

JOINT DEMENTIA STRATEGY FOR HAVERING

2014-2017

Contents

Foreword

Draft for Councillor Kelly, as Chair of Health and Wellbeing Board and Dr M Sanomi, Clinical Director/Chair of Dementia Partnership Board

Introduction

Dementia remains a high national and local priority. Since the launch of the Government's National Dementia Strategy in 2009 (Living Well with Dementia: a National Dementia Strategy), numerous additional national policy guidelines and initiatives have followed, which include:

- Prime Minister's Challenge on Dementia
- The Mandate
- Joint Commissioning Framework: National Dementia Strategy
- Outcomes Frameworks for Public Health, Adult Social Care, and Health, all with specific reference to dementia
- Establishment of National Dementia Action Alliance
- The Care Bill
- Dementia: A state of the nation report on dementia care and support in England

It is clear, therefore, that dementia and dementia care, is a key issue at a national level and will remain so, given the overall changing and ageing population.

Why have a local strategy?

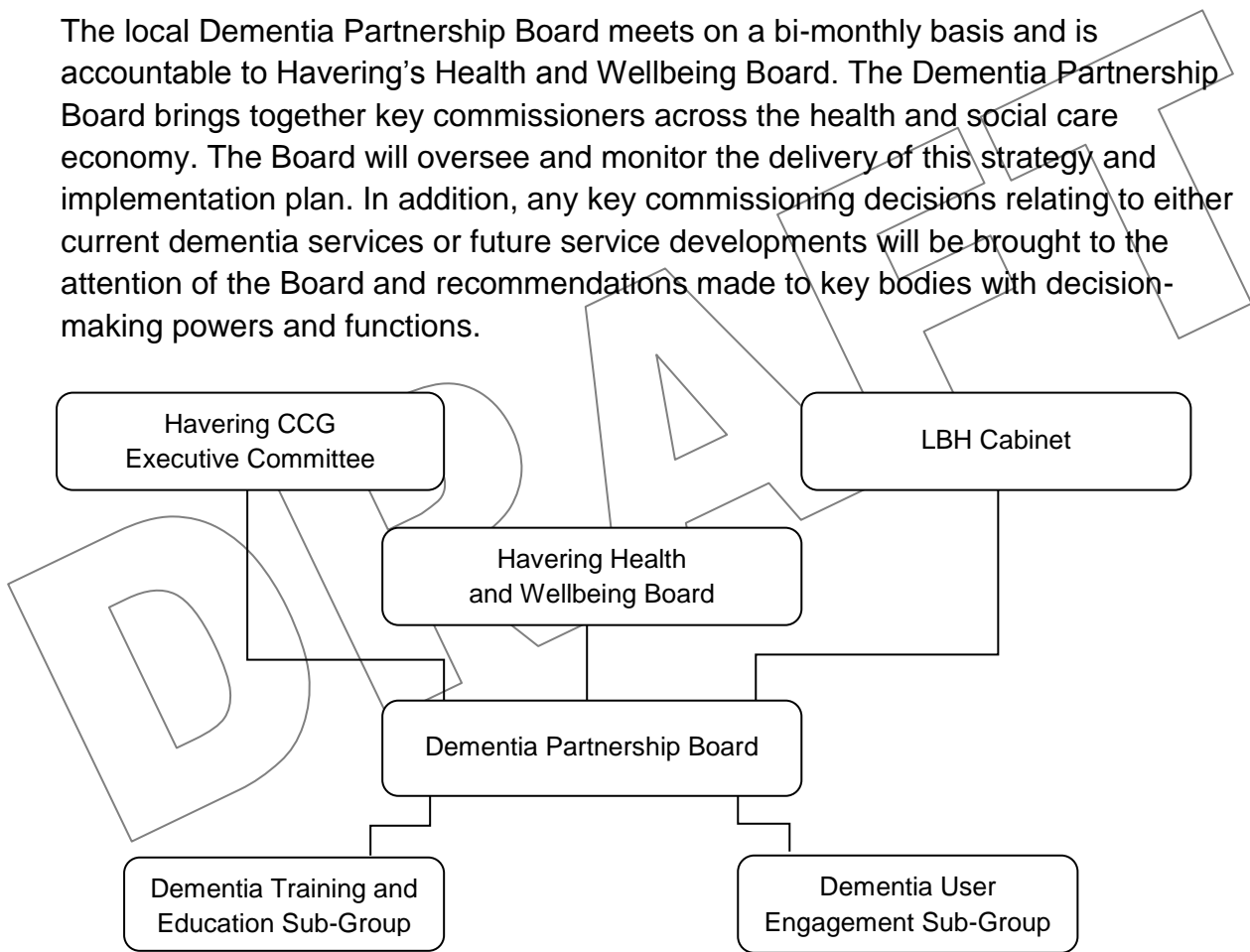
Within the National Dementia Strategy (DH, 2009), there is a requirement for all local areas to have a joint commissioning strategy for dementia. Despite the fact that the National Strategy ends in 2014, it is felt both important and timely to produce a joint strategy for Havering. It is vital that the public, stakeholders, commissioners and providers develop a shared vision of aspirations for the future with regard to dementia care and services.

Why now?

This is particularly crucial to Havering, given the ageing population and the associated anticipated rise in the numbers of people with dementia. It is also timely, in that both key commissioning organisations, that is, Havering CCG and LBH, are committed to work together, with dementia identified as a key shared priority area by the Health and Wellbeing Board. New and emerging structures within both organisations will provide an added impetus and focus for co-ordinated commissioning in the future

Governance

The local Dementia Partnership Board meets on a bi-monthly basis and is accountable to Havering’s Health and Wellbeing Board. The Dementia Partnership Board brings together key commissioners across the health and social care economy. The Board will oversee and monitor the delivery of this strategy and implementation plan. In addition, any key commissioning decisions relating to either current dementia services or future service developments will be brought to the attention of the Board and recommendations made to key bodies with decision-making powers and functions.



Vision for Dementia

Our vision is for all people with dementia (PWD) and their carers to continue to 'live life to the full' from diagnosis to end of life. To achieve this, we will create an environment where people:

- Are confident to seek help early
- Are supported to seek timely diagnosis
- Receive information on timely diagnosis – how to start process, reach appropriate services, carers support etc
- Receive information on pre dementia diagnosis – tell-tale signs – alerts of when to seek professional support
- Have access to a Directory of dementia and carer support services
- Are fully involved in involvement in service design and delivery
- Know where to go for help and what services to expect
- Have access to care and support that will help them and is of a high quality
- Know that the public and care staff are well informed
- Are treated with dignity and respect, in an environment which is not stigmatised.

This vision aligns with the Havering Health and Wellbeing Strategy 2012-14 (Theme A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing):

THEME A: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Objectives	Actions	Lead Partners
De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition	Establish a multi-agency Dementia Partnership Board to implement a Havering Dementia Strategy, in line with the national strategy	LBH (Adults and Health) & HCCG
	Mainstream the application of assistive technologies to support people with dementia as part of a programme of purposeful walking	LBH (Adults and Health)
Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations	Establish a system to monitor GP recorded prevalence and practice (any reporting unusually low prevalence will be encouraged to participate in training to aid diagnosis)	HCCG
	Share practice data to allow the CCG to monitor and take accountability for quality assurance, enabling prioritisation of dementia strategy work targeted to practices	HCCG
	Link care for people with dementia to deliver seamless care across all agencies	LBH (Adults and Health) & HCCG
Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers	Develop a new training strategy/pathway for professionals working with and supporting people with dementia	LBH (Adults and Health) & HCCG
	Support the National Dementia and Antipsychotic Prescribing Audit and Reduction Exercise	HCCG
	Review assessed and diagnosed cases, to assess success of early diagnosis and performance against QOF/DES targets.	HCCG
	Develop a training package for staff working with people with dementia, to include monitoring to record training sessions/people attending/feedback	HCCG
	Embed workforce development plans/appraisals programme into practices	HCCG
	Make available mentoring support system to key professionals, including clinical supervision	HCCG
Deliver more universal services and better quality of care for people with dementia	Investigate the potential for a dementia centre of excellence community facility and progress plans for this accordingly	LBH (Adults and Health)
	Commission a rapid response service for people with dementia and their carers to provide support and medical assistance during times of crisis or escalation of symptoms/deterioration	HCCG
	Incorporate end of life planning into services for people with dementia, to enable them to have a dignified and painless death, and adequate provision of support for their families	HCCG
	Develop education sessions for families about how to best support someone with dementia	LBH (Adults and Health) & HCCG

Implementation of this specific strategy for dementia will therefore support achievement of the priorities contained within this overall strategy.

In supporting the delivery of the vision, we will in addition seek every opportunity to test out the following statements, in terms of developing and providing excellent services for people with dementia, their families and carers. These statements sum up the outcomes we aspire to achieve through the overall delivery of this strategy.¹

- **I was diagnosed early**
- **I understand, so I make good decisions and provide for future decision making**
- **I get the treatment and support which are best for my dementia and my life**
- **Those around me and looking after me are well supported**
- **I am treated with dignity and respect**
- **I know what I can do to help myself and who else can help me**
- **I can enjoy life**
- **I feel part of a community and I'm inspired to give something back**
- **I am confident my end of life wishes will be respected**

What is dementia?

Dementia can be caused by a number of progressive disorders. It can affect memory, thinking, behaviour and the ability to perform everyday activities. Alzheimer's disease is the most common type of dementia. Other types include vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia mainly affects older people, although there is a growing awareness of cases starting before the age of 65. After 65, the likelihood of developing dementia roughly doubles every five years.² Dementia is progressive, which means the symptoms will gradually get worse and the condition is currently incurable. However, medicines and other interventions can lessen symptoms and people may live with their dementia for a further 7-12 years after diagnosis.

How will we achieve the vision?

There is still much to be done in achieving the vision for dementia care and support in Havering. We will do this by:

- Further awareness raising across the community, via the vehicle of sign up to the Dementia Action Alliance, which is the favoured model for the development of 'dementia friendly' communities and is effective in reducing stigma.
- Developing a cohesive and whole system approach to the commissioning of dementia services via partnership working with health, public health and social care.

¹ Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy (2010)

² LSE, King's College London, Alzheimer's Society. Dementia UK: The Full Report, 2007

- Commissioning and providing a range of high quality services which are accessible, integrated and in line with local levels of need, both now and in the future. This will need to take full account of the predicted increases in levels of need and demand on services.
- Developing robust data and reporting systems for services across the dementia pathway, in order to fully understand the impact of the predicted increase in demand and its impact on services.
- Ensuring that the workforce are trained to develop and acquire appropriate competencies and skills in dementia care and end of life care.
- Providing access to high quality services in the community, including advice, information, housing support and leisure activities which enables people with dementia and their carers to live well.
- Ensuring that people have access to early intervention support and advice, as well as timely access to assessment and diagnosis, in line with the Government's aspiration for achieving a diagnosis rate of at least 66% for each local area by 2015.
- Co-production of service specifications and delivery with providers / commissioners / service users.

