



# **Halton and St Helens Joint Commissioning Strategy for Dementia**

October 2009

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## Executive Summary

Halton and St Helens Boroughs and NHS Halton and St Helens have drawn up this Joint Commissioning Strategy to address the objectives of the National Dementia Strategy (NDS) with a view to achieving the best possible local health and social care services for people with dementia and their carers.

The commissioning strategy is structured around the four thematic areas of the NDS: 'Raising Awareness', 'Early Diagnosis and Support', 'Living Well with Dementia' and 'Delivering the NDS'. In addition, it addresses key issues raised in a review in 2009 by the Halton Scrutiny Committee of services for younger adults with dementia.

There is currently a 'Cycle of Stigma' that prevents people seeking help and services from offering help. The strategy proposes a number of commissioning actions that are intended to break this cycle through a public health programme, a public information programme, and the provision of information to relevant groups of employers. This will be assisted by joint work with Children's Services to ensure that non-stigmatising information is included in school curricula and through community engagement activities.

Currently only a small percentage of people with dementia ever receive a diagnosis and when they do it is usually in the latter stages of the illness. The commissioning of an Assessment Care and Treatment Services (ACTS) is proposed for each of the boroughs which will ensure that early and high quality assessment and support is available to all. This will include access to counselling and to a Dementia Care Advisor who will provide an enduring point of contact through time.

The 'Living Well with Dementia' set of objectives is focussed on improving current services such as home care, carer support, intermediate care, residential care and end of life care to ensure that they meet the needs of people with dementia and the needs of their carers. Current services have been mapped and evaluated against these six objectives and actions that will help to guide commissioning developments for each area of service have been defined.

National and regional structures are being established by the Department of Health to oversee and support the Delivery of the NDS objectives Local action to ensure the effective delivery of the NDS objectives will be focused on the effective performance management of this strategy. To assist this process the actions identified to support the delivery have been set out in separate Implementations Plans for Halton and St Helens.

## Summary of the Key Actions Identified to Address the Objectives of the National Dementia Strategy

- A Public Health programme will be established to support the prevention of dementia in general, and specifically amongst the younger population
- A strategy for community engagement will be drawn up
- A local public information programme will be developed drawing on, and aligned with the national campaign
- Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately
- Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognise and respond to the needs of carers within their workforces
- Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education
- Early Assessment, Care and Treatment Services (ACTS) for people with dementia and their carers will be commissioned for Halton and for St Helens.
- The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.
- A Dementia Care Adviser will be commissioned as part of the development of an Early Assessment, Care and Treatment Service
- The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens
- Service Commissioners will develop and promote a clear care pathway for younger adults with dementias, and will ensure that service developments reflect the additional needs of this group of people
- Objectives 6-12 of the NDS will be met through actions identified through the mapping and gap analysis exercise as detailed in the Implementation Plans

- A full and detailed analysis of the population and care needs of younger adults with dementia, and their carers, will be undertaken, to ensure that services are appropriately targeted at this group of people, with consideration given to developing a daytime resource that specifically reflects their needs
- As a part of the analysis of the population of younger adults with dementia, service providers will be asked to assess their own provision and processes, to evidence their suitability for younger adults
- Health and social care services will be restructured according to need rather than age
- Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education, and including staff who may deal with younger adults with dementia

# Halton and St Helens Joint Commissioning Strategy for Dementia

## 1. Introduction

Halton and St Helens Joint Commissioning Strategy for Dementia has been drawn up with a view to achieving the best possible local health and social care services for people with dementia and their carers, by ensuring that they are consistent with, and help to deliver the key objectives of the National Dementia Strategy 2009<sup>1</sup> (NDS). It has also been developed with reference to the *Strategic Framework for Older People's Mental Health Services in Halton* (2004 / updated in February 2009) and the Commissioning Strategy for Older Peoples Mental Health *Securing Better Mental Health for Older Adults* (2006 / refreshed in April 2009), developed jointly by the 4 Borough Alliance. The strategy is intended to be consistent with and promote the objectives of 'Our health, our care, our say' (2006), Putting People First (2007) and 'High quality care for all' (the Darzi report, 2008.)

It is a 5 year broadly based joint health and social care strategy that sets out a framework for future service development in the context of a defined vision for services for people with dementia, irrespective of age. In addition the strategy contains borough specific implementation plans that set out the main work streams and the more detailed actions required to achieve real improvements in outcomes for service users and carers.

Current provision for people with dementia and their carers in Halton and St Helens has been considered in relation to the guidance on high-quality health and social care services set out in the National Dementia Strategy, to enable gaps to be identified, and priorities for development determined.

The strategy addresses the need to raise awareness and understanding of dementia and to ensure that everyone with dementia and their carers has access to early assessment, care and treatment services.

Particular attention has been given to the needs of carers, the majority of care for people with dementia being provided by family members who are often old and frail themselves, and who, as a consequence of the heavy burden of care often experience high levels of depression and physical illness.

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<sup>1</sup> *Living well with dementia: A National Dementia Strategy* DH 2009

## 2. The National Dementia Strategy

Dementia has been recognised as a national priority by the government and it is in this context that the National Dementia Strategy has been developed to help to ensure progress in the development of health and social care services for dementia that are 'fit for the 21<sup>st</sup> Century'. The Strategy provides guidance on local service development based on sound research evidence and acknowledged best practice, informed by a major programme of consultation.

The NDS sets out 17 key objectives (full descriptions can be found in Appendix 1) most of which are to be addressed at local level. The objectives are grouped thematically:

### Raising awareness and understanding:

Objective 1: Improving public and professional awareness and understanding of dementia

### Early diagnosis and support:

Objective 2: Good-quality early diagnosis and intervention for all

Objective 3: Good-quality information for those with diagnosed dementia and their carers

Objective 4: Enabling easy access to care, support and advice following diagnosis

Objective 5: Development of structured peer support and learning networks

### Living well with dementia:

Objective 6: Improved community personal support services

Objective 7: Implementing the Carers' Strategy

Objective 8: Improved quality of care for people with dementia in general hospitals

Objective 9: Improved intermediate care for people with dementia

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers

Objective 11: Living well with dementia in care homes

Objective 12: Improved end of life care for people with dementia

### Delivering the National Dementia Strategy:

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

Objective 14: A joint commissioning strategy for dementia

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers

Objective 16: A clear picture of research evidence and needs

Objective 17: Effective national and regional support for implementation of the Strategy

Seven key priority outcomes have been identified for early delivery (NDS Implementation Plan<sup>2</sup>):

- Early intervention and diagnosis for all
- Improved community personal support services
- Implementing the New Deal for Carers
- Improved quality of care for people with dementia in general hospitals
- Living well with dementia in care homes
- An informed and effective workforce for people with dementia
- A Joint Commissioning strategy for dementia.

In order to secure and monitor the delivery of “Living well with dementia”, the Department of Health has established a National Programme Board for older people and dementia. With cross Government representation and involvement from people with dementia and their carers, it will monitor progress, highlight best practice and work to remove barriers to successful implementation.

The Programme Board will link to the regional tier through the Deputy Regional Directors for Social Care (DRDs), who progress the Department’s business in the Regions, and with the Strategic Health Authorities (SHAs). The DRDs have close links to SHAs and will support the necessary linkages between Health, Social Care and other local stakeholders.

The Department of Health is establishing a core team to help deliver the national dementia strategy. The team will support the delivery programme regionally and co-ordinate the production of materials to support the implementation, using web based materials and networks. It will also run workshops and conferences at the national level. Whilst much of this will be developed and provided in the regions according to local needs, there will also be some core support materials that will be needed everywhere and these will be produced nationally to avoid duplication and make best use of resources.

The core team is overseeing, through a steering group, the development of a national framework for the delivery of demonstration sites for particular themes in the strategy, such as peer support and dementia care advisers.

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<sup>2</sup> *Living well with dementia: The National Dementia Strategy Implementation Plan DH 2009*



### 3. What is dementia?

The National Dementia Strategy defines dementia as ‘a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills, and the ability to carry out daily activities. Alongside this decline individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression, and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness.’ The causes of dementia are not well understood but the illnesses all result in structural and chemical changes in the brain leading to the death of brain tissue. It is a terminal disorder but people may live with their dementia for 7-12 years after diagnosis.

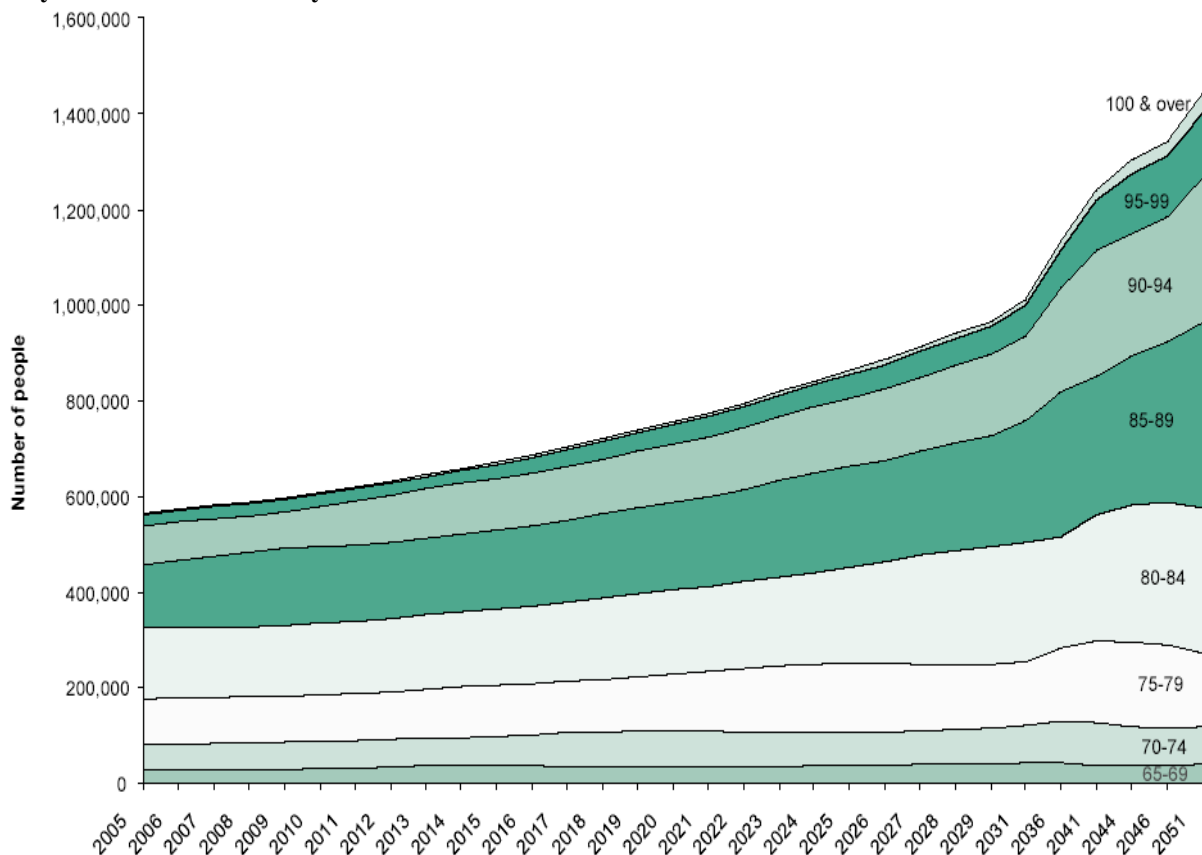
Dementia affects all groups in society regardless of gender, ethnicity and class. It is predominantly a disorder of later life but there are significant numbers of people under the age of 65 who have the illness.

