budget	A personal health budget makes it clear to someone getting support from the NHS and the people who support them how much money is available for their care and lets them agree the best way to spend it.
Personal health plan	Designed to look at your health needs, make plans for better health, and tell people who need to know about your health.
Stakeholder	Any individual or organisation with an interest in health and social care services.
Strategy	Describes the services we have now and how we will develop these services over the coming years.

Joint Commissioning Strategy for people with dementia: Action Plan 2011 - 2014

Strategic Priority 1: Improve public and professional awareness and understanding of dementia.

Key Projects and Actions	Lead	Timescale
❖ Provide good quality information for people diagnosed with dementia and carers. This will be available in a range of formats and languages to match the needs of the Borough population.	Howard Shoebridge/Marek Zamborsky	April 2013
❖ Complete a Dementia Commissioning Tool such as the Dementia Executive or the Norfolk model applied to Bedford Borough local facts and figures.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Maintain an up to date Dementia webpage with links to local and national information about dementia and services that can help people and their carers.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Design and implement a workforce development programme for all staff in health and social care, and related fields such as housing and leisure, setting out the facts about dementia, the benefits of early diagnosis and how people can be helped.	Howard Shoebridge/Marek Zamborsky	April 2014
❖ Participate and contribute to the proposed Dementia Community of Practice. An open network of people interested in dementia who commit to share ideas, good practice and evidence.	Howard Shoebridge/Marek Zamborsky	April 2012

Strategic Priority 2: Earlier diagnosis and Intervention

Key Projects and Actions	Lead	Timescale
❖ Develop early diagnosis and intervention services that work for the whole population and have the capacity to see all new cases of dementia in the Borough. They will complement existing services and arrange relevant support and care immediately from diagnosis according to each individual's circumstances.	Howard Shoebridge/Marek Zamborsky	April 2013
❖ Enable easy access to care, support and advice on personalised terms, giving information and advice at a pace, in a format, language, and level of detail that suits each individuals needs.	Howard Shoebridge/Marek Zamborsky	April 2012

❖ Develop structured peer support and learning networks for service users, carers and professionals.	Howard Shoebridge/Marek Zamborsky	April 2012

Strategic Priority 3: Improve quality of care in general hospitals		
Key Projects and Actions	**Lead**	**Timescale**
❖ Identify clinical leads for dementia with an advisory role to clinicians across Bedford Hospital hospital,	Howard Shoebridge	April 2012
❖ Appoint an acute dementia liaison nurse to provide an early detection function in the wards, and liaise with different agencies on discharge, to ensure health outcomes, patient dignity and overall experience do not suffer through lack of insight by clinical teams.	Howard Shoebridge	April 2013
❖ Increase early recognition of people with cognitive impairment at time of admission to hospital and implement early treatment plans which acknowledge the complications dementia and delirium can bring.	Howard Shoebridge	April 2012
❖ Improve discharge planning to take account of dementia related factors.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Implement a Bedford Hospital Dementia Group with clear terms of reference to improve health outcomes for dementia patients	Howard Shoebridge	April 2012

Strategic Priority 4: Improve quality of care in care homes.		
Key Projects and Actions	**Lead**	**Timescale**
❖ Ensure regular specialist input into care homes and workforce development of care home staff on the same terms as NHS and Social Care staff.	Howard Shoebridge/Marek Zamborsky	April 2014
❖ Review behavioural management guidance and ensure people with dementia are properly safeguarded form abuse, neglect and maltreatment.	Howard Shoebridge/Marek Zamborsky	April 2012

❖ Improve end of life care for people with dementia across all settings including care homes.	Nicky Bannister/Alison Shepherd	April 2014
❖ Improve assessment of local care home standards and support providers to meet their own development needs.	Glynis Blackman	April 2013

Strategic Priority 5: Reducing the use of anti-psychotic medication.		
Key Projects and Actions	**Lead**	**Timescale**
❖ Ensure availability of 'best practice' dementia training for all care home staff and domiciliary care agencies.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Ensure care homes and domiciliary care agencies receive effective support from external services, including GPs, community psychiatric nurses, pharmacists, psychologists and psychiatrists, making regular, pro-active visits to care homes.	Howard Shoebridge/Marek Zamborsky	April 2013
❖ Include the use of antipsychotics for people with dementia, in Mental Capacity Act training for care home staff.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Introduce protocols for the prescribing, monitoring and review of antipsychotic medication for people with dementia utilising pharmacists to check compliance through integrated pathways.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Undertake regular audit of antipsychotic drugs for people with dementia both through GPs and the care homes.	Howard Shoebridge/Marek Zamborsky	April 2014

Strategic Priority 6: Improving community support services.		
Key Projects and Actions	**Lead**	**Timescale**
❖ Commission the minimum necessary amount of in-patient hospital care for people with Dementia.	Howard Shoebridge/Marek Zamborsky	April 2014

❖ Develop specialist community mental health services to enable and support patients with dementia and their carers to live in their own homes and local communities for longer.	Howard Shoebridge/Marek Zamborsky	April 2014
❖ Implement and evaluate the roles of dementia support workers & dementia advisors to support the person with dementia and their carers through the patient journey.	Howard Shoebridge/Marek Zamborsky	April 2012
❖ Manage system redesign through the Mental Health QIPP (Quality, Innovation, Productivity and Prevention) Plan and in full consultation with all stakeholders.	Howard Shoebridge/George Hunt	April 2014
❖ Develop Extra Care Housing to reduce the number of people who need to be admitted to residential or nursing care homes.	Marek Zamborsky/Andrew Kyle	April 2014
❖ Ensure implementation of Personalisation and all related Joint Commissioning Strategies is consistent with the goals of this Dementia Strategy.	Howard Shoebridge/George Hunt	April 2014