What will we do?

- Adopt a preventative approach by encouraging people to improve their own health, and reduce the risk factors associated with some forms of dementia by, for example:
 - Living a healthy lifestyle can reduce the risk of heart disease and stroke and also reduce the risk of vascular dementia
- Review all currently commissioned services to ensure that the specifications for the services are fit for purpose.
- Seek to work together with people with dementia, carers and the provider sector to plan, not just for now, but for the future, and that key services are adequately resourced and provide value for money, in the context of the current and ongoing financial climate.
- Listen to service users and their carers, in order to understand their experience, and what gaps there are in the dementia pathway.
- Provide access to health and social care services at home in order to support carers, and to prevent unnecessary admissions to hospital or institutional care.
- Provide outcome focused services which refer to the impacts or end results of services on a person's life, aiming to achieve aspirations, goals and priorities identified by service users.

- Support carers to enable them to support their family member at home, via the provision of information, advice, respite care, training and peer support and appropriate services.
- Review the existing dementia pathway.
- Plan regular review and consultation with PWD and carers on the pathway and services.

Our principles: We believe we should:

- Listen to and engage with people with dementia and their carers.
- Enable and facilitate people to make informed choices and exercise choice and control over their lives.
- Involve people in decisions about their lives.
- Support people in accessing the right service at the right time.
- Involve, engage and support carers.
- Strive to tackle the stigma associated with dementia.
- Commission integrated services which are straightforward to navigate.
- PWD and carers should have appropriate and relevant support and be aware of how and where to access the support.

What do we know about levels of need in the community, both now and in the future?

Havering has the highest proportion of older people in London, and has experienced a 44% and 42% increase in the very elderly age groups (85-89 years and 90+ respectively) between 2001-2011, almost double that of London and England. Based on the projections from the Projecting Older People Population System (POPPI), It is estimated that around 3,275 people in Havering (aged 65+) have dementia. On the basis of this system, this is predicted to rise to 3,794 by 2020, with Havering having a greater number of residents with dementia than the majority of other London Boroughs.³

³ Havering JSNA 11/12: Dementia

Dementia Projection for Havering (65+ years)					
	2012	2014	2016	2018	2020
Males 65+ years	1,108	1,168	1,238	1,308	1,383
Females 65+ years	2,167	2,247	2,296	2,369	2,411
Persons 65+ years	3,275	3,415	3,534	3,677	3,794

Source: Projecting Older People Population Information System: Accessed 29/11/2013

More recent studies may provide a more precise estimate of current and future need, and this includes the Dementia Prevalence Calculator⁴, which estimates a slightly higher figure for 2012 of 3,419 people. At a national level, NHS England, with Alzheimers Society, is working to update and improve the data on dementia and its prevalence.

People under the age of 65 can also suffer from dementia, and nationally, there are approximately 18,500 people in the UK in this category. Younger people generally have rarer and/or more complex forms of dementia and are typically more likely to be physically fit, employed, have dependent children and a carer who works. Their needs are therefore very different from those of older people with a diagnosis of dementia. In Havering, it is estimated that 61 people are affected by early onset dementia (aged 30-64), and this is estimated to rise to 67 by 2020. It is acknowledged that there is a limited service via NELFT and Age Concern support for this client group, and this will require further consideration by commissioners in terms of any future developments.

People with a learning disability are more at risk of developing dementia compared with the general population, with a significantly increased risk for people with Down's syndrome and at an earlier age. It is estimated that approximately 8 people in Havering will have both dementia and Down's syndrome, with an age range of 45 to 65. This is expected to rise to 9 people by 2020.

Local dementia services need to work together with Learning Disabilities services to develop and agree the interface and pathways between them, in order that individuals with a learning disability receive a timely diagnosis and appropriate services to meet all of their needs.

⁴ Dementia Prevalence Calculator, 2013

Current Service Provision

Currently, in Havering, a diagnosis of dementia is made by a mental health professional, following referral by the GP to Havering Memory Service. However, we know that the diagnosis rate is low, and in 2011/12, the diagnosis rate, based on the population needs, was 39%. The Government have set an aspiration that the diagnosis rate for all areas should be at least two thirds of the anticipated population to develop dementia (66% plus) by 2015. Havering CCG commission NELFT to provide the Memory Service, in addition to a range of older people's mental health services, including Community Mental Health Teams (CMHT's), inpatient assessment and treatment services, and the Collaborative Care Team, based in the local acute hospital.

Social care support via a Direct Payment is commissioned by the London Borough of Havering, and is accessed if eligible following a community care assessment. This includes services such as assistive technology, social inclusion, equipment and adaptations domiciliary care, respite and residential care.

The voluntary and community sector also provide a range of jointly commissioned support via organisations such as Age Concern, Alzheimer's Society and Crossroads Care Havering.

The private and independent sector provide a number of residential and nursing home establishments within the Borough, a number of which have specialist dementia units, with experienced staff and adapted facilities.

An overview of the current service provision has been undertaken, in the context of the 17 objectives of the National Dementia Strategy. This was reported to the Health and Wellbeing Board in September, 2013, and next steps will be for the Dementia Partnership Board to undertake a more detailed and comprehensive review in order to inform priority setting.

It is therefore evident that, whilst improving diagnosis rates is important, this must be balanced with the ongoing commissioning of a range of mainstreamed community based services. Challenges will inevitably arise in terms of increases in demand, and this will need to be met by all services within the dementia pathway. There are also some notable gaps in current service provision, including access to reablement/ intermediate care services for people with dementia, and crisis support for both individuals and their carers. Consultation with users and carers, further analysis of the levels of need, research of best practise and the potential impact of developing such services will all need to be undertaken, prior to the development of any joint business cases to be taken forward by commissioners.

People with dementia

It is important that commissioners and providers work together to fully engage individuals who are concerned about memory loss, or who have a diagnosis of dementia in the planning of their care. They need to be make informed choices, following diagnosis, about practical issues and future planning, as well as sharing their likes/dislikes via tools such as the 'This is Me' document (Alzheimer's Society).⁵

The intention of this approach is to determine the individual's interests ,past experiences and strengths, in order for the services they then receive to be person-centred, and to enable people to enjoy life to the full for as long as is practically possible.

At a wider level, mechanisms for engagement such as facilitated focus groups can offer the opportunity for people with dementia to talk about their experiences of the care they receive. The Dementia Partnership Board has recently established a Dementia User Engagement sub-group, and it is envisaged that as key issues arise, workshops and forums will be held in order to engage with service users in order to be able to hear from them about their needs and experiences of services. It is also intended to utilise existing fora within which to engage with people who use services and their carers, for example via the Dementia Cafe, Carers groups and 'Have your Say' events, organised by Havering Healthwatch.

Capturing the evidence and key issues raised is important, and will be used to both inform this strategy, and to identify actions for the implementation plan. Key issues and comments captured and described so far include:

- A mixed experience of primary care, with some people and their carers describing their GP as 'excellent', whilst other raised concerns about access to GP appointments and the need for increased dementia awareness and training for GP's
- Admiral Nurses within the Memory Service were highly praised for the service they offer, alongside the support offered to carers from Adult Social Care
- Signage for mental health services is offputting for people attending the Memory Service
- Pathway to access the Dementia Advisory Service following attendance at the Memory Service is not easy
- Carers praised the number of support groups available, but there is a need for clearer information and advertising of these services
- Lack of information about what is available locally was a recurrent theme within the sessions undertaken

⁵ Alzheimer's Society 2010

Carers

At a national level, there are currently 555,000 people acting as primary carers for people with dementia. Carers for people with dementia save the nation nearly £7 billion every year.⁶ It is vital that particular attention is paid to the health, wellbeing and support needs of carers of people with dementia, in acknowledgement of:

- the vital role they play in supporting the person with dementia, and in supporting carers appropriately, enable the person to remain at home for longer
- the impact of caring for someone with dementia over time

In a recent report, this is supported by the following statement:

‘Unlike most other chronic conditions, people with dementia can develop needs for care in the early stages of the disease, and become increasingly reliant on caregivers throughout the course of the disease... given the character of the illness, people with dementia deserve and need special consideration in designing packages of care and support that meet their and their caregivers’ needs.’⁷

In addition, the Dementia Action Alliance has recently issued a Carers Call to Action, in which is set out the proposed shared vision for carers of people with dementia:

- have recognition of their unique experience
- are recognised as essential partners in care – valuing their knowledge and the support they provide to enable the person with dementia to live well
- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia
- have assessments and support to identify the on-going and changing needs to maintain their own health and well-being
- have confidence that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff for both the carer and the person for whom they care.

⁶ Prime Ministers Challenge on Dementia, March, 2012

⁷ World Alzheimer Report, 2013

In Havering, it is estimated that there are approximately 23,500 carers. In 2012/13, Havering undertook 1591 joint assessments and a further 233 separate carers assessments. Of those, this resulted in 448 services being offered and a further 1376 pieces of advice provided.⁸ There are a number of services providing support, advice, information and signposting for carers of people with dementia. These include the Dementia Advisory Service, provided by Age Concern. Respite services are available to individuals following an assessment of need, and the service can be provided in a range of settings, including the person's own home, utilising a personal budget. A total of 59 people over 65 with a diagnosis of dementia have accessed a personal budget to purchase care and support. (Data Source: RAP Return, Havering Adult Social Care 12/13). Data systems do not currently have the ability to provide information on the number of carers of people with dementia accessing community support, including respite services. Given the importance of helping 'carers care for longer', and understanding the outcomes achieved for those individuals, this will be addressed as an action point within the overall action plan for the strategy.

Further specific support for carers of people with dementia is provided by Crossroads, offering home based respite support for up to 80 carers. This service is funded until September, 2014, and will continue to be promoted in order to increase the uptake of this tailored carer support service.

Within this year's Direct Enhanced Service for Dementia, GP's are required to monitor and support the overall health and wellbeing of carers diagnosed with dementia. Given the impact of caring for someone with a dementia, local Improving Access to Psychological Services will also be required to provide assessment and interventions for both PWD and their carers.

The use of assistive technology is also being piloted, including the use of GPS technology. The evaluation of this pilot scheme indicates significant improvements in the quality of life for both service users and their carers, and further consideration is to be given to future use of such technologies.

Education and training support is critical for carers in their role, and a range of opportunities are provided by Age Concern and Alzheimers Society. The recently established Dementia Training and Education sub-group has given a stated commitment to encompass the training needs of carers in any planned future training provision.