The proportion of the population that is over 65 is increasing, and this is a trend that will continue for several decades. As there is a higher incidence of dementia in older adults the number of people in the UK with dementia is forecast to grow from 700,000 today to 1.4 million in 30 years time. In Halton the number of people with dementia is forecast to increase by 55% between 2010 and 2025 rising from 1085 to 1683 while in St Helens the forecast increase in the same period is 53% rising from 1,916 people with dementia to 2,935<sup>3</sup>.

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<sup>3</sup> Data Source: DH ‘Projecting Older People Population Information System’ Website: [www.poppi.org.uk](http://www.poppi.org.uk)

**Figure 1: The number of people with dementia in England is increasing and is forecast to reach 1 million by 2031 and 1.4 million by 2051**



There is a great deal of fear and stigma associated with dementia and a common misconception that it is a normal part of ageing and that nothing can be done to help people that have the illness. However it is now increasingly understood that there is a great deal that can be done to help people with dementia and to support their carers. Where people receive an early diagnosis, together with access to effective care and treatment it has been shown that this can improve people’s quality of life, and the quality of life of their carers, and enable them to ‘live as well as possible with dementia’<sup>1</sup>.

### Younger Adults with dementia

Dementia is a destructive and incurable condition which, at its worst, leaves people unable to manage even the simplest aspects of their care. It is commonly associated with old age (but is certainly not an inevitable consequence of ageing), and this is in itself one of the difficulties. Evidence suggests that younger people are unaware of the possibility of dementia and are reluctant to refer themselves. Even if they do refer themselves, they are even less likely than older people to be diagnosed quickly, because professionals can be more reluctant to attach this diagnosis to a younger person. In consequence, they are more likely to come to services at a late stage in their condition, and to have more complex and challenging needs as a result.

It is important to stress that younger people with dementia have many needs which **can** be met from a general service for people with dementia. However, they may also have additional issues to consider, and dementia services need to be structured to take these into account. In particular:

- There is greater likelihood that the person with the condition is a parent of younger children, and therefore there are significant impacts on family life
- There is also a potential economic impact on both the person with the condition and their family, as people may still be in employment and, without the condition, could reasonably have expected to be economically productive for some years to come
- Finally – and importantly – most services for people with dementia are set up for an older age group. Younger adults can be one, even two, generations younger than those receiving help and support around them. As a consequence they may have little in common with the other people. This is particularly important when considering residential or nursing placements for people in the later stages of their condition.

The number of younger adults with dementia in Halton is estimated by the Department of Health's PANSI tool to be 33, which is backed up by local research on cases known to professionals which puts the figure at between 30 and 35<sup>4</sup>, while in St Helens the PANSI estimate is that the population would be expected to have 48 people with young onset dementia. This is likely to be a substantial underestimate and further work needs to be done across the two Boroughs to fully assess the population and needs of this group of people.

In general, there are no additional risk factors for developing dementia at a younger age, although it is known that people with some forms of learning disability are at particular risk of developing dementia. However there is a greater lack of awareness amongst the general public that other risk factors – obesity, smoking, alcohol and drug use – can affect younger people.

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<sup>4</sup> Scrutiny Review of Services in Halton for Younger Adults with Dementia: 2009

#### 4 The vision for services for dementia

This strategy endorses the goal of the National Dementia Strategy to help people with dementia and their carers to live well with dementia, and the vision that it sets out to achieve this, which is to:

- encourage help-seeking and help-offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour
- make early diagnosis and treatment the rule rather than the exception; and achieve this by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically commissioned part of the system that can, first, make the diagnoses well, second, break those diagnoses sensitively and well to those affected, and third, provide individuals with immediate treatment, care and peer and professional support as needed
- enable people with dementia and their carers to live well with dementia by the provision of good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care homes

#### 5. Raising Awareness and Understanding

A key element of the strategy is to address the need for both public and professional awareness to be raised and to take action to address the stigma that is often associated with dementia

##### 5.1 The Cycle of Stigma

The National Dementia Strategy describes a cycle of stigma and false beliefs that currently tends to lead to inactivity. The elements of the cycle are:

##### Stigma

- Stigma creates a background where public and non-specialist professionals find it hard to talk about dementia
- Stigma within professional groups results in work associated with dementia - and the acquisition of the skills to identify and work with people with dementia - being accorded low priority

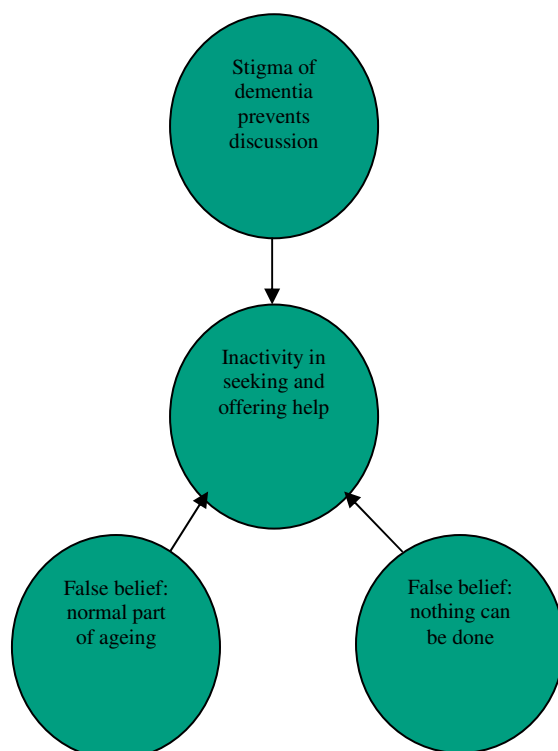
##### False belief: 1

- Dementia is a normal part of 'old age' and therefore there is unwillingness to seek or offer help

##### False belief: 2

- Nothing can be done to help people with dementia and their carers

**Figure 2: The Cycle of Stigma and False Beliefs (National Dementia Strategy: 2009)**



Together these factors combine to delay diagnosis and prevent access to good-quality care, and this is particularly significant for younger adults. People over 65 have been found to be much more worried about developing dementia than they are about cancer, heart disease or stroke, and yet they currently wait up to three years before reporting their symptoms to their doctor. At the same time 70% of their carers report being unaware of the symptoms of dementia before diagnosis while 58% of carers believe that the symptoms are just part of ageing. Of equal concern, 69% of GPs believe that they haven't had sufficient training to diagnose and manage dementia.

## **5.2 Prevention**

Current evidence suggests that up to 50% of dementia cases may have a vascular component, and that it may therefore be possible to prevent or minimise dementia by promoting better cerebrovascular health. This may be done through actions such as health promotion in relation to diet and lifestyle, and encouraging health checks with additional focus on the potential for reducing the likelihood of developing dementia. There is real scope for developing a public health programme which alerts people to the risks of developing dementia at a younger age if they adopt unhealthy lifestyles.

***ACTION:*** A Public Health programme will be established to support the prevention of dementia

### 5.3 A Local Strategy for Raising Awareness and Understanding

The NDS proposes that public information campaigns are needed at both national and local levels and it sets out the key messages for the national campaign. (See Appendix 2)

At the local level it suggests the development of strategies for community engagement to increase levels of understanding and to build supportive social networks.

An effective approach may be to target major employers and bodies with workforces that interact with the public, providing them with information about the symptoms and special needs of people with dementia and giving advice on what action to take if they are concerned about someone they are providing a service to. The campaign could also target the personnel / human resources and occupational health departments of employers so that they are aware of the early signs of dementia and its impact on carers.

Another key target group should be children, young people and younger adults. If Halton is to achieve significant change in awareness and understanding then the campaign materials should be made available to schools for inclusion in Personal, Social and Health Education and Citizenship Education.

#### ACTIONS:

- *A strategy for community engagement will be drawn up*
- *A local public information programme will be developed drawing on, and aligned with the national campaign, and will include awareness of the risks of developing dementia at a younger age*
- *Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately*
- *Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognise and respond to the needs of carers within their workforces*
- *Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education*

## 6. Early Diagnosis and Support

One of the priorities of the National Dementia Strategy is to ensure that there is 'good-quality early diagnosis and intervention for all' (NDS Objective 2.) At present only about one-third of people with dementia receive a formal diagnosis at any time in their illness. Even in the minority of cases where a diagnosis is made, it is often too late for the person with the illness to make choices, and often takes place at a time of crisis which might have been avoided if proper assessment and support had taken place earlier. This can be particularly notable for younger adults who develop dementia, who (as seen in Section 4) may be more likely to get a late diagnosis of the condition.

Early diagnosis and intervention has been shown to improve the quality of life of service users and carers, reducing levels of anxiety and depression, and allowing them to plan for the future, at the same time as accessing help, support and treatments. Such services have also been shown to be cost effective, significantly reducing the level of care home and acute hospital admissions.

The NDS proposes that new specialist services should be commissioned that:

- can deliver good quality early diagnosis and intervention
- provide a simple single focus for referrals from primary care
- work locally to stimulate understanding of dementia and referrals
- are available to people of all ages

and that can focus on:

- making the diagnosis well
- breaking the diagnosis well to the person with dementia and their family
- providing directly appropriate treatment, information, care and support after diagnosis

The new services are intended to sit alongside and complement the work currently undertaken by old age psychiatry, geriatrics, neurology and primary care and are considered likely to benefit from the core involvement of third sector organisations. With the new early diagnosis and support service in place, the role of primary care should then be to identify people with suspected dementia and then after excluding other possible explanatory disorders to refer them on to the specialist service to receive a definitive diagnosis. Following diagnosis the primary care role will then be helped by the specialist's assessment of whether the person has dementia, and of what sub-type together with advice on the appropriate treatment regime

Halton and St Helens' older persons' mental health services currently have only very limited capacity for early diagnosis and support for people with dementia and their

carers. The services have not been structured or resourced to provide an early assessment service and as a result tend, in the main, to respond to referrals for people in the later stages of dementia, often at a time of crisis. Following a review of those services in 2008 specifications for Assessment, Care and Treatment Services for Halton and for St Helens were commissioned and business case reports have been completed and are currently progressing through the relevant local commissioning bodies.

The commissioning of multidisciplinary and interagency early assessment, care and treatment services is consistent with recommendations of the recently updated *Strategic Framework for Older People's Mental Health Services in Halton* and the 2009 'refresh' of the 4 Borough Alliance's Commissioning Strategy for Older Peoples Mental Health.

