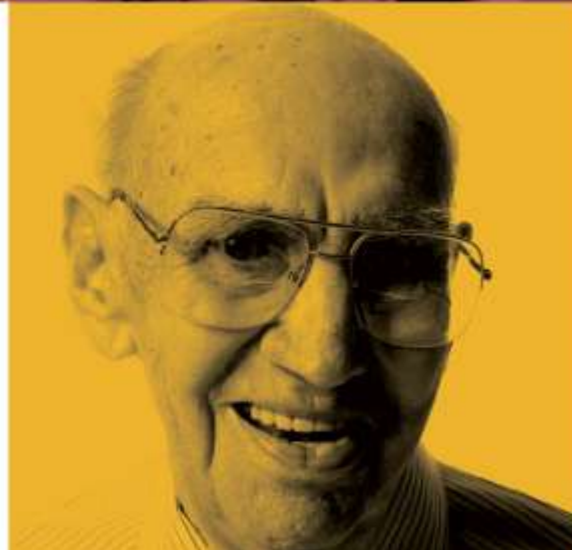
# Living Well With Dementia in Halton

Halton Dementia Strategy and
Implementaion Plan
2013-2018

Halton Clinical Commissioning Group



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## Foreword

As people live longer, Dementia is an increasing problem across the country and this picture is mirrored in Halton. It is a complex condition with widespread effects on the individual, the family and the health and social care system.

Current estimates show that about half the numbers expected in Halton have been diagnosed. Often, the first time the problem is recognised is when a crisis occurs, causing a great deal of distress to all concerned.

There seem to be two main reasons why there is a reluctance to diagnose dementia early; a fear of stigma and a belief that nothing much can be done. Yet, there is no reason why people with dementia cannot live full, happy lives. It is important for health and social care services to work with the public in order to ensure that those with dementia are identified early and are fully supported to enjoy life.

Nationally and locally it is clear that dementia is one of the biggest challenges facing the health and social care economy. Although dementia can affect adults at any age, it is most common in older people becoming more prevalent with increasing age, but this does not mean it is a natural part of the ageing process or inevitable for all older people - a message we need to communicate more widely.

This strategy aims to encourage early, accurate diagnosis and to ensure health and social services are positively organised so that those with dementia receive all the care they need.

## Our Vision

**Our vision is clear: It is for all people with dementia and their carers to continue to 'live well'. To do this we will create an environment where people feel empowered to seek help early, know where to go for help and what services to expect, have access to the care and support that they would benefit from, and are confident that this care is of high quality, where the public and professionals are well informed and where fear and stigma associated with dementia has decreased.**

***Councillor Marie Wright.***
***Halton Borough Council Portfolio Holder for Health and Wellbeing***

***Dr David Lyon. GP, Clinical Lead for Dementia and Community Services. Halton Clinical Commissioning Group Governing Body Member***

## Introduction

Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases with age, and the condition usually occurs in people over the age of 65. [i]

The term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes.

Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses will depend on the individual person and what type of dementia they have.[ii] Alzheimer's disease is the most common cause of dementia, where there is a progressive loss of brain cells.

The exact cause for this is unknown. However, there are a number of things thought to increase the risk of developing the condition, including:

- increasing age
- a family history of the condition
- previous severe head injuries
- lifestyle factors and conditions associated with vascular disease

Most types of dementia can't be cured, but if it is detected early there are ways it can be slowed down and mental function can be maintained for longer.

The 'Living well with dementia in Halton' strategy is coordinated by the Halton Dementia Partnership Board and is based on the requirements identified within 'Living well with dementia in Halton Needs Paper'. The action plan that accompanies this strategy is to be implemented over 5 years, with an update on progress to be published annually.

Whilst there is still much to do, there has been a number of positive national and local developments relating to dementia since 2009. From the national 'Prime Minister's Challenge on Dementia' to the introduction of the 'Halton Later Life and Memory Pathway' (see appedix 1) , living well with dementia is a priority for all. Seventy five percent of the objectives within the 2009 Dementia Strategy Action plan have been implemented, for example:

- Improving awareness and understanding of dementia through a range of literature and the Dementia Care Advisor service.
- Good quality early diagnosis and intervention through the Later Life and Memory pathway
- Improved intermediate care for people with dementia through professional and vocational training

The 2009 action plan and progress is available on request.

This strategy and associated implementation plan includes the remaining objectives from the 2009 action plan along with new, stretching objectives. The strategy complements other work programmes including the local Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton

Health and Wellbeing Strategy, Carer's Strategy Action Plan, Falls Strategy and Loneliness Strategy, and should be read in conjunction with these pieces of work.

This strategy provides plans for the future against the four themed objectives of the national strategy:

1. **Raising Awareness**
2. **Early Diagnosis and Support**
3. **Living Well with Dementia**
4. **Delivering the Dementia Strategy.**

## Why do we need a dementia strategy?

The population of Halton is aging. That is, a larger proportion of the total population will be found in the 60-plus age bands by 2031 compared to 2006. This section of the population will increase by 61% to 36,300 by 2031.