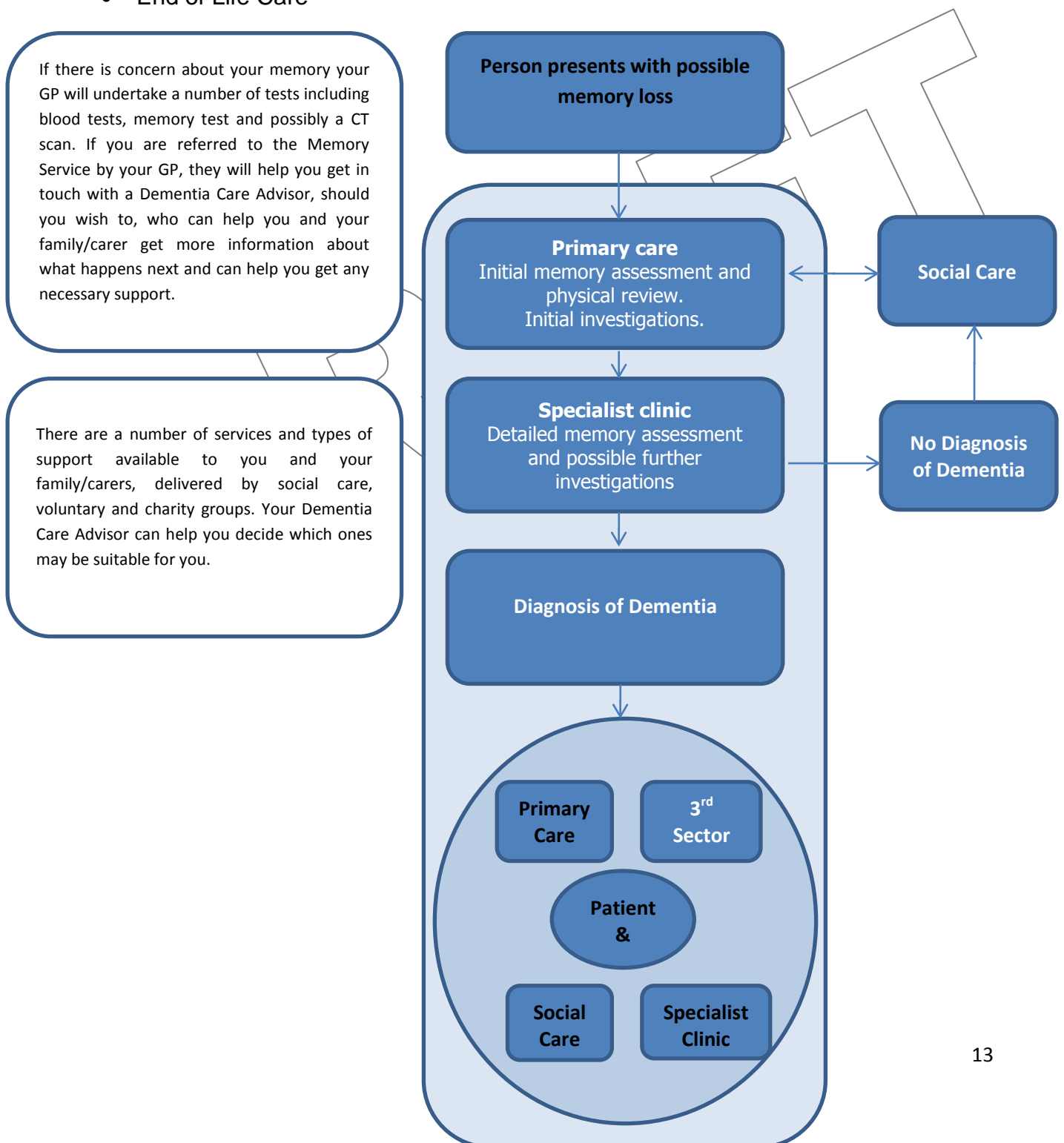
Finally, it is important that issues relating to carers of people with dementia are reflected in the wider Havering Carers Strategy.

⁸ LBH RAP Return 2012/13

Local Pathway

The Dementia Partnership Board has determined that the local dementia pathway should be straightforward and streamlined, and grouped under four key headings:

- Raising Awareness, Prevention and Identification
- Assessment and Diagnosis
- Living Well with Dementia
- End of Life Care



Raising Awareness, Prevention and Identification

Raising awareness of the needs of people with dementia in the wider community is important in tackling the stigma associated with dementia. Both the Alzheimers Society and Age Concern participate in a series of 'Memory Matters Roadshows' across the borough, in addition to providing Outreach sessions in a range of community settings, including local libraries schools, youth and faith groups.

It has recently been agreed to support and take forward the establishment of a Dementia Action Alliance in Havering, which will support the intention for Havering to become a 'dementia-friendly' borough. The National Dementia Action Alliance (DAA) is made up of over 480 organisations, and latterly saw the launch of the DAA for London. The process of signing up for membership commits organisations to improving their services for people with dementia, and to develop action plans as to how this is to be achieved. Typically, this would involve shops, businesses, housing, emergency and transport services, as well as key health and social partners.

It is therefore the intention locally to 'pump prime' this initiative, via the establishment of a Project Manager employed by Alzheimers Society, whose role will be to engage with the local community/organisations, and establish the DAA, with the aim of this being self sustaining at the end of one year. A full review and evaluation of the impact of this initiative will be undertaken.

Public Health England will be launching a national dementia campaign in May, 2014, which will support the Government's intention to demonstrate that it is possible to live well with dementia, in addition to having 1,000,000 Dementia Friends in place by March, 2015. At a local level, a number of Dementia Friends sessions will be provided to members of the public and staff within Dementia Awareness Week and beyond.

Finally, it is important to note that there need to be key links between this intention in relation to raising dementia awareness and the local Community Engagement Strategy.

Assessment and Diagnosis

The NHS Mandate (2013-2015) between the Government and the NHS Commissioning Board sets out the ambitions for the health service for the next two years. This includes the ambition for all areas to achieve a dementia diagnosis rate of 66% for their population by 2015. The benefits of a timely, high quality diagnosis of dementia for the person, their families and carers are compelling. Diagnosis is not an end in itself, but a gateway to making informed personal life choices.

As previously stated, the dementia diagnosis rate for Havering, based on data from 2011/12, was 39%.⁹ This data was obtained from the Quality and Outcomes Framework, which requires practices to establish a dementia register, for all patients who have been assessed and diagnosed. At that time, there were 1,332 people on the GP Dementia Register, and the forecast number of people was 3,419.¹⁰ Given the ageing population in Havering, and the predicted increase in the incidence of dementia, it is clearly a priority to address this via the local Strategy. An action plan is in place, and various steps are being taken, including:

- The CCG is working in partnership with Public Health colleagues, using the Dementia Prevalence Calculator and other forms of data, to establish the 'gap' between the anticipated prevalence and those people recorded on GP Dementia Registers.
- Visits to individual practices to support and encourage practice staff to examine practice lists and coding to identify people who need to be included in the GP Dementia Register.
- Proposal to pilot and evaluate iPad based assessment tool for dementia in a limited number of GP practices. This is likely to commence in the New Year, 2014 and is due for completion at the end of May, 2014.
- Provision of dementia training for GP's, practice nurses and GP reception staff to take place in New Year.
- Explore the future development of the Memory Service, and to provide additional activity in 2014/15
- Working with Health Analytics to develop information sharing processes about people across the system, to support the accurate identification of people with dementia.
- Raising awareness in public places.

GP Directed Enhanced Services for Dementia / Carers

The enhanced service has been designed by the NHS Commissioning Board to reward GP practices for undertaking a proactive approach to the timely assessment of patients who may be at risk of dementia.

This enhanced service is designed to support practices in contributing to these system wide improvements by supporting timely diagnosis, supporting individuals and their carers an integrated working with health and social care partners.

⁹ Quality and Outcomes Framework, 2011/12

¹⁰ Dementia Prevalence Calculator, 2013

The assessment for dementia offered to consenting at-risk patients shall be undertaken following initial questioning using the 6CIT (Cognitive Impairment Test) to establish whether there are any concerns about the attending patient's memory.

For the purposes of this enhanced service, 'at-risk' patients are:

- Patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
- Patients aged 40 or over with Down's syndrome
- Other patients aged 50 or over with learning disabilities
- Patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

The aims of this enhanced service in 2013/14 are to encourage GP practices to:

1. Identify patients at clinical risk of dementia
2. Offer an assessment to detect for possible signs of dementia in those at risk
3. Offer a referral for diagnosis where dementia is suspected; and,
4. Support the health and wellbeing of carers for patients diagnosed with dementia

In Havering, 48 out of 52 GP practices have signed up to the scheme. At a national level, it has been agreed that this scheme will continue for 2014/15.

Havering Memory Service

Havering Memory Service, provided by NELFT, forms a fundamental component of the dementia pathway. The service draws upon capacity and expertise from the Older Peoples Community Mental Health Teams, and has a clear pathway with the Collaborative Care Team, based at Queens Hospital. The service provides a focus for assessment, diagnosis and ongoing follow up for people with dementia. There is an agreed shared care protocol in place with primary care, so that people who are stable, can be referred back to their GP for ongoing monitoring.

As the awareness and importance of achieving a timely diagnosis is absorbed, it is anticipated that there will be an increase in the numbers of referrals to this service. The service will be required to report on this, as well as outcomes achieved for individuals, on a regular basis, in order that capacity and demand can be closely monitored. In October, the team caseload was 470 and the average waiting time for access was 5.67 weeks. There has been an average of 76 referrals to the service per month over the last year, the vast majority of which were appropriate.

It is the intention of Havering CCG to review the service, and to agree a revised model of service delivery for the future. This will include exploring the feasibility of the development of an integrated community based model in partnership with primary care and the voluntary sector, for the service to be provided on a sessional basis in a number of GP practices, and for the service to provide additional activity.

DRAFT

Living Well with Dementia

Dementia Advisory Service

The requirement for each local area to have a Dementia Advisory Service is set out in Objective Four of the National Dementia Strategy: 'Enabling easy access to care, support and advice following diagnosis'. The service also supports the delivery of other objectives contained within the National Strategy, including Objective One: which refers to 'Improving public and professional awareness and understanding of dementia and promoting timely diagnosis; Objective Three: which refers to 'Good quality information for those diagnosed with dementia and their carers and families and throughout their journey; and Objective Five: 'Development of peer support networks and learning networks.'

The local service provides a pre and post diagnosis support and advice service, which is person-centred. This includes the provision of information, awareness and advice, signposting to other services and support, as well as supporting the development of peer support, group sessions, specific carer support and advice, and outreach services in the community.