***ACTION:** Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers will be commissioned for Halton and for St Helens.*

A key objective within the development of effective early diagnosis and support services is the provision of 'good quality information for those with diagnosed dementia and their carers' (NDS Objective 3.)

The NDS proposes the national development of a comprehensive package of high-quality information on the nature of dementia which should then be adapted locally to describe the treatment and support available. There should also be information on what options there are for planning ahead for people diagnosed with dementia, to ensure that their desires and wishes are properly considered should they lose mental capacity, such as advice on how to make a Lasting Power of Attorney.

***ACTION:** The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.*

The NDS recommends the development of a new role of 'Dementia Care Adviser' to achieve its fourth objective of 'enabling easy access to care, support and advice following diagnosis'. In the consultation programme during the development of the national strategy, one of the most consistent concerns expressed was that social and health care involvement was episodic and that they 'normally discharge individuals



once the case is stable and the care package is being delivered.’ However people with dementia and their carers, faced with a serious illness with inevitable long-term decline and increase in dependency were clear that they need to be able to have continuing support available – someone that they can approach for help and advice – at any stage of the illness, and whenever they need it. It is felt that the role Dementia Care Adviser should not be case management but rather, to provide an identifiable point of contact for everyone in an area diagnosed with dementia, and their carers, with knowledge of and direct access to the whole range of local services available. When contacted they would identify the problem and signpost and facilitate engagement with the appropriate services.

***ACTION:** A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service*

The ACTS service will play a major role in helping Halton and St Helens to deliver a number of the Key Objectives of the NDS:

### **NDS Objectives supported by the Assessment, Care and Treatment Service**

Objective 1: Improving public and professional awareness and understanding

Objective 2: Early assessment and intervention services that can respond to the needs of all people in an area with dementia

Objective 3: Provide good quality information for those diagnosed and their carers

Objective 4: Enable easy access to care, support and advice following diagnosis

Objective 6: Improved community personal support services

Objective 7: ACTS will contribute to ‘Implementing the Carers Strategy’ in a number of ways including: - information to carers, support provided by the Dementia Care Advisor role, and providing carers with access to a counselling service.

Objective 11: ACTS will significantly help to ensure: ‘Improving care for people with dementia in care homes’ through its in-reach function:

Objective 13: ACTS will contribute to the development of an ‘Informed and effective workforce for people with dementia’ through its training function and by providing a reference point for advice and information

The final objective within the theme of 'early diagnosis and support' is 'The development of structured peer support and learning networks' (Objective 5). The NDS proposes that this can be delivered through:

- Demonstrator sites and evaluation to determine current activity and models of good practice to inform commissioning decisions
- Development of local peer support and learning networks for people with dementia and their carers that provide practical and emotional support, reduce social isolation and promote self-care, while providing a source of information about local needs to inform commissioning decisions
- Support to third sector services commissioned by health and social care

The development of early assessment services is expected to lead to a significant increase in the number of people that are diagnosed as having dementia during the early stages of the illness. Currently there are few services that are specifically focused on meeting the needs of people in the early stages of the illness or on meeting the needs of their carers. Peer support arrangements, and relatively low level community supports many of which will more appropriately be provided by voluntary and community organisations will need to be developed to meet these needs. This will also go some way towards meeting the needs of people who contract the condition at a younger age.

Although there has been some important early developmental work, in this regard in both Halton and St Helens, such as the Dementia Café and Dementia Reading Group projects (further details can be found in the section on Mapping of Services), there is a need to undertake focused work to achieve significant progress in this area. Accordingly the Halton Health Partnership has commissioned Age Concern Mid Mersey, through the Vulnerable Adults Task Force (VATF), to lead on developing a Dementia Network in Halton. The Dementia Network will involve the development of a peer support network and a community training, awareness and development programme.

***ACTION: The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens, with one project focusing specifically on the needs of younger people who develop dementia.***

## 7. Living well with dementia: Local Mapping and Gap Analysis

While Objectives 1-5 of the NDS represent major new areas of development for most local authorities and PCTs the services that are particularly relevant to Objectives 6 - 12 on 'Living well with dementia' are for the most part services that may need further development, but that are nonetheless significant elements within current local provision. These are services such as intermediate care, carers support, and residential care homes. Consideration of these NDS Objectives has therefore been approached through an exercise in which current services have been evaluated and gaps analysed in relation to each of the relevant NDS Objectives.

The results of the service mapping and gap analysis exercise are set out in Appendices 3a and 3b with separate analyses for the services in Halton and in St Helens. An additional mapping and gap analysis will need to be done for younger adults with dementia, to include the registration of local care homes to meet the needs of this group of people, and an analysis of the use of high cost out of area placements for younger adults who also present with more challenging behaviours.

The services considered include generic services for older people or older people's mental health, that are accessed by people with dementia and their carers, as well as services that are specifically targeted at people with dementia. The gap analysis points up areas where services are missing or insufficient to meet needs. Where development plans are proposed to meet the needs that have been identified in the gap analysis these are specified and linked to actions in the implementation plan.

The exercise has involved two parallel analyses. In the first, current services that are accessed by people with dementia have been set out in a table. The table lists services by name and category and gives details of the specific service provided followed by a description of the identified gaps. The second analysis has looked at each of the NDS Objectives 6-12 in turn, and has evaluated current services against the Objective, identified gaps, and set out under a 'Future Plans' heading the work that is required to develop services in relation to the relevant Objective.

As would be expected the boroughs have different service configurations and this is reflected in the differing gaps and service development requirements that have been identified. As there are separate borough-specific actions required to support NDS Objectives 6-12 these have been extracted from the gap analysis and set out in the separate Implementation Plans in Appendices 4a and 4b

***ACTION:*** Objectives 6-12 of the NDS will be met through actions identified through the mapping and gap analysis exercise and are detailed against each of the NDS Objectives in the Implementation Plans in Appendices 4a and 4b An additional mapping and gap analysis of the needs of younger adults with dementia, and their carers, will be completed.

## 8. Delivering the Strategy - Overview

NDS Objectives 13 to 17 are intended to ensure that the national strategy is delivered:

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

**Objective 14:** 'A joint commissioning strategy for dementia'

**Objective 15:** 'Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers'

**Objective 16:** 'A clear picture of research evidence and needs'

**Objective 17:** 'Effective national and regional support for implementation of the Strategy'

**Objectives 15, 16, and 17** are to be achieved, in the main, through nationally determined programmes of action. Objective 14 the development of a joint commissioning strategy for dementia requires local action which is being realised in Halton and St Helens through this document. Objective 13 is considered in the following section.

## 9. Workforce Development

In order to achieve 'an informed and effective workforce for people with dementia' (NDS Objective 13) professionals providing services need to have received appropriate basic training and access to continuous professional and vocational development in the principles of the Mental Capacity Act 2005, to ensure that all decisions made on behalf of dementia sufferers, where they lack capacity, are in their best interests and take their wishes and desires into account.

The national strategy says that in the medium and longer-term there needs to be curricula development for professional qualifications and continuing professional development programmes for relevant health and social care staff to ensure that they include relevant modules on dementia care. In the short term however PCTs and local authorities need to commission a trained and competent workforce using regional and local workforce development resources. The best arrangements it suggests are where health and social care system work together to develop their workforce.

The development of the local social care workforce will need to take account of 'Working to Put People First: The Strategy for the Adult Social Care Workforce in England' (2009)

***ACTION:*** Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education

## **10. Implementation Plans**

Separate implementations plans have been drawn up for Halton and St Helens reflecting the fact that the two boroughs have different service configurations. The Implementation Plans, which are attached as Appendices 4a and 4b address in turn each of the NDS Objectives and are intended to ensure that the boroughs and NHS Halton and St Helens can fulfil the Objectives and deliver high quality services for people with dementia and their carers

## Appendix 1 Dementia Financial Plan

The financial plan linked to this dementia strategy is clear that it needs a certain level of investment to deliver the changes that are outlined in the document. It is accepted that we are in a position to offer some redesign of service, however this will only scratch the surface and in no way will it be able to deliver the major shift in service delivery that this document describes. In Halton there is very limited investment in community services and the majority of investment is still channeled to bed based accommodation. However even this gives us limited opportunity to reinvest as the majority of people in residential or nursing accommodation already have complex needs that could not be managed in the community.

The development of the Assessment, Care and Treatment Service aims to deliver an improved level of early diagnosis, early intervention and community support to help both people diagnosed with dementia and their carers to gain the highest quality of support possible. There will be opportunities to carry out some of this work via redesign of existing services, however to have the major impact that the strategy is hoping to achieve then investment would be required. This investment requirement will form the basis of the business case.

<b>Section 5.2 PREVENTION</b>				
<b>ACTION</b>	<b>CURRENT INVESTMENT</b>	<b>SOURCE OF FUNDING</b>	<b>IMPLICATIONS</b>	<b>EXIT STRATEGY</b>
A public health programme will be established to support the prevention of dementia	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	Generic dementia information could be offered through existing public health programmes including Healthy lifestyle services, Cardiovascular disease and prevention services. However, the provision will be low-level and will only meet the needs of some people diagnosed with dementia.	There will only be limited success for people diagnosed with dementia within the existing programmes and with no additional investment.  The respective Older People's boards will be required to clearly monitor the activity to ensure links to prevention of dementia.	If existing measures are not supporting the agreed action then the programme could be picked up through the Older people's prevention strategy that is currently under development. However once again this would require additional funding to support an increase in specialist dementia support.

## Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
A strategy for community engagement will be drawn up	Unknown at present	£45,000 2009/10 £46,000 2010/11 Funding for the Dementia Peer Support through the Halton Health Partnership	The Dementia Peer Support project will be responsible for this action; however the project currently only has short-term funding until 31 <sup>st</sup> March 2011.	Evaluation of the Dementia Peer Support project is to commence in January 2010 with a view to building a future business case as necessary.
A local public information programme will be developed drawing on, and aligned with the national campaign, and will include awareness of the risks of developing dementia at a younger age.	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	It is clear that more investment will be required to deliver the local public information programme. Although there are existing work streams that are able to link into existing low-level networks we would still need far more to deliver in line with the National Dementia strategy	Any local campaigns need to be aligned to National campaigns to ensure maximum effectiveness. The present position would only allow us to deliver a low key generic dementia campaign and is likely to completely miss the strength and depth of any National campaign.	The Dementia Peer Support project will be tasked to support the local implementation of the dementia awareness raising campaign in the long term.
Information will be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy,	The information available through existing public health programmes will not be able to deliver anything other than low-level generic services for people diagnosed with dementia.	All employers need to be confident in the level of support available to ensure quality and consistent information is provided. Without additional investment the support for employers will be limited and is unlikely	The long-term implementation of this will be through the dementia strategy this will become a core part of business for a range of identified providers.

## Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
	however it is unlikely to be fully successful without additional resource and training.		to deliver appropriate signposting.	
Information will be made available to local employers' personnel/human resources departments so that they can appropriately recognize and respond to the needs of carers within their workforces	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without additional resource and training.	The information available through existing public health programmes will not be able to deliver anything other than low-level generic services for people diagnosed with dementia.	All employers need to be confident in the level of support available to ensure quality and consistent information is provided. Without additional investment the support for employers will be limited and is unlikely to deliver appropriate signposting.	The long-term implementation of this will be through the dementia strategy this will become a core part of business for a range of identified providers.
Joint work will be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in PSHE and Citizenship Education	There is no specific or specialist funding for dementia within existing public health programme. There is an assumption that the generic public health programme will be able to deliver some of the dementia strategy, however it is unlikely to be fully successful without	Need to review current links between adult, children and older people's services. This link will allow access to education and awareness raising across all ages. However, this currently receives no funding and there will need to be investment in place to	This would require joint ownership and funding between children's and adults services to ensure clear and successful implementation.	Separate piece of work will need to be undertaken with children's services to establish the scope of the work and the investment required.



## Section 5.3 A LOCAL STRATEGY FOR RAISING AWARENESS AND UNDERSTANDING

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
	additional resource and training.	deliver specialist dementia information and training.		

## Section 6 EARLY DIAGNOSIS AND SUPPORT

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers will be commissioned for Halton and for St Helens.	<p>This is a new and emerging development.</p> <p>There is currently no investment agreed for this service.</p>	<p>The source of funding will be primarily NHS Halton &amp; St Helens as the lead organisation for dementia. The Department of Health has allocated specific funding to each Primary Care Trust to deliver and implement local dementia strategies.</p> <p>Although there is an in principle agreement from Halton Borough Council and St Helens Council, this is dependent on the finances being available through NHS Halton &amp; St Helens and ensuring invest to save / redesign options are explored.</p>	<p>There will be opportunities to deliver some redesign of existing services, however if there is no additional investment on top of existing service provision then the ACT Service will be very limited in what it can deliver.</p> <p>There would be some small improvements in the efficiency of existing pathways and referral processes, but it would not be in a position to deliver fully on the ACTS business case.</p>	<p>If additional investment is required then there will be a clear improvement in the diagnosis, early intervention and overall support for people diagnosed with dementia. This should significantly impact on the timeliness of referral into long-term care, (including Continuing Health Care) and reduce overall bed days in hospital, residential and nursing accommodations.</p> <p>This fits with the overall aims and objectives as outlined in this document.</p>

## Section 6 EARLY DIAGNOSIS AND SUPPORT

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
<p>The ACTS service will be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' that are available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers.</p>	<p>This is a new and emerging development.</p> <p>There is currently no investment agreed for this service.</p>	<p>The source of funding will be primarily NHS Halton &amp; St Helens as the lead organisation for dementia, also the Department of Health has allocated specific funding to each Primary Care Trust to deliver and implement local dementia strategies.</p> <p>Although there is an in principle agreement from Halton Borough Council and St Helens Council, this is dependent on the finances being available through NHS Halton &amp; St Helens and ensuring invest to save / redesign options are explored.</p>	<p>By increasing the success of early diagnosis we would need to ensure that support services, both generic and specialist are in place and prepared for an increase in earlier detection of dementia. This will need investment that is currently only available in some low-level amounts.</p>	<p>This will need to be continually reviewed through the Older people's Boards, but only if additional investment is identified and utilised in the right areas as outlined in this document and the ACTS business case.</p> <p>The main priority would be the development of Dementia Care Advisers and the continued support for the Dementia Peer Support Network.</p>
<p>A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service</p>	<p>No investment in this area at present</p>	<p>No investment at present</p>	<p>The Dementia Care Adviser is a vital part of the overall delivery of improved dementia services. A business case will be submitted in December, but it is clear that this is a major risk in the development of services.</p>	<p>Redesign of existing generic roles will be explored, but this is more likely to yield results in later years as ACTS becomes established</p>

## Section 6 EARLY DIAGNOSIS AND SUPPORT

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
<p>The development of peer support and learning networks will be progressed through specific focused projects in Halton and St Helens, with one project focusing specifically on the needs of younger people who develop dementia</p>	<p>£45,000 2009/10 £46,000 2010/11 Funding for the Dementia Peer Support (Halton Only)</p>	<p>Halton Health Partnership</p>	<p>It needs to be clear that the dementia peer support network that is delivered through Age Concern will be in a position to support younger people who develop dementia. It is clear that we do not want to duplicate this service.</p>	<p>Evaluation of the Dementia Peer Support project is to commence in January 2010 with a view to building a future business case as necessary.</p>

## Section 9 WORKFORCE DEVELOPMENT

ACTION	CURRENT INVESTMENT	SOURCE OF FUNDING	IMPLICATIONS	EXIT STRATEGY
Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia and training and education	Not Applicable	Not applicable as there is currently no funding, however there is much work required in the area of training and this will need joint investment from NHS St Helens, each Local Authority and Warrington and Halton Foundation Trust.	Halton and St Helens can ensure improved efficiencies by jointly implementing the local dementia strategies	Need to ensure that the Older People's Boards play an active role in performance managing the implementation of the dementia strategies.

## Appendix 2 The Key Objectives of the National Dementia Strategy

The key objectives of the National Dementia Strategy are:

- **Objective 1: Improving public and professional awareness and understanding of dementia.** Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.
- **Objective 2: Good-quality early diagnosis and intervention for all.** All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.
- **Objective 3: Good-quality information for those with diagnosed dementia and their carers.** Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.
- **Objective 4: Enabling easy access to care, support and advice following diagnosis.** A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.
  - **Objective 5: Development of structured peer support and learning networks.** The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.
- **Objective 6: Improved community personal support services.** Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.
- **Objective 7: Implementing the Carers' Strategy.** Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

- **Objective 8: Improved quality of care for people with dementia in general hospitals.** Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.
- **Objective 9: Improved intermediate care for people with dementia.** Intermediate care which is accessible to people with dementia and which meets their needs.
- **Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.** The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.
- **Objective 11: Living well with dementia in care homes.** Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services
- **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
- **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.

## Appendix 3: National Dementia Strategy - Key Messages for a Public Information Campaign

### Emerging key messages for a national public information campaign

- Dementia is a disease.
- Dementia is common.
- Dementia is not an inevitable consequence of ageing.
- The social environment is important, and quality of life is as related to the richness of interactions and relationships as it is to the extent of brain disease.
- Dementia is not an immediate death sentence; there is life to be lived with dementia and it can be of good quality.
- There is an immense number of positive things that we can do – as family members, friends and professionals – to improve the quality of life of people with dementia.
- People with dementia make, and can continue to make, a positive contribution to their communities.
- Most of us will experience some form of dementia either ourselves or through someone we care about.
- We can all play a part in protecting and supporting people with dementia and their carers.
- Our risk of dementia may be reduced if we protect our general health, e.g. by eating a healthy diet, stopping smoking, exercising regularly, drinking less alcohol and generally protecting the brain from injury.

**Source:** *Living Well with Dementia* - National Dementia Strategy DH 2009

## Appendix 4: Service Mapping and Gap Analysis – Halton

The service mapping and gap analysis is in two parts. Part 1 is an evaluation of the performance of current services in relation to Objectives 6-12 of the National Dementia Strategy that points up actions that will be needed (see under ‘future plans’) to enable the Objectives to be met. Part 2 is a more detailed and service specific analysis. It provides details of the broad range of current services accessed by people with dementia and their carers, and gives details of the services provision and identifies gaps that are specific to each service category.

### 1) Evaluation of current services, gaps and future plans in relation to NDS Objectives 1-12

**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.

**Current Provision:** Public and professional awareness is limited, information is provided through the Alzheimer’s Society on a National and local basis, however there are still major concerns on the amount of timely information and knowledge available to people.

**Gaps in Service:** Gaps include the quantity, quality and frequency of information that is available. There are also possible gaps within information that would support early diagnosis and access to improved community services. In relation to community services there is a gap in specialist knowledge that often leads to people with dementia being unable to access some generic community services and facilities.

**Future Plans:** in line with National plans to offer additional support to GPs and other professionals we aim to commission training that will range from basic awareness skills up to specialist accredited training. In addition developments within existing voluntary and community service providers will allow us to improve skills across the whole sector. This will include engaging with a wider range of providers e.g. Sport, leisure, culture, arts, retail etc.

**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.



**Current Provision:** In Halton the provision of early diagnosis and intervention is poor. It is not unusual for people to wait for a period of some years before receiving a definitive diagnosis. There is a Community Mental Health Team, however due to capacity issues the service often spends time dealing with complex cases and does not have the time to deal with earlier interventions.

**Gaps in Service:** No designated team specifically designed to address early diagnosis and intervention.

**Future Plans:** The Assessment, Care and Treatment Service are specifically designed to address early diagnosis and intervention. It is planned that the service will be operational from April 2010.

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

**Current Provision:** As in objective 1, information provision is limited, mainly through the Alzheimer's Society.

**Gaps in Service:** Consistent, timely and widely available information available for people with dementia and their carers.

**Future Plans:** dementia will be included in the overall marketing strategy for older people's services in Halton. This will include a range of communication methods that will help to inform the population on activities, support, opportunities and where to get help.

**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.

**Current Provision:** Community family support is available through The Alzheimer's Society, however capacity is limited.

**Gaps in Service:** Capacity is only available to offer support to a maximum of 30 people with dementia in Halton.

**Future Plans:** The Dementia Care Advisors role will be a key element of the Assessment, Care and Treatment service that is planned to begin operating from April 2010.

**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.

**Current Provision:** A newly formed dementia peer support network delivered through Age Concern Mid Mersey has been established and will begin to facilitate a range of peer support groups and opportunities for people diagnosed with dementia and their carers.

**Gaps in Service:** None identified at present, see future plans.

**Future Plans:** Over the next two years capacity for the above service will need to be monitored to ensure that there is enough service provision. In addition an exit strategy will need to be developed as the service is only grant funded for the next two years.

**Objective 6:** *Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services*

**Current Provision:** Oak meadow, day care offers 13 people 2 days a week. 5 Short stay dementia beds are offered on a short-term basis as part of the intermediate care service as part of the rapid rehabilitation service.

**Gaps in Service:** Specialist training at a higher level is required. Increased capacity in relation to day care or alternative social activities to support people with dementia to remain independent in their own homes and communities.

**Future Plans:** Need to develop professional and vocational training to support continuing professional development. Ensure that dementia is included in the plans to develop the personalisation agenda in both health and social care. Further analysis to be done on the needs of younger adults with dementia.

**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*

**Current Provision:** The specific needs of carers of people diagnosed with dementia are addressed in the carers commissioning strategy. However, the additional support needs of carers of younger adults with dementia require further consideration.