- The number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. It is projected that there are 1180 people aged 65+ living in Halton who have some form of dementia in 2012 and by 2020 this figure is estimated to be as high as 1518. In addition it is estimated that there are currently about 34 people aged between 30-64 who early onset dementia
- Our current diagnosis rate is **63.3%,** with an aspiration of taking this to over 66% during 2014/15
- Based on National Audit Office research it is estimated that of the people with some form of dementia 788 will live in the community and 392 in a care home. This will rise to 1367 living in the community and 683 requiring care home places by 2030.

With prevention, an early diagnosis and appropriate information and support, a good quality of life is possible. While the costs of dementia are expected to rise in coming years because of growing numbers of people affected, there is significant scope for spending money more efficiently and effectively. A local dementia strategy, over 5 years, will provide the focus and direction of actions to be taken to achive better outcomes for people with a dementia diagnosis.

## What would success look like?

Through consultation and research undertaken by Health Watch Halton[iii] and Halton Borough Council and Alzheimer's Society [iv] we have been able to understand what success for people with a dementia diagnosis, their family and carers would look like in Halton.

### Raising Awareness and Understanding

"*Need to ensure that health and social care professionals have an awareness of dementia"* "Need *to raise awareness across Halton of how to prevent dementia"*
*"Need to raise awareness of care staff in residential and community settings."*
*"young people need to understand Dementia."*
This led to an overall agreement and discussion that dementia *'does have an impact on children and grandchildren.'*

### Early Diagnosis and Support

*"I think there has been improvement in dementia care but it appears to be sporadic, it is not right across the board"*
"*Health Passport to improve communication between staff and between staff and patients"*

### Living well with Dementia

*"Dignity needs to be included in the training and All health staff need training but it needs to be done properly."*
"there *should be an awareness of telecare products and services to help people remain independent."*

## Raising Awareness

A sustainable and skilled workforce in the care of people with dementia, their family and carers. Our communities are supported to adapt to become dementia friendly to tackle the fear and stigma of dementia.

"First of all is getting my wife to accept there's something wrong"

## Early Diagnosis and Support

Early assessment and diagnosis, so that appropriate treatment and support can be put in place as soon as possible to help maintain a good quality of life.

"We want quality time with somebody who knows"

## Living well with dementia

People with a dementia diagnosis, their family and carers have access to appropriate information at the right time, help to understand information and are supported through treatment and support.

"I had so many questions"

## Delivering the strategy

Seamless, wrap around support commissioned through integration of Public Health, Halton Clinical Commissioning Group and Adult Social Care

"The quality of our lives has changed so much"

## Halton Dementia Pledges

Complementing the person centred ouctomes devised by the National Dementia Partnership [v] through consultation with people with a dementia diagnosis, their family and carers, a set of local dementia pledges have been developed and are to be adopted in Halton.

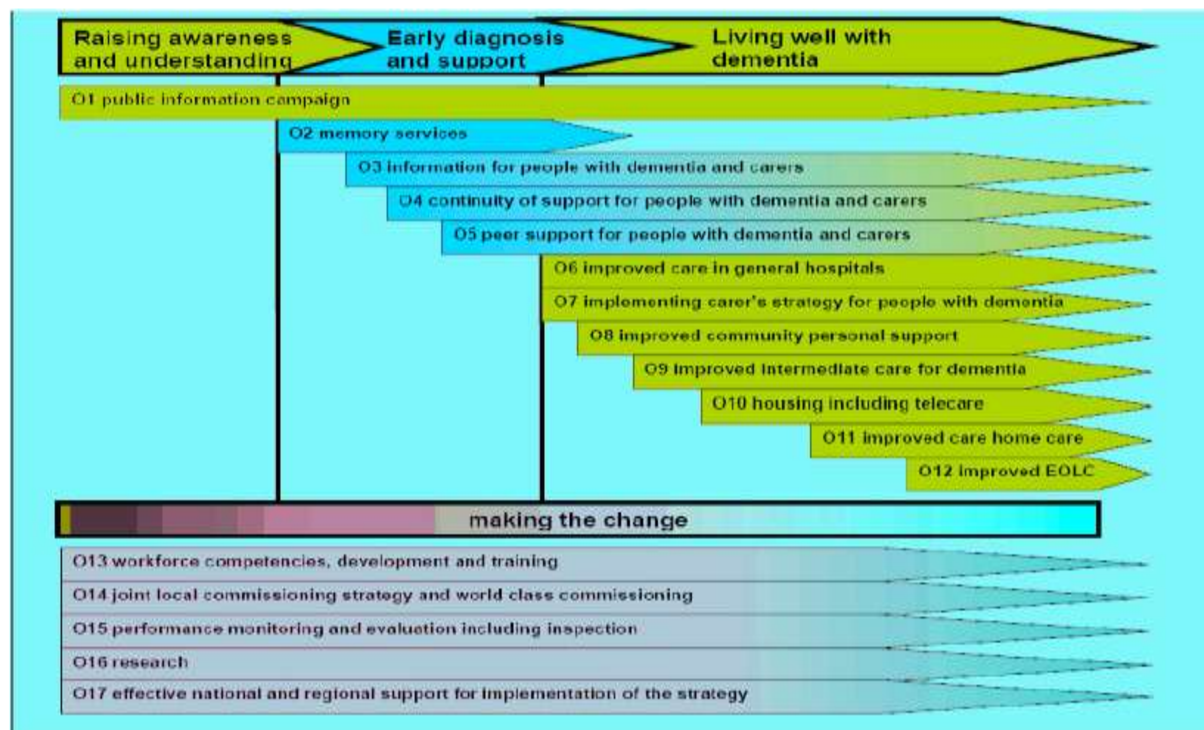
Our pledges are:

1. You will be diagnosed early
2. You will be supported to understand information so that you can make good decisions and you know what you can do to help yourself and who else can help you
3. You will get the treatment and support which are best for your dementia and your life
4. Those around you and looking after you are well supported
5. You will be treated with dignity and respect
6. You will be supported so that you can enjoy life
7. You will be supported to feel part of a community and be inspired to give something back
8. You will be supported to ensure that your end of life wishes will be respected.

The pledges not only demonstate commitment to developing and providing excellent services for people with a dementia diagnosis, their families and carers, but define the quality of those services. The pledges set the bar for expectations, and against which patient, family and carer experiences can be measured and outcomes improved for them over the lifecourse of this strategy.

## Realising the vision

The National Dementia Strategy 2009-2014, in its development, was clear that Local Authorities and Primary Care Trust's (at the time) should take a radical approach to whole system transformation to meet the twin aims of better outcomes at lower cost, with outcomes defined within the care pathway, as illustrated below:




When translating the national objectives to local action, a number of priority areas are highlighted for action.

## Priorities for 2013-2018

### 1) Prevention and raising awareness

Actions within this theme are focussed on better public information about dementia, reducing stigma, informing the public what services are available, informing staff how to signpost and support people with dementia and their carers. To achieve this we will work with a wide range of colleagues, including those in Public Health, Housing, Social Care, Police, Fire, Health and voluntary sector to improve the way we provide information.

### 2) Early diagnosis, information and advice

The first step is to encourage people to visit their GP for an assessment, as soon as they become aware of a problem with their memory. In this way people with dementia and their carers are identified and part of the system. From then on they can be pro-actively offered information and support and helped to access services appropriate to their needs. To achieve this we will link up primary and secondary care services via the simple but effective, multidisciplinary Later Life and Memory Service care pathway, enhance the dementia adviser's service, offer more and varied peer support opportunities, provide training to GP-practices, increase Quality Outcome Framework (QOF) registrations, have screening in place for people with learning disabilities and for people at risk of vascular dementia and ensure capacity in secondary care memory clinic.

## 3) Living well in the community

More people with dementia are living well for longer in their community. Key factors are keeping physically and socially active, getting the right encouragement and support, knowing the right coping strategies and supporting carers. Providing a variety of peer support networks across the borough is crucial in achieving this. Also, current housing, health and social care services need to be more joined-up and able to offer greater flexibility and continuity. Mainstream services in particular need to be dementia-friendly and provided by well-trained staff. Furthermore, GP-practices need to offer service users a regular health check and dementia advisers need to be in regular contact with service users and carers so they can signpost them to the right services at the right time to avoid a crisis developing. (Such services may include extra care housing / supported housing, telecare, carers support, well-check, peer support, and home care support). Clear pathways for different groups of people with dementia are being designed ensuring appropriate services are joined up and service provision is commensurate with the changing needs of service users and their carers as the disease progresses. Aiming to advance equality of opportunity for dementia patients , carers and wider communities, in line with The Equality Act 2010, by empowering people with a dementia diagnosis to have high aspirations and feel confident to continue to partake in activities within the community, achievable by Halton becoming a dementia friendly community.

## 4) End of Life

End of life care has to be considered early when the person with dementia still has capacity to express their future preferences regarding their preferred place to die. To achieve good end of life care we are ensuring that all staff and providers within dementia care utilise the principals of the Gold Standards Framework for end of life care and are trained and competent in the use of end of life tools and policies so that decisions and preferences for care at the end of life can be communicated and documented effectively.

In addition, the dementia end of life pathway will be supported by a robust clinical support network, including GP's, District Nurses, Consultants in Palliative Care, Speciality Doctors, Macmillan Nurses and Social Care teams operating within an Integrated Care Network. The service provision in Halton is designed to take a whole system approach to delivering end of life care, which includes an End of Life Social Service, Palliative Care Sitting Service, 7 day access to Macmillan Nurses, Family support and bereavement services, Palliative Care advice services along with access to Specialist Palliative care teams within in the community, hospice and hospital environments.