In 2012/13, the service was provided to 1,435 people, and the total number of people registered on their database was 2,680. The service collects both quantitative and qualitative information to assess how well the needs of both individuals and their carers are being met. In the most recent survey of carers, this demonstrated that they felt more supported, had more choice in their caring role and felt less stressed, following the involvement of the service. For example:

- 26% always felt worn out from caring – this reduced to 10% post intervention
- 16% of people felt they had the tools to always deal with difficult situations – this increased to 35% post intervention

Within the annual Service Evaluation undertaken for 2012/13, the following are a sample of comments:

'You have maintained contact with me and I know who to call on if I need help'

'I am more confident to deal with situations as I have a point of contact for help and advice'

'Very informative'

Havering CCG are currently undertaking a review of this service, and are seeking to build on the outcomes based approach with a revised and refreshed specification for the service. This will be in place for April, 2014.

Peer Support

In meeting the requirements of Objective Five of the National Dementia Strategy (Development of peer support networks and learning networks), Alzheimers Society are commissioned to provide this service. Following an evaluation of this service in 2012, it was reconfigured to provide and deliver three monthly Peer Support Groups across the Borough, in addition to three 'Singing for the Brain' programmes, taking place on a weekly basis. In 2012, there were 991 opportunities (attendances) for Havering residents accessing peer support, broken down by 846 opportunities via Singing for the Brain and 145 opportunities via Peer Support Groups.

Service users and carers who attend the Singing for Brain programmes are quoted as follows:

Person with dementia: 'I consider it is a lovely way to get together with friends more than a therapy'

Person with dementia: 'It's the best thing I go to, it makes my week, it has done us a power of good.'

Carer: '...does not want to leave the house, and does not engage with anything at home-today at the group she has been smiling, singing and even dancing'

Respite care

As previously stated, respite care for individuals and their carers is available via Adult Social Care, based on an assessment of need. However, data and information about the specific numbers of people with dementia and their carers who access this source of support is not currently available, and systems are not equipped to capture this currently. Given that there is a need to clearly understand how many people are accessing respite care, and in order to plan for meeting future need, it is critical that this issue is addressed.

With the introduction of Short and Long Term Support (SALT) replacing the Referrals, Assessment and Packages data collection within the Local Authority during 2014/15, there is an opportunity to improve dementia data collection by the Council. SALT will record a person's primary support reason (Cognitive/Memory problem) as well as identifying their health condition (Dementia). Data will be available from this system in 2015/16.

As also previously mentioned, a specific respite care service for people with more complex levels of dementia need is also in place, and funded until September, 2014. It will be necessary to review the impact of this service, in conjunction with the generic access to respite care, in order to determine how best to meet local levels of identified need.

Domiciliary Care

The Council's Care Home and Home Care Contracts acknowledge the growing prevalence of dementia need amongst the residents of Havering. To ensure safe and appropriate dementia care provision, the Contracts require that members of Provider staff receive appropriate training in dementia care and awareness, and that their staff are kept up to date with details of relevant services available in the Borough to those with dementia. Providers need to be able to demonstrate that they are able to meet the presenting needs of their residents and/or those receiving care and support in the community.

Extra Care Housing

Extra care housing is an important resource in helping people to maintain their independence and to age sociably by actively promoting social inclusion. There are currently three extra care housing schemes operating in partnership with the Council, made up of a total of 161 socially rented units and 25 shared ownership units. At these schemes, staff are trained to be familiar with the signs and management of dementia and aware of the support available in Havering to people who have the condition.

The ethos of extra care housing is based on a 'person centred' approach where carers get to know each service user. For all prospective and current residents a risk assessment is undertaken which can identify a range of conditions, including dementia. Through carefully developed care plans, involving family and friends, a personal package of support is delivered. All schemes promote activities aimed at engaging people and tackling isolation, acknowledged contributors to dementia. Extra care housing is suited to people in the early stages of dementia who are able to develop familiarity with the scheme. As more is learnt about dementia, and the level of local need increases, the services will evolve so that all the schemes are in a position to adopt best practice and work with the voluntary and statutory services to redesign their approach. This is in line with the local strategy for Extra Care.¹¹

Adult Social Care

Based on data routinely captured by Adult Social Care (Data Source: RAP Return 2012/13), a total of 466 people with dementia accessed services. This figure includes four people under the age of 65. Of the 462 people aged over 65, 288 were in the community, 161 were in residential care and 69 in nursing home care. 179 people were in receipt of home care, 82 people were in receipt of day care, 126 people were in receipt of equipment and adaptations, and has been previously stated 59 individuals were in receipt of a direct payment.

¹¹ Havering Extra Care Strategy (2011-2021)

Residential and Nursing Home Care

Objective 11 of the National Dementia Strategy sets out the standards and requirements for living well with dementia in care homes. In Havering, there are a total of 17 Nursing Homes and 22 Residential homes with a total capacity of 1523 beds. As at October, 2013, there were 82 vacancies across the sector for people with dementia. At the point of writing, there is no immediate intention to commission any additional beds in care homes. The strategy firmly commits partners to supporting people with dementia to remain in the community for as long as possible, via the provision of more and improved community services in the future.

The Dementia Liaison Officer (DLO) postholder, employed by LBH, has provided Dementia Champions training to care home managers, and has established a Dementia Champions Forum which meets on a regular basis. The DLO has also provided a range of training to care home staff, including training in End of Life Care, Mental Health Awareness and Dementia Awareness. This is now being made available to domiciliary care staff. The overall aim of establishment of this post has been to drive up the quality of care in care homes, in partnership with providers.

In 2011, the Government launched a Call to Action, with the aim of reducing anti-psychotic prescribing for people with dementia. At the time, it was estimated that over 20% of people with dementia, around 180,000 people, were prescribed this medication. The use of antipsychotic medication has been evidenced to increase people's symptoms of dementia and cause dizziness and unsteadiness, leading to increased risks of falls and injury. In a Pan-London Audit undertaken in 2012, 217 of 1221 people with dementia were prescribed antipsychotic medication in Havering, equating to 17.8% of the known population. There was a 2.7% reduction in this number following completion of the audit, and it remains a priority area, both in the community and in care homes. It is the intention of the Department of Health to re-run the national audit to monitor the level of prescribing and regional variation. The audit results are expected to be available in Spring, 2014.

Creating dementia friendly environments within care homes is evidenced to improve the overall wellbeing of residents¹², and a number of local providers have made recent improvements. Four local homes were successful in a bid for DH Funding to improve their outdoor/garden environments, and residents and staff were engaged in the design and planning of these projects. All providers should be proactively encouraged to work towards establishing dementia friendly environments within their homes.

¹² University of Stirling Standards (Dementia Services Development Centre)

Following the establishment of Havering CCG, a number of GP practices are now aligned to specific care homes in order to provide a primary care service to residents and to also provide continuity of care, whilst establishing good communication links with care home staff.

Admissions to acute hospital for people with dementia

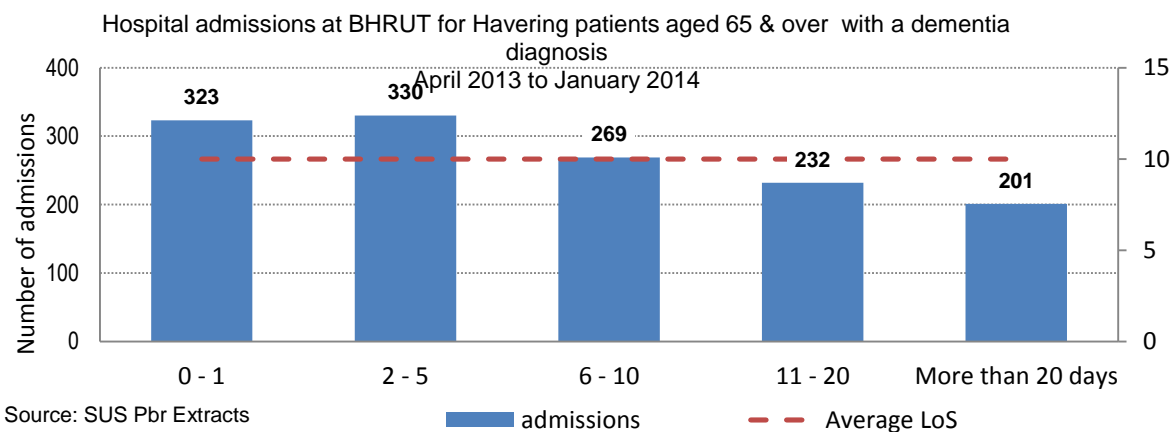
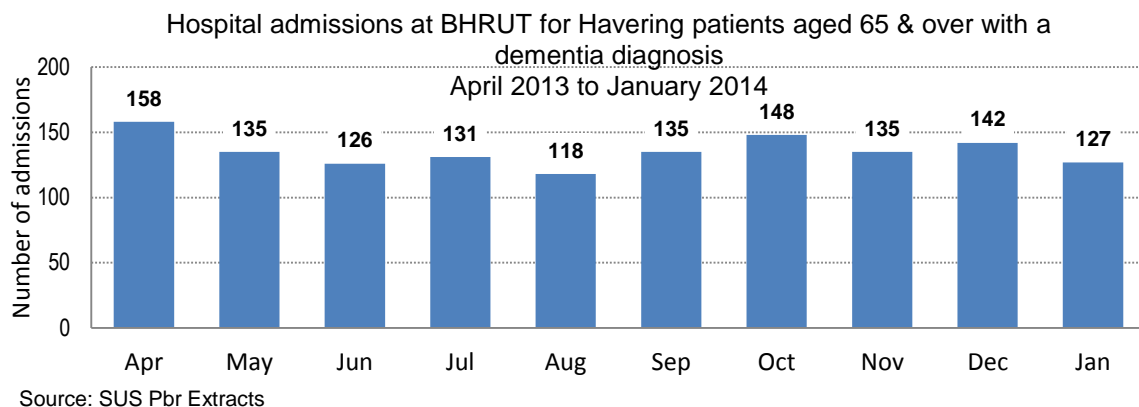
Aiming to reduce the number of all unnecessary admissions to hospital is a key priority for health and social care partners. This is particularly pertinent for people with dementia, for whom the experience of hospital admission can be particularly distressing and unsettling. However, there are times when this clearly cannot be avoided, and providers of acute care in general hospitals need to address the needs of their patients with a diagnosis of dementia in a responsive and appropriate way. Havering CCG is working closely with the hospital to fully understand and improve the experience of admission to hospital for people with dementia.