**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*

**Current Provision:** A psychiatric liaison service has been operating in Halton since 2006. Initially set up as a pilot the service was mainstreamed and expanded in 2008 and now operates in Warrington and Whiston Hospital. Evaluation of the service clearly demonstrated the positive impact for individuals accessing the service, clinicians and from a financial point of view. In addition the Local Authority has recently recruited a dignity co-ordinator who will be responsible for ensuring that dignity standards are raised across a range of disciplines including general hospital settings.

**Gaps in Service:** Plans are being developed to identify a specific lead for dementia in general hospital.

**Future Plans:** Implement action plan for dignity co-ordinator and identify lead for dementia within the hospital.

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

**Current Provision:** Intermediate Care in Halton offers inclusive access to all parts of their service. However, it is important to clearly identify that intermediate care services are generic and not specialised.

**Gaps in Service:** Access to specialist training for dementia and to the specific issues facing younger adults.

**Future Plans:** Need to develop professional and vocational training to support continuing professional development. This needs to be tailored to the needs of individuals linked to the capacity and specialisms within each specific team.

**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*

**Current Provision:**

**Telecare:** Telecare services in Halton are provided on 3 levels with a range of manually or automatic operated telecare sensors. Installation of which is dependant on need, currently very much focused on risk management and intervention to potential crisis.

Ongoing awareness sessions re the availability of Telecare and assistive technology and the potential benefit its use can have to both service users and their carers is delivered to colleagues in health/social care private and voluntary sectors.

Technical support and advice is available in relation to standalone assistive technology.

**Gaps in Service:**

Better communication is needed across all services involved as lack of this can impact on the effectiveness of the service

Need to increase public awareness of assistive technology and Telecare Service.

**Future Plans:**

Progressing towards using virtual sensor technology and lifestyle monitoring technology to enable us to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and potential crisis to maintain independence.

Consideration is being given to joint work between the Borough and PCT/Practice based commissioner in the use of telehealth applications to monitor and manage long term conditions.

***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*

**Current Provision:** Halton offers 330 registered beds in Halton and has 15 people placed outside of the borough. Regular monitoring visits are conducted; however there are clear indications that there is a lack of parity in the level of care and support that a resident might receive. This is particularly acute when looking at the ability for providers to deal with challenging behaviour.

**Gaps in Service:** Improved professional training relating to dementia.

**Future Plans:** Develop new service specification for residential and nursing homes to include the dignity charter. Implement action plan for dignity co-ordinator and identify lead for dementia within the hospital. Registration requirements to be addressed to ensure that younger adults with dementia do not have to change placements as they get older. Commissioners to consider cross-boundary commissioning for younger people with more complex needs, to avoid high cost out-of-area placements.

***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.*

**Current Provision:** A multi-professional group of specialists in Palliative Care, Older People's Mental Health services, the Alzheimer's Society, General Practice, Dietetics, Speech Therapy and Care of the Elderly met to formulate symptom control

guidelines for health care professionals caring for patients with end stage dementia. These focus on symptoms, which are common or troublesome in this patient group. The Care Pathway, symptom control guidelines developed will be followed up by a series of educational events for health care professionals. The Care Pathway aims to help provide continuity of care for this patient group, whose care needs are often provided by a range of carers.

**Gaps in Service:** Clarity around direction of service provision and multi-agency working.

**Future Plans:** There is a clear need to develop a multi-agency end of life strategy relating to people who have dementia and including support for their families and carers. NHS Halton & St Helens is beginning this work and the details outlined above in the current position show progress made to date, however more detailed work is required.

## Appendix 4a. Halton: Current Service Analysis

The mapping of current services in Halton has been split into two distinct categories:

- Specialist dementia services
- Generic services that support people diagnosed with dementia.

The strategy has also produced a financial summary of the specialist services, breaking them down in the following areas, low-level community services, domiciliary care services and residential or accommodation based services.

It is important to acknowledge that although the second table begins the process of mapping some of the generic services that provide support for people diagnosed with dementia; this is by no means an exhaustive list. It is also clear that by classing services as generic as opposed to specialist dementia services do not assume that they are in any way unable to meet the needs of service users with dementia. The generic services do have high levels of knowledge and training in relation to dementia and also allow access to their service for a range of service users across the population. An example of this would be Adult Placement that is equipped to support people diagnosed with dementia and currently supports a total of twenty-one, however also supports a number of service users with different conditions.

### Financial breakdown of Specialist dementia services

Category	Service Name	Investment
Community Services	<b>Oak Meadow: day-care and carers break day-care</b>	<b>£25,686 p.a.</b>
	<b>Older Peoples Community Mental health Team</b>	Investment £120,000* - Halton Borough Council £259,000 – NHS Halton and St Helens
	<b>Intermediate Care – current provision</b>	£49,978
<b>Total</b>		<b>£454,664</b>
Low-level services	<b>PSS</b>	£40,000
	<b>Dementia reading group</b>	£7,500

	<b>Alzheimers Society</b>	£30,000 p.a.
<b>Total</b>		<b>£77,5000</b>
Accommodation based	<b>Long stay dementia care residential/nursing homes Continuing Health Care</b>	<b>£1.49 million (Local Authority) £3.57 million (NHS Halton &amp; St Helens)</b>
	<b>Out of Borough Placements (Residential)</b>	£251,719.
	<b>Oak Meadow: short stay dementia beds</b>	<b>£145,600 p.a. (£560.00 per bed per week)</b>
<b>Total</b>		<b>£5,457,319</b>

### Mapping of Current Services and Gaps - Halton: Specialist dementia services

Service Name / Description	Service Provided	Gaps	Development Plans
<b>Oak Meadow: day-care and carers break day-care</b>	Oak Meadow provides day care for up to 13 people 2 days a week. Capacity for 26 carers to receive 1352 breaks per year  <b>Investment £25,686 p.a.</b>	Quality specialist service provision  Specialist training  Staffing cover	
<b>Oak Meadow: short stay dementia beds</b>	Oak Meadow has a 5 bedded dementia unit for short-term care including respite, transitional, shared care and support for carers in crisis. The unit provides care for people whose needs relate primarily to their mental health.  Currently operating on a 1-5 staffing level with dedicated specially trained staff for dementia.  <b>Investment: £145,600 p.a. (£560.00 per bed per week)</b>	Specialist support activity  Enhanced training  Support for younger adults	Ensure working locally within DoH workforce strategy  DOH working with professional and vocational bodies to support continuing professional development  Develop pre and post qualification and occupational training.  Commissioners to specify necessary dementia training for

Service Name / Description	Service Provided	Gaps	Development Plans
<p><b>Long stay dementia care residential/nursing homes</b></p>	<p>See summary details at end of table</p> <p>Halton has a total of 330 beds registered for people with dementia, it is important to note the vacancy rates on these beds are regularly high. If we operated at 100% occupancy then the total cost would be in excess of £7 million and the premium payment on top of the standard residential rate would be £1.1million (if all funded through Local Authority or NHS Halton &amp; St Helens)</p> <p><b>Actual Investment for 2008/09 for the local authority on dementia beds: £1.49 million</b>  <b>Continuing Health Care: £3.57 million</b>  <b>This does not include any self funders, out of area placements.</b></p>	<p>Specialist support activity</p> <p>Enhanced training</p> <p>Specialist local unit for younger people</p>	<p>service providers</p> <p>Ensure working locally within DoH workforce strategy</p> <p>DOH working with professional and vocational bodies to support continuing professional development</p> <p>Develop pre and post qualification and occupational training.</p> <p>Commissioners to specify necessary dementia training for service providers</p>
<p><b>Out of Borough Placements (Residential)</b></p>	<p>Investment: Dementia specific financial information for placements is only available for Frodsham Christian NH which is 100% dementia care the total for 08/09 was £251,719. This supports 15 people out of the borough.</p>	<p>Capacity issue in Runcorn due to shortage of EMI nursing provision</p> <p>Specialist Training to support quality of service</p>	<p>2 existing providers changed registration in Widnes ( Ferndale and Millbrow)</p> <p>Ensure working locally within DoH workforce strategy</p> <p>DOH working with professional and vocational bodies to support continuing professional</p>



Service Name / Description	Service Provided	Gaps	Development Plans
			<p>development</p> <p>Develop pre and post qualification and occupational training. Commissioners to specify necessary dementia training for service providers</p>
<b>PSS</b>	<p>PSS provide a sitting service for people with dementia.</p> <p>Currently the service supports 28 service users (<i>June 2009</i>)</p> <p>Investment: £40,000</p>	Capacity – no weekend or evening cover currently being offered	Recommission service – develop new service specification to include higher level of flexibility.
<b>Dementia reading group</b>	<p>Two sessions operating on one day a week reading with people diagnosed with dementia</p> <p>Currently 14 people access the service, however there is capacity for 16 people</p> <p>Investment £7,500</p>	Capacity issues in both residential and community settings	Identify funding to increase the service provision.
<b>Older Peoples Community Mental health Team (100 per cent)</b>	<p>Assessment and care management for older people with mental health needs</p> <p>Investment £120,000* - Halton Borough Council</p>	<p>Capacity – managed through accepting a narrow band of referrals</p> <p>Access for people in the early stages of dementia is inconsistent</p> <p>No crisis response capacity</p>	<p>The gaps identified are currently being addressed in the proposals to develop the Assessment, Care and Treatment Service (ACTS)</p> <p>Continued developments to support the improved integration of the existing team</p>
<b>Alzheimers Society</b>	Monthly educational groups, luncheon club (dementia café), Activities group – memory clinic, home visits, social	Peer networks	Currently developing a Dementia peer support service funded

Service Name / Description	Service Provided	Gaps	Development Plans
	<p>events, information and signposting service.</p> <p>700 breaks to 120 individuals carers (The carers will relate to the service users with dementia)</p> <p>£ Investment 30,000 p.a.</p>	Capacity for dementia café	through Working Neighbourhood Fund and delivered through Age Concern Mid Mersey
<b>Intermediate Care – current provision</b>	<p>Specialist provision within Intermediate Care in the form of 1.0 Whole Time Equivalent Community Psychiatric Nurse (CPN)</p> <p>Investment: £49,978 approx</p>	Input from specialist mental health teams needs to be increased.	