## 5) Workforce development

Developing dementia friendly services requires a whole system approach. Mainstream staff from Older People's and Adult Services are often in contact with people with dementia. It is therefore important that all staff are able to signpost people to the right services, that they can encourage people to visit their GP when they have concerns about their memory and know in general how best to approach and actively support people with dementia. Work with 'Skills for Care' (an organisation that provides work force development resources for Adult Social Care employers in England) is already underway in Halton, with funding secured to implement dementia awareness training and life story work. Reminiscence work and House of Memories[vi] are already in place in nursing homes across the borough.

## 6) Links to other workstreams

The dementia strategy doesn't stand alone. In order to improve dementia care links are identified with other strategies including End of Life Care, Telecare, Housing and Carers Strategies, and to other workstreams including Personalisation and Dignity in Care.

## Underlying principles in developing dementia treatment and support services

- regularly consult people with dementia and their carers to ensure we take account of their needs;
- support equality in access and service provision;
- commission quality and state of the art services and regularly monitor actual provision against agreed outcomes;
- encourage best use of available resources across the borough;
- facilitate working in partnership between providers of dementia care;
- consistency with priorities of the Health and Well-being Partnership Board and Halton Dementia Partnership Board
- Facilitate training and awareness raising for dementia.
- Safeguarding is a priority for all

## Resources

### Budget received for 2013/14 for Mental Health Services (as a whole)

| | £000T |
|---|---|
| Halton Clinical Commissioning Group | 17,223 |
| Halton Borough Council Adult social Care | 2,934 |
| Halton Clinical Commissioning Group – Continuing Health Care (Mental Health) | 2,500 |
| Halton Borough Council Public Health | 250 |
| Halton Borough Council Children's and Enterprise | 191 |
| TOTAL | **23,098** |

### How the budget was allocated 2013/14

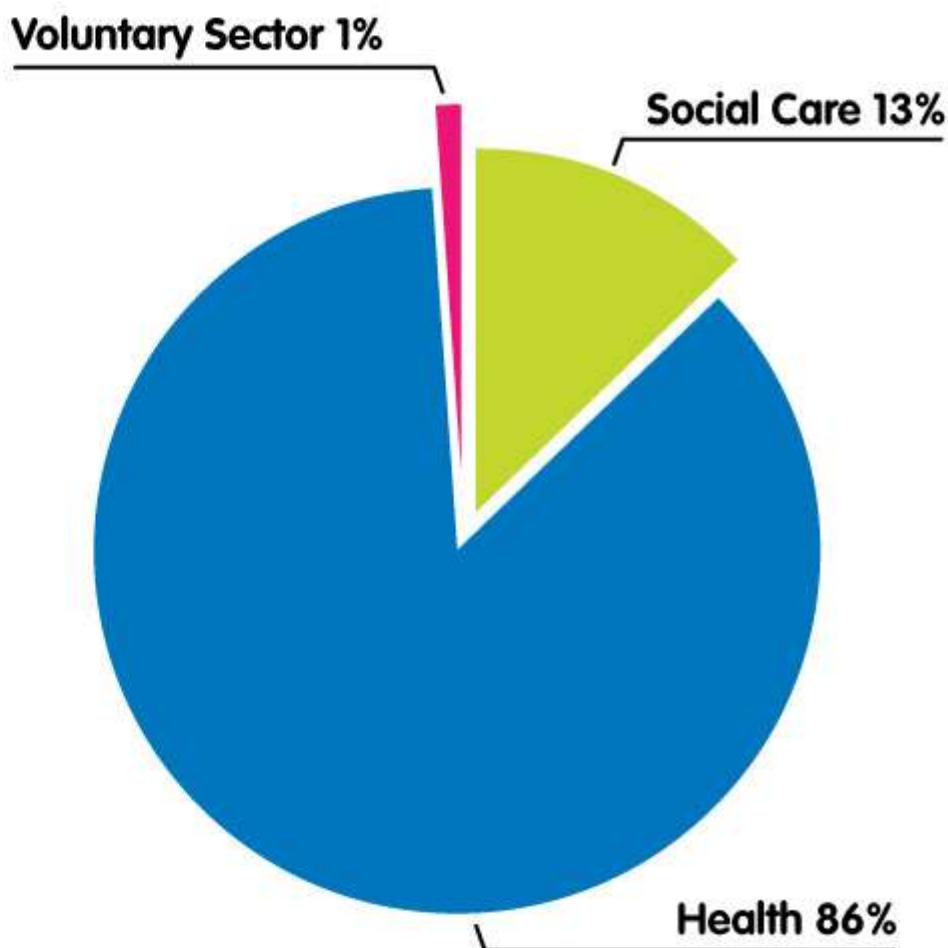
| Halton Clinical Commissioning Group | £000 |
|---|---|
| 5 Boroughs Partnership NHS FT | 13,508 |
| 5 Boroughs Partnership ADHD Clinic | 35 |
| 5 Boroughs Partnership Asperger's Pilot | 23 |
| 5 Boroughs Partnership State of Mind | 4 |
| 5 Boroughs Partnership ADOS (CAMHS) | 8 |