As it is estimated that up to 25% of older people¹³, being treated and cared for in Older Peoples Wards, have some form of dementia, and their lengths of stay in hospital are longer, this is clearly a priority. Improving the quality of care for people with dementia in general hospitals is reflected in Objective 8 of the National Dementia Strategy. In response to this, BHRUT have:

- developed an internal dementia pathway within the hospital, in partnership with colleagues from NELFT
- have established a named Clinical Lead for Dementia within the hospital
- established the use of the Butterfly Scheme on appropriate wards to help staff identify those with dementia
- recruited two Dementia Nurse Specialist Posts
- trained 750 staff in dementia awareness and dementia care, including domestic and reception staff.

Admissions of people with dementia to acute hospital and their length of stay are detailed below, covering the period April, 2013 to January, 2014.

¹³ Counting the Cost: Caring for people with dementia in hospital wards' (Alzheimers Society, 2009)



Additional information about attendance at hospital by people with dementia emerged in a recent survey of patients, aged 75 and over, attending A&E at Queens Hospital (September, 2013). 293 patients from a consecutive cohort of 500 presentations to the Accident and Emergency Department at Queens Hospital participated in an interview programme. The aim of the programme was to identify the patient's journey to hospital and to identify alternative interventions which might have provided an alternative to hospital attendance. A few of the summary key findings included:

- 25% presentations were as a result of a fall
- Over 50% attendances were called by a carer
- 53 people were recorded as having dementia (18%), and 12 people were in a confused state (4%)

The Collaborative Care Team (psychiatric liaison for older people) is provided by NELFT and located at Queens Hospital, The team works with people aged 65 and over with mental health difficulties or people of any age with dementia.

The Collaborative Care Team provides responsive and comprehensive mental health assessments of older people with mental health problems, including dementia and early onset dementia in Queen's Hospital, Romford. They work collaboratively with health care professionals in the general hospital setting to identify the mental health needs of older people and promote patient-centred care.

They also work to prevent and reduce lengthy admissions in acute hospital for older people with mental health difficulties and people with dementia by working closely with A&E, medical assessment units and in-patient wards at Queens Hospital, Romford. They provide advice, education and support to healthcare professionals, older people and their carers in the general hospital setting.

The team maintains close links with the Memory service and Older People's Mental Health Teams and Older People's Home Treatment teams to ensure continuation of care for service users and their families.

The Collaborative Care team is made up of psychiatric liaison nurses, consultant psychiatrists and an occupational therapy manager.

CQUIN in Acute Hospitals

The Dementia Commissioning for Quality and Innovation (CQUIN) payment is a financial incentive in acute hospitals, which was introduced in April, 2012. It is for all patients over the age of 75 admitted to hospital for more than three days and involves finding people who may have dementia, assessing their risk and referring them for further investigations. As part of the CQUIN for 2013/14, hospitals must confirm they have a named lead clinician for dementia and an appropriate staff training programme. They must also undertake a monthly audit of carers of people with dementia, including how supported carers feel and the findings must be reported to the Trust Board at least twice a year. The outputs and outcomes from the Dementia CQUIN are reported to and monitored by the CCG on a regular basis. It is likely that this scheme will be extended into next year, that is 2014/15.

At a local level, the table below sets out the current position with regard to BHRUT performance in relation to the national Dementia CQUIN:

		Q1 target	Q1 actual	Q2 target	Q2 actual	Q3 Target	Oct 13	Nov 13	Dec 13	Q3 actual
3.1	Dementia - Find, Assess & Refer	Find 90% Assess 90% Refer 90%	F 90% A 53% R 23%	Find 90% Assess 90% Refer 90%	Find 89% Assess 84% Refer 65%	Find 90% Assess 90% Refer 90%	Find 79% 763/945 patients Assess 90% 28/31 patients Refer 90% 28/31 patients	88% Find 753/859 patients Assess 78% 25/32 patients Refer 31% 10/32 patients	Find patients Assess patients Refer patients	TBC
3.2	Dementia - Clinical Leadership									n/a
3.3	Dementia - Supporting Carers	Adequately supported	64% adequately supported 70% onward referral	Adequately supported	95% adequately supported 96% onward referral 59% response rate	Adequately supported	98% adequately supported 92% onward referral 68% response rate	100% adequately supported 83% onward referral 68% response rate	TBC	TBC

Reablement/Intermediate Care

Objective 8 of the National Dementia Strategy sets out the requirements for improving intermediate care for people with dementia. Locally, this type of provision is referred to as 'reablement' services, and includes services to support people nearing a crisis and to support them on discharge from hospital.

There are a number of reablement services in Havering which can be accessed for people with dementia and their carers, but it is recognised that the services are not Dementia specialist and thus impacts on the quality of delivery and overall intention to avoid and prevent acute hospital admissions. This needs to be considered and addressed in the light of the overall intention to avoid acute hospital admissions and to facilitate earlier discharge.

End of Life Care

Objective 12 of the National Dementia Strategy sets out the intention to improve end of life care for people with dementia. Every person with dementia should receive excellent care at the end of their life and be treated with dignity and respect. Forward planning and the use of Advance Directives should be embedded within practice, with the intention of giving people more choice and control over their care, an improved experience and their needs and wishes respected. It is therefore the intention to establish a baseline understanding of the numbers of people with dementia who have such a plan in place.

In Havering, a local End of Life Steering Group has recently been established, and will seek to identify and address the needs of people with dementia and their carers within the work of the group. For people with dementia and their carers, information and support about the use of Advance Directives are key to planning for the future, within the context of an overall care plan.

In 2012, Gold Standard Framework Training was provided for 21 GP practices. More recently, this specific training has been offered at no cost to care home staff, domiciliary care providers and GP's via the Local Steering Group. A new programme of training, delivered jointly by GSF and St. Francis Hospice, will start in January 2014.

Training and Education

Objective 13 of the National Dementia Strategy sets out the intention to have an improved and effective workplace across all services in place. This is further supported by the NICE Clinical Guideline 42, which states:

'Health and social care managers should ensure that all staff working with older people in health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities'.¹⁴

Locally, the Dementia Partnership Board has recently established a Dementia Training and Education Sub-group. The group is currently in the process of agreeing a set of underpinning principles, will act as the co-ordinating and focal point for the monitoring of all dementia training in the borough, and is currently in the process of undertaking a mapping exercise, which captures all of the training currently being planned and/or provided across all sectors.

¹⁴ NICE Clinical Guideline 42 Para. 1.1.9.1 (Revised October, 2012)

Delivering the Dementia Strategy

On the basis of this strategy, an implementation plan has been developed and is attached at Appendix 3. The delivery of the implementation plan will be monitored and overseen by the local Dementia Partnership Board.

Financial Resources

Dementia costs the UK economy £19 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

The Dementia UK report (Dementia UK: Report to the Alzheimers Society, 2007) calculated the overall costs of dementia in the UK as £17.03 billion per annum, an average of £25,472 per person. This included care provided by formal agencies, as well as the value of unpaid care provided by carers, and included loss of earnings. The estimated cost of unpaid care amounted to £6 billion.

It is important to note that dementia and dementia care costs the health and social economy more than those for cancer, heart disease and stroke combined.

Funding for local dementia services is provided from two major statutory services:

- London Borough of Havering
- Havering CCG

Increasingly, both of the organisations are seeking to jointly commission appropriate services in a more integrated approach, and access to funding via S256 funding, more recently referred to as the Better Care Fund, has provided a vehicle and springboard to enable this to be tested out.

This strategy will inform and support the achievement of the goals of the Better Care Fund and vice versa. Generally, the Better Care Fund will look to integrate services to the benefit of users. In practice, in Havering, this will look to improve diagnosis rates and provide appropriate solutions quicker, meaning better treatment and response for people with dementia and their carers. Improved focus on carers and the services to support them will also be an aspect of Better Care Fund development and will impinge directly on carers of people with dementia. In regard to services available the fund will support the development of integrated commissioning which will, again, mean better and more responsive services designed against local need.

Going forward, commissioners will need to take informed decisions and secure appropriate levels of funding about which services are most effective, have most impact, and should therefore be commissioned on a longer term basis. This will mean having access to:

- Views and experiences of people accessing those services
- Outcomes achieved for the individuals and for the service
- Information on the quality of the services provided

and a full understanding of the impact of the service on other services, for example, hospital admissions.

Current levels of local levels of investment per annum in dementia services are as follows:

Havering CCG

Memory Service	£900,000
Older Peoples CMHT'S	£700,000
Older Peoples Mental Health Inpatient Services	£1,144,105 ¹⁵
Collaborative Care Team	£1,200,000
Dementia Advisory Service	£394,000
Heatherbrook Care Home	£1,093,000
Heatherbrook Care Home 1-2-1 care	£30,000
Continuing Health Care	£2,754,785
Total:	£8,215,890

Directed Enhanced Service for Dementia

In Havering, 48 of the 52 GP practices are signed up to the Enhanced Service scheme. Payments will comprise two components, with approximately half of the total funding available under this enhanced service.

Component 1 - An upfront payment of £0.37 per registered patient. This represents a payment of £2,587 to an average-sized practice (where average size is based on a registered population of 6,911).

Component 2 - The remaining funding will be distributed as an end of year payment based on the number of completed assessments carried out by practices during the financial year as a proportion of the total number of assessments carried out nationally under this enhanced service.

¹⁵ Data Source: NELFT/NELCSU, based on occupied bed days from April,2013-January, 2014 @ref.cost of £330.38 per day

Extraction of the data will take place at the end of the financial year, 2013/14, which will then enable the impact of the scheme on the local diagnosis rate and care provided to be assessed.

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London Borough of Havering: Adult Social Care

Domiciliary Care	£559,580.57
Day Care and Transport	£344,682.26
Respite Care	£88,481.99
Residential Care	£3,877,398.05
Nursing Home Care	£1,002,871.22
Direct Payments	£443,161.96
Assistive Technology	£15,446.60
Total:	£6,321,622.65

The figures for Havering Adult Social Care constitute the committed gross spend for 2013/14.

In addition, identified and agreed funding for dementia services and developments has been earmarked within the Better Care Fund.

This includes the following:

Dementia Action Alliance for Havering	£10,000
Information and Advice Service	£22,000
Peer Support (Singing for the Brain)	£42,273
Carers additional support	£37,492
Dementia Liaison Officer post	£24,637
Total:	£136,402

The current level of investment across the health and social care economy in dementia care and services is therefore **£14,673,914.65**.