\* Finance figures are indicative – pending completion of PSSEX1

## Summary of expenditure on residential care for dementia 2008/9

External provision within Halton	Total for 08/09
Widnes Hall and Lodge (Orchard Care Homes)	6,870.34
Trewan House	140,200.34
Simonsfield Residential Home	391,744.18
Norton Lodge Care Home	87,105.68
Hannah & Olivia Court Nur/Res	143,793.33
Ferndale Court & Mews	504,477.59
Croftwood	103,859.31
Cartref Residential Home	78,374.66
Beechcroft Nursing Home	41,665.16
<b>Sub-total external provision</b>	<b>1,498,090.60</b>

### Mapping of Current Services and Gaps - Halton: Generic services for people diagnosed with dementia

Service Name / Description	Service Provided	Gaps	Developments
<b>Oak Meadow: day-care and carers break day-care</b>	Social day-care is held on 3 days a week providing up to 20 places on each day and can accommodate people with low to moderate diagnosis level of dementia	People with dementia often attend the venue on days when no sessions are planned. Therefore it is clear that there is a capacity issue for this service.  This service would need an increase in specialist support to increase quality.	
<b>Older Peoples Teams – safeguarding (About 1/3 of the service is provided to people with dementia of all social care staff community and hospital)</b>	Assessment and care management for older people including older people with dementia.  Investment £558.282*	Continue to build on existing specialist knowledge through training to support the highest quality of service provision	Ensure working locally within DoH workforce strategy  DOH working with professional and vocational bodies to support continuing professional development  Develop pre and post qualification and occupational training.  Commissioners to specify necessary dementia training for service providers
<b>Adult Teams (About 5 per cent of the service is provided to people</b>	Assessment and care management for adults including adults with young onset dementia.	Continue to build on existing specialist knowledge through training to support the highest	Ensure working locally within DoH workforce strategy

Service Name / Description	Service Provided	Gaps	Developments
<b>with dementia)</b>	£154,595 Investment *	quality of service provision	<p>DOH working with professional and vocational bodies to support continuing professional development</p> <p>Develop pre and post qualification and occupational training.</p> <p>Commissioners to specify necessary dementia training for service providers</p>
<b>Younger adults with dementia</b>	<p>Investment £300,000</p> <p>22 people between 45 – 64 diagnosed with dementia requiring out of area support.</p>	Of the 22 service users receiving a service 12 of them are aged between 60 – 64 and the implication of transition would need to be considered in relation to these people	The element of transition will be considered in the development of the Assessment, Care and Treatment Service
<b>Domiciliary care</b>	<p>It is estimated that a third of the budget is for dementia care.</p> <p>Investment :The overall annual budget is made up of £4,500,748 (HBC) and £51,543 (Grant) 1/3 = £1,517,430</p>		
<b>Adult placement</b>	119 day care places per week. 21 of 31 carers currently provide care to people suffering from dementia.	Continued specialist training for staff to support people diagnosed with dementia.	<p>Ensure working locally within DoH workforce strategy</p> <p>DOH working with professional and vocational bodies to support continuing professional development</p> <p>Develop pre and post</p>

Service Name / Description	Service Provided	Gaps	Developments
			<p>qualification and occupational training.</p> <p>Commissioners to specify necessary dementia training for service providers</p>
<p><b>Intermediate Care – current provision</b></p>	<p>14 Intermediate Care beds with registration for one dementia bed</p> <p>Intermediate care services in Halton do support access to their services for people diagnosed with dementia, however they are generic and not specialist</p>	<p>Clear pathways from Intermediate Care services to local Mental Health services provision</p> <p>Better communication needed across all services &amp; need to increase public awareness of the service</p>	<p>Ensure working locally within DoH workforce strategy</p> <p>DOH working with professional and vocational bodies to support continuing professional development</p> <p>Develop pre and post qualification and occupational training.</p> <p>Commissioners to specify necessary dementia training for service providers</p>

## **Appendix 4b: Service Mapping and Gap Analysis – St Helens**

The service mapping and gap analysis is in two parts. Part 1 is an evaluation of the performance of current services in relation to Objectives of the National Dementia Strategy that points up actions that will be needed (see under 'future plans') to enable the Objectives to be met. Part 2 is a more detailed and service specific analysis. It provides details of the broad range of current services accessed by people with dementia and their carers, and gives details of the services provision and identifies gaps that are specific to each service category.

## 1) Evaluation of current services, gaps and future plans in relation to NDS Objectives

**Objective1:** *Improving public and professional awareness and understanding of dementia.*

**Current Provision:** St Helens, Adult Social Care offers training in dementia awareness and the Alzheimer's Certificate programme to a variety of service providers. These include the voluntary and independent sectors as well as to their own staff. Within the Reablement Team, the psychiatric nurse provides additional training, advice and support to staff on working with people living with dementia. Adult Social Care has also worked with Bradford University on a 4 day intensive programme on dementia care.

**Gaps in Service:** There is no coherent or co-ordinated public or professional awareness raising programmes for dementia across Health and Social Care. There are limited services and information available to people with dementia. Moreover, these services are targeted at older people and consequently younger people are often unaware of the possibility of dementia and are reluctant to self refer. There is an inconsistency in professional knowledge and skills and professionals are often reluctant to diagnose dementia in younger people.

**Future Plans:** *There is a need to engage with Public Health and professionals to raise awareness and understanding of dementia. Therefore a public health programme to support the prevention of dementia will be developed. Local dementia awareness campaigns to coincide with national campaigns will be planned. A skills audit will be conducted across a range of professionals who are already involved in caring and supporting people with dementia. The results from the audit will inform training needs and a programme of training will be planned and rolled out to professionals.*

**Objective 2:** *Good quality early diagnosis and intervention for all*

**Current Provision:** Early diagnosis is variable across the borough. This is compounded by the stigma attached to dementia and the difficulty in making the diagnosis. The Cognitive Function Clinic (memory clinic) undertakes specialist assessment and monitoring of cognitive impairment as well as the effects of pharmacological interventions that are designed to delay cognitive impairment.

**Gaps in Service:** Services are not currently well resourced to provide a good quality early diagnosis. Consequently the effects of early interventions that will delay or reduce cognitive impairment may be implemented at a later stage with reduce efficacy.

**Future Plans:** The commissioning and implementation of the planned Assessment Care and Treatment Service (ACTS) will provide for good quality early diagnosis and intervention for all people with dementia irrespective of age. The ACTS is currently awaiting final sign off from the PCT.

***Objective 3:** Good quality information for those with diagnosed dementia and their carers*

**Current Provision:** Information is available from the local Alzheimer's Society, the 5 Borough Trust and the Carers' Centre. People living with dementia and their carers will need to be in contact with these services in order to access these services.

**Gaps in service:** Good quality information is not easily accessible locally for those with diagnosed dementia. There is no locally recognisable main place to obtain information on Dementia in the Borough. This can result in a number of people not having access to information on dementia.

**Future Plans.** The planned ACTS will improve the dissemination of information and will be a focal point for people to obtain information on dementia. The dementia advisor, attached to the ACTS will also help to enable people to access the necessary information

***Objective 4:** Enabling easy access to care, support and advise following diagnosis*

**Current Provision:** Some support and advise are available from Adult Social Care , Primary Care, GPs, the Carers Centre , the Alzheimer's Society, the 5 Borough Trust and some voluntary groups. This support and advise is not uniformed and access is inconsistent and variable.



**Gaps in service:** Access to care and support is not uniform and consistent. The support may not be timely and easily accessible to the individual.

**Future Plans:** The Acts service will be designed to enable people with dementia and their carers to access the care and support they need. The role of the dementia advisors will be vital to delivering this objective of the NDS.

***Objective 5:** Development of structured peer support and learning networks.*

**Current Provision:** There is very limited structured peer support and learning networks for people with dementia in St Helens. The Carers Centre runs a dementia support group for carers of people living with dementia and the Alzheimer's Society provides some support.

**Gaps in Service:** There is insufficient peer support within the borough for people with dementia and their carers.

**Future Plans:** St Helens will be developing Peer Support networks which will be hosted within the voluntary sector. Knowledge gained from the Peer Support Pilots in the Department of Health programme will be used to inform the further development of the local peer support Groups.

***Objective 6:** Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services*

**Current Provision:**

St Helens Council's Domiciliary Care Team provides general domiciliary care for people with dementia.

There is also a Specialist domiciliary service, commissioned from the independent sector which provides specialist domiciliary care for people with dementia.

**Gaps in Service:**

The demand for specialist domiciliary care hours is greater than what has been commissioned by Adult Health & Social Care Services.

## **Future Plans**

The service is currently being reviewed. The Council will be increasing the number of specialist domiciliary care support for people living with dementia.

**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*

## **Current Provision:**

Carers are given a Carers assessment irrespective of their diagnosis. Joint Carers' assessments are undertaken with the Carers' Centre

The carers Centre also runs a Carer Dementia support group.

## **Gaps in Service:**

Development of personalised breaks for carers. Support for children who are in a caring role needs to be strengthened.

## **Future Plans:**

Work is in hand to develop personalised breaks for carers

Work with Young Carers to ensure that their needs as children are protected.

Further work needs to be done to implement the Carers Strategy

**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*

## **Current Provision:**

A nurse consultant and a hospital consultant provide leadership for dementia in the local general hospital.

A Psychiatric liaison service has recently been established at the local hospital.

**Gaps in Service:**

**Future Plans.** Ensure that there is sufficient capacity to provide the service to manage demand

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

**Current Provision:** The Intermediate care service is inclusive of people with mild to moderate dementia. Referrals are accepted based on whether the service is able to meet the individual needs. A Community Psychiatric Nurse is based within the service to provide support and advice to team members as well as therapeutic interventions to people with mental health issues.

**Gaps in Service:**

There is no intermediate care service available to meet the needs of people with severe dementia.

**Future Plans:**

Explore the feasibility of developing intermediate care for people with severe dementia

**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*

**Current Provision:**

Housing:

The St. Helens Housing Strategy for Older people has actively encouraged the development of a range of housing options for people living with dementia both from a specialist and a non-specialist perspective.

Portland House 1, is a specialist extra care facility providing 8 rented flats for people with dementia. Flexible support is provided by a domiciliary care agency.

Helena Housing has established 30 flats at Parr Mount Court, which are available for rent to people with dementia. An independent provider will provide domiciliary care support to these tenants. Other housing developments include Heyeswood, a 92 unit facility

and Heald Farm Court which provide 89 units of general housing for people including those living with dementia. Reeve Court, a 206 unit will provide support for residents who develop dementia.

The introduction of a specialist domiciliary care service has provided people who have mild to moderate dementia with home care support. This home care support has made it possible for people to remain in their own homes for as long as possible. Consequently, a number of Residential and Nursing Homes are experiencing voids in their facilities. This has led some Homes to consider diversification into the provision of day care and respite care.

Telecare: St Helens provides a Careline service as well as a range of manually or automatic operated telecare sensors. The provision of this service is based on need and the recipient and carer's acceptance of the service. This service is very much focused on risk management and intervention to prevent crisis.

Ongoing awareness sessions re the availability of Telecare and assistive technology and the potential benefit its use can have to both service users and their carers is delivered to colleagues in health/social care.

#### **Gaps in Service:**

Better communication is needed across all services to ensure the effectiveness of the service

Need to increase public awareness of assistive technology and Telecare Service.

#### **Future Plans:**

Housing : A Portland House 2 consisting of 15 mixed tenure flats is currently being planned for the future.

The Local Authority is currently reviewing the usage of a residential facility to provide a service for young people with early onset dementia, older people who challenge and short breaks to benefit both carers and people with dementia.

Telecare : Progress needs to be made in implementing further sensor and lifestyle monitoring technology. This will enable clinicians and professionals to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and avert possible crisis in order to maintain the independence of people with dementia.

#### **Future Plans:**

Consideration needs to be given to joint work between the Borough and PCT/Practice based commissioner in the use of telehealth applications to monitor and manage long term conditions.