| | |
|---|---|
| **Cheshire & Wirral Partnership** | 44 |
| **Manchester Mental Health & Social Care** | 6 |
| **MerseyCare** | 64 |
| **CAB Halton** | 116 |
| **Making Space** | 22 |
| **Women Supporting Women** | 20 |
| **MIND** | 20 |
| **Halton Service User Forum** | 10 |
| **SHAP** | 22 |
| **Bereavement Service** | 1 |
| **Youth Offending Team** | 8 |
| **IAPT (Including Open mind and Well Being Nurses)** | 986 |
| **MH Access** | 737 |
| **PICU - Vancouver House** | 150 |
| **PICU - Other** | 50 |
| **MH Capacity** | 77 |
| Dementia Nurses and Care Advisors | **200** |
| **WHHFT (A&E Liaison)** | 35 |
| **StHKHFT (A&E Liaison)** | 85 |
| **Primary CAMHS** | 492 |
| **High Cost Mental Health Funding** | 500 |
| | |
| Continuing Health Care | 2,500 |
| | |
| Adult Social Care | |
| **Older people community mental health team** | 147 |
| **Mental Health Support (Outreach)** | 194 |
| **Mental Health Resource Centre** | 117 |
| **Mental Health Recovery Team and Community Care** | 2,366 |
| **Emergency Duty Team** | 103 |
| **Women's Centre** | 7 |
| | |
| Public Health | |
| **Campaign against living miserably (CALM)** | 10 |
| **Health Improvement Team & Weight Management Service – Bridgewater** | 240 |
| | |
| Children's and Enterprise | |
| **Children in Care Service** | 59 |
| **Hear 4 U** | 132 |

It is important to understand the complexities of the existing budget and the challenges in ensuring that people are diagnosed and supported in an appropriate way. The budget above and the chart below is for the total mental health allocation in Halton, however it is not always straight-forward to align a particular expenditure against dementia. For example there is a wide range of generic activity with older people and also in relation to awareness raising and prevention, that may not necessarily be captured specifically as dementia expenditure.

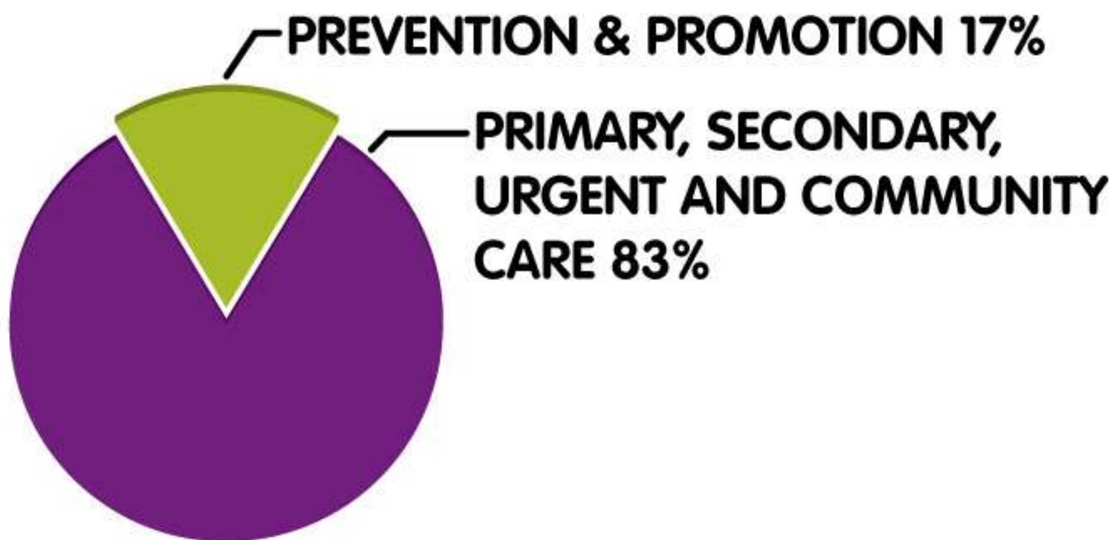
The chart below does begin to demonstrate the challenge facing commissioners in the next five years. Shifting the budget allocation away from high end health interventions to earlier voluntary sector and prevention measure is a key priority. This in turn will help to support the improving early diagnosis rate in Halton.

## How the budget was allocated between health, social care and voluntary sectors 2013/14




The pie chart overleaf illustrates how the £22.9 million budget for mental health (as a whole) has been invested. It is clear that the majority of resource is currently invested in health treatment and services. In the future the focus for mental health disorders, as whole, will be on supporting people within the community to improve person centred outcomes for individuals and their carers.- The CCG are currently working with 5 Boroughs Partnership to scope out and pilot Payment By Results (PBR) Cluster packages for adult mental health and Children and Adolescent Mental Health Services (CAMHS) and Later life and memory services. In the future this will mean a more robust costing structure based on diagnosis and care pathways.

The pie chart below illustrates that 17% of the £5.7 million health budget for organic mental disorders (including dementia) is spent on prevention and promotion. It is well documented that promotion can increase awareness and therefore early diagnosis, enabling people to access lower level treatment and support at an earlier stage to slow the progression of the disease. We intend to rework our reconfiguration of this allocation and focus on prevention and promotion investment. This will be governed by the Dementia Partnership Board.