Appendices

- 1. National guidance**
- 2. National Dementia Strategy: Objectives and Self Assessment Toolkit**
- 3. Implementation Plan**
- 4. Dementia Dashboard**

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Joint Dementia Strategy for Havering

National Policy and Guidance

National Dementia Strategy : Living Well with Dementia: a National Dementia Strategy (DH, 2009)

Joint Commissioning Framework: National Dementia Strategy, (DH, 2009)

Counting the Cost: Caring for people with dementia on hospital wards (Alzheimers Society, 2009)

NICE Quality Standard QS1: Dementia (NICE,2010)

Prime Minister's Challenge on dementia.(DH, 2012)

The Mandate: A mandate from the Government to the NHS Commissioning Board: April, 2013 to March, 2015 (DH, Nov.2012)

Adult Social Care Outcomes Framework 2013/14 (DH, Nov.2012)

Public Health Outcomes Framework 2013-16 (DH, Nov. 2012)

NHS Outcomes Framework 2013/14 (DH, Nov. 2012)

CCG Outcomes Indicator Set 2013/14 (DH, Nov.2012)

Commissioning for quality and innovation (CQUIN): 2013/14 Guidance (NHS Commissioning Board, December, 2012)

Quality and Outcomes Framework (QOF) (DH, 2013)

Facilitating Timely Diagnosis and Support for People with Dementia Direct Enhanced Service (DES) 2013/14 (NHS Commissioning Board, April, 2013)

NICE Quality Standard QS30: Supporting People to Live Well with Dementia (NICE, April, 2013)

The Care Bill (HM Government, May,2013)¹⁶

Dementia: A state of the nation report on dementia care and support in England (DH, Nov.2013)

¹⁶ The Care Bill was announced in the Queen's Speech in May, 2013 and aims to modernise adult social care law, in order to clarify the issues of eligibility and service delivery. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support.

National Dementia Strategy: Objectives and Self-Assessment Toolkit

Objectives

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

To provide people with dementia and their carers with good-quality information on the illness, and on the services available. This is 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

The 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 and set out in Annex 1.

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.

2013




Dementia Strategy Self Assessment Tool Kit






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1. Improved public and professional awareness and understanding of dementia




Red 	Amber 	Green 
<ul style="list-style-type: none"> • No evidence of any local Public Information Campaign within the last 12 months. • No evidence of accessible public information as to how to seek help. • No evidence of activities to reduce Stigma. • No Community Engagement Strategy in place (with reference to Dementia) • No evidence of dementia training undertaken by GP's and health professionals in the last 12 months. • There are no plans to address the Prime Minister Challenge. • There is no local sign up to the Call to Action and/or Dementia Action Alliance 	<ul style="list-style-type: none"> • A Public Information Campaign is scheduled within the next 6 months. • Limited Information is available in the public domain on how to seek help, • Some activities have been developed and implemented to reduce Stigma, but a full programme is not implemented. • A Community Engagement Strategy (with reference to Dementia) is in place, but not fully developed. • A Dementia training programme is in place for GP's, Health and social care Professionals, other workers, but is not fully implemented. • Plans to progress the Prime Minister's Challenge are in development but not implemented. • There is a plan in place to sign up to the Call for Action and/or Dementia Action Alliance but sign up has not yet commenced. 	<ul style="list-style-type: none"> • Robust and well published Awareness Campaign has been undertaken locally in the last 12 months. • GP's and other health professionals within the GP setting have completed one accredited training programme in dementia. • A Community Engagement Strategy is in place with a detailed Dementia section. • Detailed Work is in progress to establish a Dementia Friendly Community, which is driven by the local Health and Wellbeing Board. • GP's and other health professionals within the GP setting have completed one accredited training programme in dementia. • Plans to progress the Prime Minister's Challenge are developed and implementation has commenced. • The Local Team are fully signed up to a Call for Action and/or the Dementia Action Alliance.

2. Good quality early diagnosis and intervention for all




Red 	Amber 	Green 
<ul style="list-style-type: none"> • No accessible memory service is available in the locality • Pathways are not in place to facilitate diagnosis • The number of people diagnosed with dementia 	<ul style="list-style-type: none"> • A memory service is in the process of being commissioned, but is not fully operational. • Pathways are in development but not in place and agreed 	<ul style="list-style-type: none"> • An accessible local memory service is available in the locality • A clear care pathway with a single point of access in place • Increase in the number of

<p>and included on the QOF register has not increased in the previous 12 months.</p> <ul style="list-style-type: none"> • Waiting times for access to Memory Services are outside MSNAP guidelines and are greater than 9 weeks. • The local Memory service has not commenced the process to achieve MSNAP accreditation. • There is no local plan in place to improve the diagnosis rate, in line with national requirements 	<ul style="list-style-type: none"> • The number of people diagnosed with dementia and included on the QOF register has increased in the previous 12 months by xxx%. • Waiting times for access to Memory Services are outside MSNAP guidelines and are more than 6 weeks but less than 9 weeks. • The local Memory service is in the process of MSNAP accreditation and is expected to be accredited within the next 6 months. • There is a local plan in place to improve the diagnosis rate, in line with national requirements, but this is not fully implemented. 	<p>people diagnosed with dementia by xxx% and included on the QOF register to the previous 12 months.</p> <ul style="list-style-type: none"> • Patient waiting times for access to Memory Services are in accordance with MSNAP guidelines of 6 weeks or less. • The local Memory Service is fully accredited with MSNAP. • There is a local plan in place to improve the diagnosis rate, a local ambition rate has been agreed, and this is monitored and reviewed on a regular basis
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3. Good quality information for people with dementia and their carers

Red 	Amber 	Green 
<ul style="list-style-type: none"> • A review of relevant information sets has not been undertaken. • No information is readily available for people with dementia and their carers at the point of diagnosis and beyond. 	<ul style="list-style-type: none"> • A review of relevant information sets, which has resulted in an Improvement plan has been developed, but is still to be implemented. • Limited information is available for people with dementia and their carers at the point of diagnosis and beyond. 	<ul style="list-style-type: none"> • A full review of relevant information sets, which has resulted in an Improvement plan has been developed, and implemented to ensure information sets are current and accurate. • A full range of information is available for people with dementia and their carers at the point of diagnosis and beyond, and is evidenced via systematic user and carer feedback.




4. Easy access to care, support and advice following diagnosis, facilitated by dementia advisor

Red 	Amber 	Green 
<ul style="list-style-type: none"> A local Dementia Advisory Service has not been commissioned and no plans are in place to commission a Dementia Advisor Service 	<ul style="list-style-type: none"> A local Dementia Advisory Service is in development and will be commissioned within the next 6 months. 	<ul style="list-style-type: none"> A local Dementia Advisory Service has been commissioned and is providing and co-ordinating care, information, support, signposting and advice, and this is evidenced via Service review/reports.

5. Peer support and learning networks for people with dementia and their carers are available.




Red 	Amber 	Green 
<ul style="list-style-type: none"> No Peer support or learning networks for people with dementia and their carers are available. There are no facilitated models of care or groups available for people with dementia and their carers. 	<ul style="list-style-type: none"> Plans to establish Peer support or learning networks for people with dementia and their carers are in place, but not yet available. Models of care or groups for people with dementia and their carers are and will be implemented within the next 6 months. 	<ul style="list-style-type: none"> A strong and robust network of Peer support or learning networks for people with dementia and their carers are in fully in place. Evidence can be provided of user and carer feedback. Models of care or groups for people with dementia and their carers are well established and can be evidenced though user and carer feedback.

6. Community personal support services




Red 	Amber 	Green 
<ul style="list-style-type: none"> Specialist Home Care is not available Specialist Home Care is available but less than 50% of staff are fully trained in Dementia. 	<ul style="list-style-type: none"> Specialist Home Care is available but less than 80% of staff are fully trained in Dementia. Home Care provision is available but feedback from service users and carer's 	<ul style="list-style-type: none"> Specialist Home Care is available with a fully trained workforce in Dementia. Home Care provision can demonstrate quality outcomes which can be evidenced via a robust

<ul style="list-style-type: none"> • Feedback from service users and carers indicate substantial improvements are needed in relation to the quality of care. • No contract review process is in place • There is no evidence of good quality Home Care via user and carer feedback. • No Personal Budgets are in place for eligible Service users. • No respite services are available. 	<p>indicate improvements are needed in relation to the quality of care.</p> <ul style="list-style-type: none"> • The contract is monitored reviewed on annually or six monthly basis. • There is evidence of good quality Home Care via user and carer feedback • Service users are eligible to a Personal Budget but the budget is not active. • Some respite services are available but they are not specialised in dementia care, and not sufficient to meet local need. 	<p>Contract Monitoring process.</p> <ul style="list-style-type: none"> • The contract is reviewed on a minimum of a quarterly basis. • There is evidence of good quality Home Care services via user and carer feedback. • Service users who are eligible have access to a Personal Budget. • A full range of specialist respite care and breaks are available for people with dementia and their carers, and are sufficient to meet local need.
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7. Services within the Carers Strategy




Red 	Amber 	Green 
<ul style="list-style-type: none"> • There is no local Carers Strategy in place. • No Carers break programme is available for carers of people with dementia. • There is no access to good quality carers breaks. • There is no specialist Day care provision is available for people with dementia. 	<ul style="list-style-type: none"> • There is a local generic Carers Strategy in place, but it does not have specific reference to carer's of people with dementia. • A Carer's break programme is available for carers of people with dementia is available, but uptake is less than 50% of known carers. • Day care provision is available for people with dementia ,but it is not specialised to provide dementia care/management 	<ul style="list-style-type: none"> • There is a local Carer's Strategy in place ,which includes detailed to reference to carers of people with dementia. • A Carers break programme is available for carers of people with dementia and the uptake is more than 70% of known carers. • A full range of specialist Day care provision is available for people with dementia.