**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*

**Current Provision:**

A Nurse Specialist for Older People provides education and training in dementia care to the local nursing homes.

**Gaps in Service:**

There needs to be a specialist in reach service from the community mental health team into nursing homes.

**Future Plans:**

The planned Dementia support care worker will be required to establish links with care homes. The work of the Older People Mental Health Team needs to be reviewed in light of the future establishment of the Assessment Care and Treatment Service.

**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.*

**Current Provision:**

There is no specific end of life care for people with dementia. The PCT is currently piloting a Gold Standard Framework in a nursing home in St Helens for all patients, irrespective of diagnosis and whose needs require end of life care. On the successful completion of the pilot, it is anticipated that this provision will be made available in all care homes. The implementation of is Framework will benefit people with dementia.

**Gaps in Service:**

People with severe dementia have difficulties in communicating their needs and wishes. There is no end of life care pathway which is specific to people with dementia.

**Future Plans:**

Work needs to commence on an end of life care pathway for people who have dementia to include support for their families and carers. Halton & St Helens NHS is piloting a Gold Standard Framework (GSF) in a nursing home in St. Helens.

Although this GSF is not specific to people with dementia much of this work can be applied to this group of people.

### Mapping of Current Services and Gaps –St Helens

Service Name / Description	Service Provision	Gaps in Service
<b>Intermediate Care Service</b>	<p><b>St Helens Intermediate Care Services - Newton Community Hospital Inpatient Unit, Reablement and Rapid Response Team and Seddon Suite Intermediate Care Unit.</b></p> <p>This service is inclusive of people with mild to moderate dementia. Referrals are accepted based on whether the service is able to meet the individual need. A Community Psychiatric Nurse post is based within the service to provide support and advice to team members as well as therapeutic interventions to people with mental health issues.</p>	<p>Service to meet the needs of people with severe dementia and those with Alzheimer’s disease both within their own home and also unit based.</p> <p>There is currently limited resource to provide a crisis response for older people with mental health needs within the community (e.g. a rapid response within 2 hours of referral).</p>
<b>St Helens Access and Advice Team</b>	<p><b>St Helens Access and Advice Team</b></p> <p>This service provides a single point of referral for primary and secondary mental health services. Provides advice and/or signposting to PCMHT and local non-statutory services. Provides specialist assessments for access into secondary mental health services.</p>	
<p><b>5 Borough Mental Health Trust</b></p> <p><b>Inpatient Care - Older Adult</b></p>	<p><b>Stewart Assessment Ward</b></p> <p>Provides inpatient care and treatment to older people having mental health problems of a degree and</p>	<p>There is currently no service available for early diagnosis of dementia. A business case has been put forward to the PCT for</p>

<b>Service Name / Description</b>	<b>Service Provision</b>	<b>Gaps in Service</b>
<b>Acute Assessment –</b>	nature which require services beyond those which can be provided within a community setting Referral is via the Care Co-ordinator; Specialist Mental Health Service; Consultant.	the development of an Access Care and Treatment Service which will include a dementia care worker
<b>Memory Assessment service</b>	<b>The Cognitive Function Clinic (memory clinic)</b>  Undertakes specialist assessment and monitoring of cognitive impairment and the monitoring of the effects of prescribed anti dementia drugs	
<b>Out Patients</b>	<b>Psychiatric Outpatients</b>  Appointment for first and follow up appointment. Appointments can take place in service users usual place of residence Referral: Primary Care Mental health Team, Specialist mental Health Service	
<b>Primary and Community Care - Day Services</b>	<b>Stewart Day Hospital</b> The Stewart Day Hospital provides time limited support to people with moderate dementia via an assessment group. This is an eight week programme which provides a safe and supportive environment in which patients are able to demonstrate and practise their functional and motor skills, ability to follow instruction and the use of long and short term memory. The hospital also provides one to one care and support and education as and when required for Carers A range of therapeutic interventions are available.	Stewart Day hospital will be reconfigured and instead of offering traditional hospital based services only, will also provide outreach services to older people and support for people with memory problems in the community
<b>Psychiatric Liaison Service</b>	<b>Psychiatric Liaison Service</b> This nurse-led psychiatric liaison service provides	This service may need to be enhanced due to the large numbers of older people with a

Service Name / Description	Service Provision	Gaps in Service
	<p>specialist knowledge to staff on the management of depression, dementia and delirium in older people. The service is provided by the 5 Boroughs Partnership Trust with performance oversight provided by St. Helens &amp; Knowsley Hospital Trusts</p>	<p>mental health need, who require psychiatric care input, and who are occupying an acute general hospital bed</p>
<p><b>Integrated Community Mental Health Team</b></p>	<p><b>Older People Mental Health Team</b></p> <p>A multi-disciplinary team providing assessment care and treatment to older people with mental health problems. Care is provided in various community based settings including the service user's residence.</p> <p>Referral; Primary Care Mental Health Team; Specialist Mental Health Service</p>	
<p><b>Advocacy Services</b></p>	<p><b>Advocacy Services</b></p> <p>These services are currently provided under the 'Mental Capacity Act 2007. The services are provided by independent mental health advocates working in the independent sector. The advocates act on behalf of the person only if there are no relatives available to do so.</p>	<p>Improvements in the availability of advocacy services for all older people living with dementia was one of the recommendations included in the Older Peoples CSCI Inspection 2006.</p> <p>Currently Mental Health Commissioners in the Primary Care Trust are working with Commissioners in Adult Social Care &amp; Health Older Peoples services on how to identify and implement extra capacity in this service area.</p>
<p><b>Primary Care Mental Health</b></p>	<p><b>PCMHT</b></p>	<p>This service, although available to older</p>



Service Name / Description	Service Provision	Gaps in Service
<b>Team (PCMHT)</b>	The primary care mental health team offers brief evidence based (generally CBT type) interventions to people presenting with mild to moderate mental health problems with manageable risk	people, receive very few referrals for older people with dementia. Consideration needs to be given as to how these services can be accessed by people living with dementia
<b>Specialist Day/Resource Centres</b>	<p><b>Kershaw Day Centre</b> This Centre provides traditional day care for people with dementia. It is run by the Local Authority. Customers are usually provided with transported to the Centre by the Council. The service operates Monday to Friday. It can accommodate up to a maximum of 60 places. It offers various activities for people with dementia. Referral is via: Specialist Mental Health Service; customer services</p>	
<p><b>Primary and Community Care</b></p> <p>- Homecare - Crisis Intervention</p>	<p><b>Home Care -</b> Specialist Domiciliary care is provided by an independent agency to people with dementia in their own homes. It provides a minimum of 750 hours Co-ordinator; Specialist Mental Health Service</p> <p><b>Crisis Intervention</b> A service level Agreement has been agreed with the Crisis Resolution Team to provide a service for older people who qualify and are aged 65 years and over. This includes people with dementia</p>	This service is currently under review. The number of care hours needs to be increased to cope with the demand for the service
<b>Emergency Duty Team</b>	<p><b>EDT</b> This service provides an emergency social care assessment service, including ASW, outside normal working hours</p>	

Service Name / Description	Service Provision	Gaps in Service
<p><b>Primary and Community Care - Residential</b></p>	<p><b>Seddon Court</b></p> <p>This local Authority facility is a 30 bedded unit offering care for people with dementia. It has 3 respite places for service users who have a confirmed diagnosis of dementia and are over 65 years age. As all other service areas Seddon Court will be reviewed and redesigned to meet a large part of the missing gaps in the St Helens provision. It has been agreed that the PCT allocation within Seddon Court will remain to support this new development. This alongside large scale redesign will meet a significant part of St Helens contribution to the strategy.</p> <p><b>Brookfield &amp; Mossbank</b></p> <p>These 2 facilities, although not specialist dementia residential homes will accept people with a mild form of dementia.</p>	
<p><b>Primary and Community Care Specialist Housing – Extra Care Housing</b></p>	<p><b>Portland House</b></p> <p>This is an extra care facility providing 8 rented flats for people with dementia. Flexible support, is provided by a domiciliary care agency</p>	<p>This service has been very successful and there is a demand for further provision. A Portland House 2 consisting of 15 mixed tenure flats is currently being planned for the future.</p>
<p><b>Voluntary Sector Services</b>  <b>-Carers Centre</b>  <b>-Alzheimer’s Society</b></p>	<p><b>Carers</b></p> <p>The Carers Centre provides advice, information and emotional support for anyone visiting the centre or contacting them by telephone. Most specifically, the</p>	<p>Action plan for the promotion of ways for Carers of Older People with Mental Health problems to access advice and support.</p>

Service Name / Description	Service Provision	Gaps in Service
	<p>Centre provides training on dementia via a 6 week dementia awareness course. It also produces a dementia guidelines leaflet. It also loans Carers a DVD 'How to care for someone with dementia'. It also runs a dementia support group</p> <p><b>Alzheimer's Society</b> The St Helens Alzheimer's Society meets on a monthly basis and provides support to people with dementia and their carers.</p>	
<p><b>Registered Social Landlords (RSLs)</b></p>	<p><b>Helena Housing</b> This RSL has established 30 flats at Parr Mount Court which are available for rental to people with dementia. An independent provider will provide domiciliary care support to these tenants.</p>	<p>Another 180, 1 and 2 bedroom flats will be available at Heald Farm Court and Heyeswood will become available in September and October 09. People with dementia will be able to become tenants</p>
<p><b>Mental Health Promotion</b></p>	<p><b>Mental Health Promotion</b> This generic service is provided by the PCT. The Mental health Directory has been reviewed to include older people</p>	<p>There needs to be targeted structured campaigns to raise awareness of dementia. There is also a need for a peer support network</p>

## Appendix 4c. Financial breakdown of Dementia Services – St Helens

The strategy has also produced a financial summary on dementia services, breaking them down in the following areas, Community services and residential or accommodation based services.

It is important to note that there may be other services e.g. domiciliary care, Careline etc that are not included in the financial mapping as it is difficult to break down the spend across dementia services.