Given the complex nature of funding arrangements within the council, it is difficult to determine the precise amount of funding available and used for people with dementia. This is primarily because of the difficulties in diagnosing someone with dementia and the fact that the expertise to meet individual needs are based within older people mental health teams. Whilst the prevalence of dementia continues to grow and will become a significant factor in future years, it is not economically viable to separate out the needs of people with dementia from other older people with mental health issues, such as depression.

There are a variety of different factors that will 'push and/or pull' the funding for services, for example; residential care – price inflation and demographics will push the price but at the same time improvements in Public Health, Telecare and Prevention, will all pull expenditure on residential care down. For each type of expenditure there are all these factors pushing and pulling. We will shift resources from the point of crisis to prevention and early intervention.

## How are we going to achieve the priorities?

The implementation plan that follows below details what actions will take place over the life course of the strategy to achieve the vision of living well with dementia in Halton

[i] What is Dementia? NHS Choices

[ii] What is Dementia? Alzheimer's Society Web site

[iii] Halton HealthWatch consultation with 'Lunch Bunch' group for carers of people with a dementia diagnosis. Sept 2013

[iv] 'The Dementia Journey Halton 2009/10'

[v] Transforming models of care for people living with dementia - Improving experiences and outcomes for people with dementia and their carers and families Report 2012

[vi] House of Memories is a training and delivery programme built around the objects, archives and stories held within the Museum of Liverpool. It aims to provide social and

health care staff (in domicile and residential settings) with new skills and resources to share with people living with dementia, and to promote and enhance their wellbeing

and quality of life, as a potential alternative to medication

# Implementation Plan 2013 - 2018

## 1: Prevention & Raising Awareness

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 1.1<br>**Establish a Halton Dementia Training and Information Alliance** | 250 health and social care staff dementia awareness trained.<br><br>17 GP practices to attend dementia awareness training within Protected Learning Time | Phase 1: Dementia awareness raising and training delivered to front line social care, primary care and secondary care staff<br><br>Phase 2: Dementia awareness raising and training to other service areas within the Local Authority, Fire Service, Police Service, Housing providers<br><br>Utilise Dementia Friends awareness raising sessions<br><br>Training to include advice on reducing risks of developing dementia e.g. advise around healthy lifestyle and referral to support services as appropriate<br><br>Awareness raising sessions delivered throughout each year to GPs via Practice Learning Time Events delivered by CCG and Learning Disability Clinical Lead. Dementia Clinical Lead to champion raising awareness within practices through general duties as a CCG clinical lead | **You will be treated with dignity and respect.**<br><br>**You will have access to a skilled workforce**<br>**Your GP will be more able to diagnose you earlier** | Dave Sweeney, Halton NHS CCG | Brian Hilton<br><br>Linda Birtles-Smith<br><br>Dr David Lyon | October 2014 |
| 1.2<br>**Develop Dementia Ambassadors within teams/organisations to maintain awareness raising and promote dementia friendly service** | Minimum of 1 Dementia Ambassador within each member organisation of the Dementia Partnership Board. | Each Dementia Ambassador to undertake Alzheimer's Society Dementia Friends awareness raising session and Dementia Champions Training | **You will be treated with dignity and respect.**<br><br>**Halton will adopt a consistent approach to your care** | Dementia Partnership Board member from each partner organisation | | August 2014 |

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 1.3<br>**Ensure dementia is defined in the delivery of the NHS Health-checks programme in Halton** | 7667 people will be invited to attend an NHS Healthcheck<br><br>75% (5750) of people invited will receive an NHS Healthcheck<br><br>Baseline of 850 people aged 65-74 are eligible to receive the dementia component of the Healthcheck, of which 76% (650) will be given information on the signs of dementia | Over a five year rolling period, everyone aged between 40 and 74 (who hasn't already been diagnosed with one of a series of specific conditions) will be invited for an NHS Health Check at their GP surgery. The check will include personal and family history, a range of physical checks and the provision of information and advice. For those aged 65 and over the check will also include the provision of general information about dementia. | **You will be diagnosed early. You will receive care and support at the earliest possible point** | Dr Ifeoma Onyia, Halton Borough Council Public Health | Joanne Sutton and Commis-sioned Practices | 2013-2018 |