8. Good quality care within general hospitals




Red 	Amber 	Green 
<ul style="list-style-type: none"> • A senior clinician within the local general hospital has not been identified as the responsible lead for quality improvements in dementia care within the general hospital. • A care pathway for the management of people with dementia is not in place. • There is no commissioned Psychiatric Liaison Service available within the general hospital. • None of the wards are 'Dementia ' friendly' • There is no dedicated process of recruitment of ancillary staff and/ or volunteers for patients with dementia. • Minimum of staff (less than 30%) in a one year period have access to a regular and 'tiered' level of training in dementia, based on job role and responsibilities. • The training and its impact are not reported to the Trust Board. • There is no evidence of collaborative and partnership working across the statutory, private and voluntary sector. • There are no plans to sign up to the Dementia Action Alliance, in relation to Dementia Friendly Hospitals. • There is no system of establishing Dementia Champions in hospital wards. 	<ul style="list-style-type: none"> • A senior clinician within the local general hospital has been identified, but is not in post as the responsible lead for quality improvements in dementia care within the general hospital. • A care pathway for the management of people with dementia has been developed but has not been communicated or implemented. • There is an established and commissioned Psychiatric Liaison Service available within the general hospital but is not available to older people. • Some ward environments are 'Dementia 'friendly' but the full programme is incomplete. • There is a process of recruitment of ancillary staff and/ or volunteers but this is not specifically dedicated to patients with dementia. • Some staff (less than 50%) in a one year period have access to a regular and 'tiered' level of training in dementia, based on job role and responsibilities. • The training and its impact are reported to the Trust Board on a less frequent basis (6 monthly or more). • There is some evidence of collaborative and partnership working across the statutory, private and voluntary sector. • There are plans to sign up to the Dementia Action Alliance in relation to Dementia 	<ul style="list-style-type: none"> • A senior clinician within the local general hospital is in post and is the responsible lead for quality improvements in dementia care within the general hospital. • An explicit care pathway for the management of people with dementia is in place, led by the named senior clinician, and this has been communicated to all relevant staff. • There is an established and commissioned Psychiatric Liaison Service for older people available within the general hospital. • Specific ward environments are 'Dementia ' friendly' • There is a proactive recruitment of ancillary staff and/ or volunteers to support and deliver the Dignity in Care Campaign, specifically for nutrition and hydration. • All staff (minimum 80%) have access to a regular and 'tiered' level of training in dementia, based on job role and responsibilities. • The training and its impact are reported to the Trust Board on a regular basis (at least 3 monthly). • There is evidence of collaborative and partnership working across the statutory, private and voluntary sector. • There is sign up to the Dementia Action Alliance in relation to Dementia Friendly Hospitals.

	<ul style="list-style-type: none"> • Friendly Hospitals. • There is a proposal to develop Dementia Champions in hospital wards, but this is not fully implemented. 	<ul style="list-style-type: none"> • There are Dementia Champions in place in each relevant hospital ward.
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9. Intermediate care for people with dementia

Red 	Amber 	Green 
<ul style="list-style-type: none"> • No intermediate care services are available for people with dementia. 	<ul style="list-style-type: none"> • Some intermediate care services are available for people with dementia 	<ul style="list-style-type: none"> • A full range of intermediate care services are available for people with dementia

10. Good housing, housing –related and telecare support




Red 	Amber 	Green 
<ul style="list-style-type: none"> • A Housing needs assessment has not been completed. • The local Housing Strategy does not include provision for housing for people with dementia. • No Extra Care Housing facilities are available within the local area. • A programme of Assistive Technology is not available. • A programme of Telecare is not available. 	<ul style="list-style-type: none"> • A Housing needs assessment has been completed but has not specifically identified the housing needs of people with dementia. • The local Housing Strategy includes some housing options for people with dementia. • A range of Extra Care Housing facilities are being developed within the local area. • Some housing staff working within Extra Care have access to a rolling programme of training in relation to dementia care. • A programme of Assistive Technology is in development and will be implemented within the next 12 months. • A programme of Telecare is in development and will be implemented within the next 12 months. 	<ul style="list-style-type: none"> • A Housing needs assessment has been completed and identified the housing needs of people with dementia. • The local Housing Strategy includes a full range of housing options for people with dementia. • A range of Extra Care Housing facilities are available within the local area. • Housing staff working within Extra Care have access to a rolling programme of training in relation to dementia care. • A programme of Assistive Technology is available. • A programme of Telecare is available.

11. High quality services within care homes




Red 	Amber 	Green 
<ul style="list-style-type: none"> • Less than 50% of local Care Homes have a named Champion/lead for dementia. • Less than 50% of Care Homes have a local strategy for the management of people with dementia in home, led by the named lead. • There is no Multidisciplinary reviews process including the service user/carer /members of the care team and lead professional in place. • There is no strategy within the care home to reduce the number of service users who have been prescribed antipsychotic medication. • Less than 50% of staff have access to specialist dementia training which includes the management of risk • There are no in-reach services regularly visiting the care home. • There are no facilities and therapies available within the care home. • There is no support for carers at an individual and group level available within the care home. • The care home environment is non compliant with a dementia friendly environment (e.g. University of Sterling) guidelines. • The provider has no plans to sign up to the Dementia Care and Support Compact. 	<ul style="list-style-type: none"> • Less than 75% of local Care Homes have a named Champion/lead for dementia. • All local (less than 75%) of Care Homes have a local strategy for the management of people with dementia in home, led by the named lead. • Multidisciplinary reviews including the service user/carer/members of the care team and lead professional take place every 6 months. • A strategy is being developed within the care home to reduce the number of service users who have been prescribed antipsychotic medication. • All staff (less than 75%) have access to specialist dementia training which includes the management of risk • There are some in-reach services regularly visiting the care home. • There are some facilities and therapies available within the care home. • There is some support for carers at an individual and group level available within the care home. • The care home environment is partially compliant with a dementia friendly environment (e.g. University of Stirling) guidelines. 	<ul style="list-style-type: none"> • All local (80% minimum) Care Homes have a named Champion/lead for dementia. • All local (80% minimum) Care Homes have a local strategy for the management of people with dementia in home, led by the named lead. • Multidisciplinary reviews including the service user/carer/members of the care team and lead professional take place every 3 months. • There is a proactive strategy within the care home to reduce the number of service users who have been prescribed antipsychotic medication. • All staff (minimum 80%) have access to specialist dementia training which includes the management of risk • There is a comprehensive range of in-reach services regularly visiting the care home. • There is a comprehensive range of facilities and therapies available within the care home. • There is appropriate range of support for carers at an individual and group level available within the care home. • The care home environment is fully compliant with a dementia friendly environment (e.g. University of Stirling) guidelines.

<ul style="list-style-type: none"> • There are no strategies in place to reduce hospital admissions from the care home. • The Care Home has not undertaken an annual service mapping process using an appropriate mapping tool. 	<ul style="list-style-type: none"> • The provider is intending to sign up to the Dementia Care and Support Compact within the next 6 months. • A strategy is in development to reduce hospital admissions from the care home. • The Care Home undertakes an annual service mapping process using an appropriate mapping tool, but has not completed the process in the last 12 months 	<ul style="list-style-type: none"> • The provider has signed up to the Dementia Care and Support Compact. • A strategy is in place to reduce hospital admissions from the care home. • The Care Home undertakes an annual service mapping process using an appropriate mapping tool, and has completed the process in the last 12 months.
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12. Good end of life care

Red 	Amber 	Green 
<ul style="list-style-type: none"> • A local End of Life Strategy is not in place for people with dementia. • There is no evidence of full use of the planning tools within the Mental Capacity Act, including the use of Advance Statements • Less than 50% with dementia and their carers are involved in the planning of their End of Life Careplan. • End of Life Care Pathways for people with dementia are not in place. 	<ul style="list-style-type: none"> • A local End of Life Strategy is in development and will be implemented within the next 6 months. • There is some evidence of the use of the planning tools within the Mental Capacity Act, including the use of Advance Statements. • Some people (minimum 50%) with dementia and their carers are involved in the planning of their End of Life Careplan. • End of Life Care Pathways are in development for people with dementia and will be consistent with the Gold Standard Framework 	<ul style="list-style-type: none"> • A local End of Life Strategy is in place for people with dementia. • There is evidence of full use of the planning tools within the Mental Capacity Act, including the use of Advance Statements. • All people (minimum 85%) with dementia and their carers are involved in the planning of their End of Life Careplan. • End of Life Care Pathways are in place for people with dementia and are consistent with the Gold Standard Framework

13. An improved and effective workforce across all services

Red 	Amber 	Green 
<ul style="list-style-type: none"> • There are no plans in place to improve the effectiveness of staff working with people dementia. • An overall training plan and strategy for the management of care for people with dementia is not in place. 	<ul style="list-style-type: none"> • An overall training strategy, for the management of care for people with dementia is in development and will be implemented in the next 12 months. • An integrated training plan for the management of care for people with dementia is in place is in development and will be implemented in the next 12 months. 	<ul style="list-style-type: none"> • An overall training and education strategy, for the management of care for people with dementia is in place. • An integrated training plan for the management of care for people with dementia is in place and is being implemented and monitored for its effectiveness.

14. Joint commissioning strategy

Red 	Amber 	Green 
<ul style="list-style-type: none"> • There is no Joint Commissioning Strategy in place. • There is no local Dementia Strategy group/Board in place • There are no local governance arrangements in place for dementia 	<ul style="list-style-type: none"> • A Joint Commissioning Strategy is being developed and will be completed within the next 6 months. • A local Dementia Strategy group/Board is in the process of being established and will be in place within the next 6 months • Local governance arrangements for the Dementia Strategy group/Board are in the process of being established and will be in place within next 6 months. 	<ul style="list-style-type: none"> • A Joint Commissioning Strategy is in place. • The Joint Commissioning Strategy is reviewed and updated on at least an annual basis. • The Joint Commissioning Strategy includes addressing the needs of people with a Learning Disability • A local Dementia Strategy group/Board is in place • Local governance arrangements for the Dementia Strategy group/Board are clear, agreed and in place

Joint Dementia Strategy for Havering

Implementation Plan

Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
I was diagnosed early Links to: NICE QS 30.1: Discussing concerns about possible dementia PHOF 4.16: Estimated diagnosis rate for people with dementia NHSOF 1.5: Excess under 75 mortality rate in adults with serious mental illness NICE QS1.2: Memory Assessment Services	Work with Public Health, using the Dementia Prevalence Calculator, to fully understand the 'gap' between the local prevalence rate and those diagnosed with dementia	Improve the local diagnosis rate	The local prevalence rate and gap in diagnosis rate will be clear and fully understood	Data from the Calculator is reconciled with local intelligence and arrangements, including GP liaison scheme with nursing homes	Public Health	Ongoing
	Work with GP's and primary care staff to continue to raise awareness of the target in relation to diagnosis rates, including providing information, education and guidance on read coding	Improve the diagnosis rate	Increased number of individuals will receive a timely diagnosis	Increase in numbers on GP Dementia Registers	Clinical Director/GP Mental Health Lead/Dementia Programme Manager	Ongoing
	Pilot the use of iPad based assessment tool for dementia in a number of agreed local GP practices	Improve the diagnosis rate	Increased number of individuals will receive a timely diagnosis	Increase in numbers on GP Dementia Registers	Clinical Director/Dementia Programme Manager	May,2014
	Provide training for GP's/practice nurses/GP reception staff	Raising awareness	The role of key clinicians and front-line staff in identifying dementia symptoms is promoted	Increase in referrals to a range of agencies, including voluntary sector	Clinical Director/Dementia Programme Manager/UCL Partners	February, 2014 Completed

Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
I was diagnosed early	Continue to develop and deliver programme of training for primary care staff, including GP's, with UCL Partners	Raising awareness, and developing skills and knowledge base	The role of key clinicians and front-line staff in identifying dementia symptoms is promoted	Increase in referrals to a range of agencies, including voluntary sector	Clinical Director/GP Clinical Lead/Dementia Training and Education sub-group	December, 2014
	Support the national PHE Dementia Friends Campaign	Raising awareness	Raised awareness and understanding of the public and staff about the issues faced by people with dementia	Increased number of people are Dementia Friends	Public Health	June, 2014
	Target awareness raising for those with specific risk factors for dementia, particularly those over 65, people with Down's syndrome, people with long term conditions. This will include analysis of the outcomes of the Dementia DES in primary care	Raising awareness	Raised awareness of the risk of dementia within this cohort of the population	Increase in referrals/self-referrals to primary care	Public Health/CCG	Throughout 2014
	Require within relevant contracts that providers of dementia services work together with providers of Learning Disabilities Services to develop an agreed interface protocol	Raising awareness	Smooth pathway for people with a Learning Disability and dementia	Clear pathway and interface agreed between the services	CCG/LBH	December, 2014

Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
	between the services Undertake review and model of service delivery for Memory Service	Improving diagnosis rate	Revised and fit for purpose Service Specification is in place	Increase in referrals to Memory Service	Dementia Programme Manager/Clinical Director	March, 2014 Completed
	Develop proposed model of integrated community based Memory Service, communicate and share the model, and explore options and feasibility of delivery with all key stakeholders	Improving diagnosis rate within an integrated model of service delivery	All key stakeholders are signed up to the model, and work together to implement this. This will offer people with dementia and their carers a smooth pathway of care, within an accessible and integrated service	Increase in referrals to Memory Service	Clinical Director/CCG/LBH	December, 2014
	Further develop needs assessment for people with early onset dementia in order to understand the level of current and future levels of local need	Raising awareness	Needs of this group of people are clear and understood, in order to inform future commissioning	Needs assessment will inform future plans	Public Health	TBA

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Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
I understand, so I make good decisions and provide for future decision making Links to: NICE QS 30: Supporting people to live well with dementia	Re-commission Age Concern within a revised Service Specification for the Dementia Advisory Service	Living Well with Dementia	People with dementia, their families and carers receive high quality information, advice and support.	Individuals and their carers report that they are appropriately supported.	Havering CCG	March, 2014 Completed
	Develop information packs for service users and carers (Alzheimers Society booklet) to be used within GP practices, the Memory Service and other associated services	Living Well with Dementia	People with dementia, their families and carers receive high quality information, advice and support	Individuals and their carers report that they are appropriately supported.	LBH/Havering CCG	TBA
I get the treatment and support which are best for my dementia and my life Links to: NHSOF 2.1: Proportion of people feeling supported to manage their condition	Consider repeat of anti-psychotic prescribing audit, following publication of national Audit in Spring, 2014	Living Well with Dementia	People with dementia are treated appropriately and safely	Further reduction in the numbers of people with dementia who are prescribed anti-psychotic medication	Medicines Management	June, 2014
	Consider the options/ issues relating to the development of reablement/intermediate services for people with dementia	Living Well with Dementia	Full consideration is given to this requirement of the National Dementia Strategy	Options appraisal is completed with recommendations for consideration by DPB	ASC, LBH	September, 2014
	Continue to progress the proposed information sharing between Age Concern and BHRUT	Living Well with Dementia	Smooth pathway for individuals, and raised awareness and access to level of information about individuals within BHRUT	Information sharing system in place	Dementia Programme Manager	June, 2014

Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
Those around me and looking after me are well supported	Undertake a full review of the respite needs for carers of people with dementia	Living Well with Dementia	There is a clear understanding of the needs of carers in relation to accessing respite care and support	Increase in the numbers of individuals/carers accessing respite care	ASC, LBH	December, 2014
Links to: ASCOF 1D: Carer reported quality of life	Develop an appropriate and accurate system for capturing the numbers of people accessing respite services	Living Well with Dementia	Data quality is improved	Commissioners have a clear understanding of the numbers of people accessing respite care	ASC, LBH	April, 2015
ASCOF 3D: The proportion of people who use services and carers who find it easy to find information about services	Following above, review commissioning of the services and make recommendations for the future	Living Well with Dementia	Appropriate access and level of service in place to meet current and ongoing level of need	Increase in the numbers of individuals/carers accessing respite care	ASC, LBH	April, 2015
NHSOF 2.4: Health-related quality of life for carers	Review the use of assistive technology to support individuals with dementia and their carers	Living Well with Dementia	People with dementia and their carers are supported and enabled to remain in the community for longer	Increase in the numbers of people accessing assistive technologies	Joint Commissioning Board	TBA
	On completion of procurement process, promote access to psychological therapies services (IAPT) to carers	Living Well with Dementia	Carers of people with dementia will have appropriate access to psychological therapy services if they need them	Increase in the numbers of carers of people with dementia accessing IAPT services	Havering CCG	April 2014 onwards

Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
<p data-bbox="188 229 432 320">I am treated with dignity and respect</p> <p data-bbox="188 352 353 472">Links to: NICE QS1.1: Appropriately trained staff</p> <p data-bbox="188 903 371 994">NICE QS 30.8: User and carer engagement</p>	<p data-bbox="461 320 781 592">Adopt the use of these statements across Health and Social care, and appropriate methods and systems to capture evidence and the experience of people with dementia and their carers who access services</p>	<p data-bbox="810 320 911 376">Strategy Delivery</p>	<p data-bbox="999 320 1240 376">Services adhere to person centred care</p>	<p data-bbox="1270 320 1512 376">Person centred care plans in place</p>	<p data-bbox="1568 320 1803 344">LBH/Havering CCG</p>	<p data-bbox="1901 320 2002 344">Ongoing</p>
	<p data-bbox="461 624 781 807">All staff should receive appropriate training and have access to dementia care training that is consistent with their roles and responsibilities</p>	<p data-bbox="810 624 911 679">Strategy Delivery</p>	<p data-bbox="999 624 1240 871">All staff, working in health, social care, private and voluntary sector, will have access to a rolling programme of appropriate training in dementia</p>	<p data-bbox="1270 624 1534 711">Individuals are treated with dignity and respect</p>	<p data-bbox="1568 624 1803 711">Dementia Training and Education Sub-group</p>	<p data-bbox="1901 624 2002 647">Ongoing</p>
	<p data-bbox="461 895 781 1023">Engage with people with dementia and their carers via established fora/ planned workshops</p>	<p data-bbox="810 895 911 951">Strategy Delivery</p>	<p data-bbox="999 895 1240 1118">Range of opportunities to engage and listen to people with dementia and their carers are identified and acted upon</p>	<p data-bbox="1270 895 1512 1142">Increase in the numbers of people engaged with commissioners in providing feedback and commentary on their experience of services</p>	<p data-bbox="1568 895 1803 983">Dementia User Engagement Sub-group</p>	<p data-bbox="1901 895 2002 919">Ongoing</p>

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Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
<p>I know what I can do to help myself and who else can help me</p> <p>Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life</p>	Individuals have access to a written copy of their care plan and know how to access support when they need it, including in a crisis	Living Well with Dementia	There is a clear person centred plan in place for every individual known to services	Numbers of people with a copy of their own care plan	LBH/CCG	Ongoing monitoring via Dementia Dashboard
<p>I can enjoy life</p> <p>Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life</p> <p>NICE QS 30: Living well with dementia</p>	The range, scope and quality of activities available in the community will be regularly reviewed	Living Well with Dementia	People with dementia have access to a choice of activities and services.	There is range and choice of accessible, good quality activity and support services available in the community	LBH/CCG	TBA

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Vision Statement	Action	Objective	Outcome	Measure	By Whom	By When
<p>I feel part of a community and I'm inspired to give something back</p> <p>Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life</p>	<p>Achieve 'Dementia Friendly' status for Havering, via the launch and implementation of the Dementia Action Alliance</p>	<p>Living Well with Dementia</p>	<p>People with dementia are empowered to have high aspirations, and to feel confident that people in the local community will treat them with dignity and respect</p>	<p>Havering achieves 'dementia friendly' status</p>	<p>LBH/CCG</p>	<p>January, 2015</p>
<p>I am confident my end of life wishes will be respected:</p> <p>Links to: ASCOF 1B: The proportion of people who use services who have control over their daily life</p>	<p>Ensure that the needs of people with dementia are included within any work undertaken in relation to End of Life Care</p>	<p>End of Life Care</p>	<p>There is clear link between the work of the Dementia Partnership Board and the End of Life Steering Group</p>	<p>Numbers of people with dementia with Advance Directive in place</p>	<p>LBH/CCG</p>	<p>Ongoing monitoring via Dementia Dashboard</p>

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Dementia Dashboard

Key:

	Measure is on target or needs no remedial action at this time
	Achievement of target is at risk of being met or possible remedial action required
	Target is not met or remedial action is required

Vision Statement	Measure	Target	Actual	Comments
I was diagnosed early	Number of people diagnosed with dementia (Source: QOF Register) % of people in Havering diagnosed with dementia	66%	39%	
I understand so I make good decisions and provide for future decision making	Numbers of people with ISF ¹⁷ (Data Source: ASC)		142 people with dementia in 2012/13	
I get the treatment and support which are best for my dementia and my life	Reduction in the numbers of people prescribed antipsychotic medication (Data Source: DH National Audit, 2014)			
Those around me and	Dementia CQUIN for BHRUT Total number of Dementia			

¹⁷ ISF: Independent Service Fund (Managed Account)

Vision Statement	Measure	Target	Actual	Comments
looking after me are well supported	Carers Assessments undertaken (Source: RAP data/Carers Survey)		191 people with dementia in 2012/13	
I am treated with dignity and respect	<p>Numbers of safeguarding referrals for people with dementia (Source: ASC)</p> <p>Numbers of admissions to residential and nursing home care for people with dementia (Source: ASC)</p>		<p>58 referrals</p> <p>153 admissions (April-Dec.2014)</p>	<p>9.5% of total number of safeguarding referrals for 2012/13. % increase for those in higher age band of 85+, rises to 17.7%</p> <p>Trend is numbers of admissions rising incrementally throughout the year; contributing factor could be seasonal variance.</p> <p>The numbers of admissions for people with dementia make up 20% of total number of admissions</p>
I know what I can do to help myself and who else can help me	Numbers of people with dementia with a copy of their own care plan			
I can enjoy life	Numbers of people with dementia who have access to a direct payment (Source: RAP data)		59 people with dementia in 2012/13	
I feel part of a community and I'm inspired to give	Numbers of engagement events held during the year		2 (Dementia Cafe and Carers Session)	

Vision Statement	Measure	Target	Actual	Comments
something back	2014/5			
I am confident my end of life wishes will be respected	Numbers of people with dementia with an advanced directive in place			Establish Baseline

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