## 2: Early Diagnosis

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 2.1<br>**Delivery of Direct Enhanced Service for Dementia (DES) within general practice, to increase awareness and screening for dementia.** | CCG Quality Premium target is a 62.1% (807 people) diagnosis rate based on a prevalence of 1300 people with dementia. | DES payment data via NHS England Primary Care Team (annually). Dementia Board will request exception reporting from NHS England relating to delivery outcomes | **You will be diagnosed early.** | NHS England contractual arrangements Dave Sweeney, Dementia Board Dr David Lyon, Halton NHS CCG | Jo O'Brien, Primary Care Commission-ing Manager | 2013-2014 |
| 2.2<br>**Dementia Preliminary Screening Pilot Develop and evaluate a dementia case finding pilot with non-clinical community based workers.** | Output figures to be determined as the pilot is developed.<br><br>Anticipated outcomes are increased awareness amongst community based staff about dementia.<br><br>Increased awareness of dementia risk factors and symptoms amongst those most vulnerable within the community.<br><br>Increased attendance at GP with screened cognition concerns, seeking further investiga-tion from GP.<br><br>Increased referrals to Later Life and Memory Service Pathway.<br><br>Increase in diagnosis rate. | The pilot will be delivered in partnership with Liverpool Housing Trust, Riverside Housing and Halton Housing Trust, Halton Borough Council Bridge Building Team, Sure Start to Later Life team and Community Development Workers.<br><br>Working with the CCG Clinical Lead for Dementia to develop referral, information sharing and data protection protocols and evaluation methods. Non clinical Community based staff already supporting people who may have expressed concern, or display symptoms of cognitive impairment, to be offered the 6CIT screening test and referred to GP for further investigation where indicated. | **You will be diagnosed early.** | Dave Sweeney, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Emma Bragger, Policy Officer Communities Directorate | Evaluation of pilot completed by October 2014 |
| 2.3<br>**Develop a business case around the evidence of the effectiveness of the Rapid, Assessment, Interface and Discharge (RAID) programme for people with dementia that could be applied within local hospitals.** | Recommendations to be made to the Dementia Partnership Board | The business case will identify potential improvements/risks relating to<br>• satisfaction for dementia patients<br>• experience for staff<br>• choice for the acute trust<br>• better health outcomes for the patient with dementia<br>• value for our economy. | **You will be diagnosed early.** | Commissioning Managers | Mark Holt | March 2015 |

## 3. Living well with dementia

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 3.1<br>**Improve quality of residential and domiciliary care for people with a dementia diagnosis.** | Pooling of health and social care budgets to commission an integrated model of clinical, social and dementia care across all residential care, not just dementia nursing homes.<br><br>NICE Care Audit Tool for people with Dementia (due for publication during 2014) is implemented across domiciliary and residential care | The Dementia Partnership Board to contribute to the evaluation of the 5 Boroughs Partnership Care Home Pilot and the Halton Borough Council care Home Model.<br><br>Implementation of the NICE Care Audit Tool to be included as a contractual requirement in future service specifications.<br><br>Provide specialist training and support to social workers, residential and domiciliary care staff to support individual and carers in making end of life plans.<br><br>Consider the results of the evaluation of the 5 Boroughs Partnership Care Home Liaison Project and the existing Halton Borough Council Care Home model and make commissioning recommendations. | **You will get the treatment and support which are best for your dementia and your life.**<br><br>**You will receive a better level of care in your own home**<br><br>**You will be confident of the standards of care being delivered in residential care** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Damien Nolan, Divisional Manage, Halton Borough Council | Summer 2014 |
| 3.2<br>**Provision of appropriate information to people with a dementia diagnosis, and their carers, at the appropriate time** | 100 % of people accessing Dementia Care Advisor or Support Worker service to have access to the dementia guide<br><br>100% of the Dementia Training and Information Alliance (to be formed) members to receive a copy of the Dementia Guide.<br><br>100% of carers of people accessing the Dementia Care Advisor and Support Worker service to be informed of the services available through IAPT | Requirement to provide Dementia Guide and IAPT information to be included in future service specification of Dementia Care Advisor and Support Worker<br><br>Dementia Care Advisors and Support Workers to provide the Alzheimer's Society resource 'The Dementia Guide. Living well after diagnosis'.<br><br>Promote to carers of individuals with a dementia diagnosis the availability of psychological therapies through the Improved Access to Psychological Therapies (IAPT) investment programme | **You will get the treatment and support which are best for your dementia and your life.**<br><br>**Those around you and looking after you are well supported** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council | Mark Holt, Commissioning manager, Halton Borough Council | October 2014 |

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 3.3<br>**Development of a Carer's on line forum to enable carers to get direct access to clinicians for information and advice on the condition.** | Measure – standardised tool of wellbeing to be used | Evaluation of the on line Carer's Forum pilot, with analysis considered in development of future commissioning intentions. | **Those around you and looking after you are well supported**<br><br>**You will have direct access to key professionals** | Dementia Partnership Board Carers Board | Steve Eastwood | March 2015 |
| 3.4<br>**Delivery of community based care and support** | 50% increase in the number of people diagnosed with dementia who have access to a Dementia Care Advisor/Support Worker or equivalent trained staff in the voluntary sector | Develop a business case for the Dementia Care Advisor/Support worker service and the potential to skill the voluntary sector and make commissioning recom-mendations.<br><br>Evaluate current Dementia Care Advisor and Dementia Care Support Worker Service, including,– capacity and outcomes and impact of any change in service (increase/decrease in capacity) on other services.<br><br>Evaluate the use of voluntary sector organisations in supporting the dementia agenda. Including skilling of volunteers who are already providing support to people in their own home . | **You will be supported to understand information so that you can make good decisions and know what you can do to help yourself and those who can help you.**<br><br>**Those around you and looking after you are well supported.** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Mark Holt, Commission-ing manager, Halton Borough Council | 2014/15 |
| 3.5<br>**Halton to become a recognised Dementia Friendly Community** | Measures for the Safe in Town scheme to be determined. Anticipated outcomes include:<br>• Improved social inclusion for person with dementia diagnosis<br>• Improved independ-ence for person with a dementia diagnosis<br>• Increased awareness of dementia amongst retailers and service providers<br>Awarded the Alzheimer's Society 'Dementia Friendly Communi-ties' recognition | Use the Alzheimer's Society Dementia Friendly Society web resources and support to achieve dementia friendly status.<br><br>Expansion of the 'Safe in Town' pilot to include people with dementia.<br><br>Work towards achieving the Alzheimer's Society Dementia Friendly Community Award. | **You will be supported to feel part of a community and be inspired to give something back.**<br><br>**You will be supported so that you can enjoy life.** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council | Safe In Town Steering group | May 2014 |

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 3.6 **Coordinated approach to assistive technology for people with a dementia diagnosis.** | Increase in number of people who are prescribed specialist equipment. | Base line of use of assistive technology amongst people with a dementia diagnosis to be established.<br><br>Scope the use of alternative technologies to improve outcomes for people with a dementia diagnosis and their carers by participating in the Innovate Dementia programme<br><br>Needs analysis to be undertaken<br><br>Recommendations to be considered in commissioning intentions. | **You will be supported so that you can enjoy life.**<br><br>**You will be able to access equipment that will improve your quality of life** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br>Dr David Lyon, Halton NHS CCG | Steve Eastwood, Commissioning Manager, Halton Borough Council | 2014/15 |
| 3.7 **Provide specialist input to Care Management and Care Planning teams to improve the quality of end of life care plans for people with dementia.** | Increase in the number of people supported to complete an end of life plan. | End of life tools training delivered by Advanced Care Planning Team | **You will be supported to ensure that your end of life wishes will be respected.** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Jenny Owen/Emma Alcock, Commissioning Manager, Halton NHS CCG | On going |
| 3.8 **Improve access to out of hours service for end of life patients** | Increase in number of completed Special Patient Notes for diagnosed dementia patients within Halton | Cleansing and auditing of current Special Patient Notes to provide baseline.<br><br>Training to be provided to GP practices as part of Gold Standard Framework of care by Advanced Care Planning Team<br><br>Utilising the red flag system for end of life dementia patients – to highlight as emergency to be seen within 1 hour. | **You will be supported to ensure that your end of life wishes will be respected.** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Jenny Owen/Emma Alcock, Commissioning Manager, Halton NHS CCG | On going |

## 4 Delivering the strategy

| Outcome | Output Measure | Delivery Method | Outcomes for person with dementia and their carer | Accountable Organisation & Manager | Delivery Manager /Officer | When |
|---|---|---|---|---|---|---|
| 4.1 **Development of a performance dashboard** | Qualitative and quantitative evidence of improved outcomes for people with a dementia diagnosis and their carers | Dashboard to be devised around Halton's 8 dementia pledges<br><br>Development of patient/carers group to enable their qualitative contribution to performance management. | **You will be confident that decisions are being made based on the most up to data information available** | Dave Sweeney, Operational Director for Integrated Care, Halton Borough Council<br><br>Dr David Lyon, Halton NHS CCG | Mike Shaw, Performance Officer, Halton NHS CCG | Quarter 1 2014/15 |

# Appendix 1 Later Life and Memory Service Pathway

## Halton Later Life and Memory Service Pathway for Professionals. September 2013

Click here for NICE Pathway for Dementia Diagnosis and Assessment

Patient undertakes '6 CIT' Test (or other). Link to '6 CIT' questions and scoring:http://www.patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

Routine bloods and ECGPrimary Care Referral to Dementia Care Advisors

Click here for NICE Pathway for Dementia Specialist Assessment

Referral triaged at single point of access (5BP) Patient offered face to face assessment appointment within 10 days (routine) and 24/48hrs if Urgent

Full Assessment within 6 weeks

- History taking
- Cognitive and mental state examination
- Physical examination
- Review of medication to identify any drugs that may impair cognitive functioning.
- Specialist Interventions

**Later Life and Memory Service – New Referral letter faxed to 01925 666641**

Tel. 01928 753162

Click here for NICE Pathway for Dementia Diagnosis and Assessment

- Holistic approach
- Brain scan
- Clarify diagnosis
- Prescribe Medication
- Ensure social support

If non dementia diagnosis refer back to Primary Care

Dementia Care Advisors to assist patient and carer to navigate pathway and provide information on services available, including community delivered services Call Alzheimer's Society for referral to Dementia Care Advisors 0151 420 8010

Social care referrals via Later Life and Memory Service Social Care Support Service Pathway