Category	Service Name	Investment
<b>Community Services</b>	Kershaw Day Centre	£ 562,744 p.a.
	50 places per day	
	Older Peoples Community Mental Health Team	£ 400
<b>Total</b>		<b>£ 962,744</b>
<b>Accommodation based</b>	Long stay dementia care residential/nursing homes ( in borough)	£2,149.601
	Long stay dementia (in house)	£1,087.145
	Out of Borough Placements ( but within a 2 miles of the Borough)	£1,048,334.
<b>Total</b>		<b>£5,247.824</b>

## Summary of expenditure on residential and Nursing care for dementia 2008/9

<b>Out of Borough Approved Providers - St Helens</b>	<b>Total for 08/09</b>
Ashton View	128,263
Callands	23,422
Green Park	65,895
Hillside	65,574
Knowsley Manor	21,429
Rosevilla	407,524
Shawcross	218,581
Stocks Hall	78,374.66
Beechcroft Nursing Home	117,646
<hr/>	
<b>Sub-total of out of borough provision</b>	<b>1,048,334</b>
<b>In Borough Approved Providers</b>	<b>Total for 08-09</b>
Broad Oak Manor	399,000
Cedric House	284,155
Eccleston Court	110,000
Elizabeth Court	408,000
Elm Tree House	281,000
Prospect House	393,446
Tree Tops	164,000
Victoria	110,000
<b>Grand Total</b>	<b>2,149,601</b>

## Appendix 5

### Halton and St Helens Joint Commissioning Strategy for Dementia



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# Implementation Plan

## Halton

NDS Objectives	National NDS Implementation Plan: Key Priorities
<p>1: Improving public and professional awareness and understanding of dementia  2: Good-quality early diagnosis and intervention for all  3: Good-quality information for those with diagnosed dementia and their carers  4: Enabling easy access to care, support and advice following diagnosis  5: Development of structured peer support and learning networks  6: Improved community personal support services  7: Implementing the Carers' Strategy  8: Improved quality of care for people with dementia in general hospitals  9: Improved intermediate care for people with dementia  10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers  11: Living well with dementia in care homes  12: Improved end of life care for people with dementia  13: An informed and effective workforce for people with dementia  14: A joint commissioning strategy for dementia  15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers  16: A clear picture of research evidence and needs  17: Effective national and regional support for implementation of the Strategy</p>	<ul style="list-style-type: none"> <li>• Early intervention and diagnosis for all</li> <li>• Improved community personal support services</li> <li>• Implementing the New Deal for Carers</li> <li>• Improved quality of care for people with dementia in general hospitals</li> <li>• Living well with dementia in care homes</li> <li>• An informed and effective workforce for people with dementia</li> <li>• A Joint Commissioning strategy for dementia</li> </ul>

## Halton and St Helens Joint Commissioning Strategy for Dementia

### Implementation Plan - Halton

Objectives	Actions	Tasks	Lead	Progress to date	Expected outputs / outcomes
<b>Theme: Raising Awareness and Understanding</b>					
<p><b>Objective1:</b> Improving public and professional awareness and understanding of dementia</p>	<p>1. A Public Health programme to support the prevention of dementia should be developed and progressed</p> <p>2. A strategy for community engagement should be drawn up</p> <p>3. A local public information programme should be developed drawing on, and aligned with the national campaign and will include awareness of the risks of developing dementia at a younger age</p> <p>4. Information should be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately</p> <p>5. Joint work should be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy and are provided with suitable information for inclusion in PSHE and Citizenship Education</p>	<ul style="list-style-type: none"> <li>• Agree key messages for publication</li> <li>• Identify funding</li> <li>• Agree distribution</li> <li>• Evaluate impact of campaign</li> <li>• Establish community engagement steering group</li> </ul>	<p>NHS HStH - Public Health</p>		<ul style="list-style-type: none"> <li>• Increase in the number of people presenting at primary care</li> <li>• Major increase in the number of people receiving a timely diagnosis</li> <li>• Increase in support for people diagnosed with dementia to access community services</li> <li>• Reduction in the cycle of stigma and discrimination associated with dementia.</li> </ul>



Theme: Early Diagnosis and Support					
<b>Objective 2:</b> Good-quality early diagnosis and intervention for all	Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers should be commissioned for Halton and for St Helens	<ul style="list-style-type: none"> <li>• Investment to be approved</li> <li>• Tender exercise – NHS H&amp;StH</li> <li>• Approve provider</li> <li>• Implementation plan led by a Project Manager overseen by a Steering Group</li> </ul>	HBC, St H C, and NHS HStH	Specifications for ACTS completed & business cases progressing through commissioner approval processes. It will then be subject to a tendering exercise	<ul style="list-style-type: none"> <li>• Increase in the number of people presenting at primary care</li> <li>• Major increase in the number of people receiving a timely and early diagnosis</li> <li>• Increase in support for people diagnosed with dementia to access specialised services</li> <li>• Improved quality of life for patient and carer</li> <li>• Reduction in high-end, high-cost support</li> </ul>
<b>Objective 3:</b> Good-quality information for those with diagnosed dementia and their carers	ACTS should be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers	ACTS service provider to produce appropriate information Commissioners should assess outcomes through the performance monitoring process	ACTS service provider  NHS HStH	See 2 above	See 2 above
<b>Objective 4:</b> Enabling easy access to care, support and advice following diagnosis	A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service		HBC & St H Commissioners	See 2 above. The development of the DCA post will need to be timed to fit with the ACTS implementation time-table	<ul style="list-style-type: none"> <li>• Increase in support for people diagnosed with dementia to access specialised services</li> <li>• Increase in support for people diagnosed with dementia and their carers to access community services</li> <li>• Increased access to information</li> <li>• Improved quality of life for patient and carer</li> <li>•</li> </ul>

Continued: Theme: **Early Diagnosis and Support**

<p><b>Objective 5:</b> Development of structured peer support and learning networks</p>	<p>A Dementia Network Project will be commissioned through Age Concern Mid Mersey to develop Peer Support and Learning Networks with one project focusing specifically on the needs of younger people who develop dementia</p>	<p>Applications will be made to Halton Health Partnership for funding for the Project</p> <p>Age Concern will establish a project framework, establish a Task Group, Stakeholder Group and enlist consultancy support</p> <p>ACMM will recruit a part time project lead An Action Plan will be drawn up and implemented</p>	<p>Age Concern Mid Mersey Support offered through Partnership Commissioning</p>	<p>Funding has been agreed Project lead has been recruited Steering group has been established Dementia event has taken place</p>	<ul style="list-style-type: none"> <li>• Increase in support for people diagnosed with dementia to access specialised services</li> <li>• Increase in support for people diagnosed with dementia and their carers to access community services</li> <li>• Increased access to information</li> <li>• Improved quality of life for patient and carer</li> <li>• The project will also undertake an analysis of what training is required for both Professionals and carers in relation to dementia</li> </ul>
<p><b>Theme: Living Well with Dementia</b></p>					
<p><b>Objective 6:</b> Improved community personal support services</p> <p><i>An additional mapping and gap analysis of the needs of younger adults with dementia, and their carers, will be completed.</i></p>	<p>Professional and vocational training will be developed to support continuing professional development.</p> <p>People with dementia will be supported to remain independent in their own homes through inclusion in the health and social care personalisation developments</p>	<p>Training needs analysis completed through the dementia peer network Agree training programme Commission training Establish links to personalisation to ensure people diagnosed with dementia have opportunities to access direct payments and individualised budgets</p>	<p>Training leads for Local Authority and NHS Halton &amp; St Helens</p>	<p>On going</p>	<ul style="list-style-type: none"> <li>• Improved awareness for professionals</li> <li>• Improved awareness for the public</li> <li>• Improved choice, quality and independence for people diagnosed with dementia and their carers.</li> </ul>

Continued: Theme: **Living Well with Dementia**

<p><b>Objective 7:</b> Implementing the Carers' Strategy</p>	<p>The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy</p>	<p>Ensure dementia is covered in carers commissioning strategy</p>	<p>Carers - service development officers</p>	<p>This Objective has been addressed in the current Carers Commissioning Strategy</p>	<ul style="list-style-type: none"> <li>• Improved access to carers support</li> <li>• Greater choice and quality of service for carers</li> <li>• Increased opportunity for carers to maintain some level of independence and quality of life</li> </ul>
<p><b>Objective 8:</b> Improved quality of care for people with dementia in general hospitals</p>	<p>The action plan for the Dignity Coordinator will be implemented A specific lead will be identified for dementia in the general hospital</p>	<p>Dignity action plan agreed through the Older People's Local Implementation Team Invite Hospital lead to attend dignity group</p>	<p>Dignity Co-ordinator  Warrington and Halton Hospital foundation trust</p>	<p>Action plan currently in draft – awaiting sign off</p>	<ul style="list-style-type: none"> <li>• Framework established to identify poor quality</li> <li>• Improved access to information for hospital patients whilst in hospital and on discharge</li> </ul>
<p><b>Objective 9:</b> Improved intermediate care for people with dementia</p>	<p>Professional and vocational training will be developed to support continuing professional development, linked to the capacity and specialisms in each team</p>	<p>Agree training programme Commission training</p>	<p>Training leads for Local Authority and NHS Halton &amp; St Helens</p>	<p>On going</p>	<ul style="list-style-type: none"> <li>• Improved awareness for professionals</li> <li>• Improved awareness for the public</li> <li>• Improved choice, quality and independence for people diagnosed with dementia and their carers.</li> </ul>
<p><b>Objective 10:</b> Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers</p>	<p>Use of virtual sensor and lifestyle monitoring technology will be progressed Joint HBC / NHS H&amp;StH action on telehealth will be considered</p>	<p>Develop and implement joint telecare and telehealth strategy</p>	<p>HBC / NHS H&amp;StH</p>	<p>On going</p>	<ul style="list-style-type: none"> <li>• Increase in number of people supported to remain independent in their own homes</li> <li>• Increased support for carers</li> <li>• Reduction in bed based provision</li> </ul>

Continued: Theme: **Living Well with Dementia**

<p><b>Objective 11:</b> Living well with dementia in Care Homes</p>	<p>ACTS will provide an in-reach support service for people with dementia in care homes and contribute to the training of staff A new service specification for residential and nursing homes will be developed that includes the dignity charter The action plan for the dignity coordinator will be implemented A lead for dementia in the hospital will be identified</p>	<p>ACTS provider's operational policy will include details of the in-reach service arrangements Commissioners will assess outcomes through the performance monitoring process</p>	<p>ACTS provider</p>	<p>See 2 above</p>	<ul style="list-style-type: none"> <li>• Increase in the number of people presenting at primary care</li> <li>• Major increase in the number of people receiving a timely and early diagnosis</li> <li>• Increase in support for people diagnosed with dementia to access specialised services</li> <li>• Improved quality of life for patient and carer</li> <li>• Reduction in high-end, high-cost support</li> </ul>
<p><b>Objective 12:</b> Improved end of life care for people with dementia</p>	<p>To ensure people with dementia and their carers receive the best quality end of life care.</p>	<p>A multi-agency end of life strategy for people who have dementia including support for their families/carers will be developed. Implement Gold standard</p>	<p>NHS Halton &amp; St Helens</p>	<p>Part of commissioning plan for NHS Halton &amp; St Helens</p>	<ul style="list-style-type: none"> <li>• Reduce acute care admissions</li> <li>• Improve choice, quality and independence for people with dementia at any stage of their life.</li> </ul>
<p><b>Theme: Delivering the Strategy</b></p>					
<p><b>Objective 13:</b> An informed and effective workforce for people with dementia</p>	<p>Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education</p>	<p>Agree training programme Commission training</p>	<p>Training leads for Local Authority and NHS Halton &amp; St Helens</p>	<p>On going</p>	<ul style="list-style-type: none"> <li>• Improved awareness for professionals</li> <li>• Improved awareness for the public</li> <li>• Improved choice, quality and independence for people diagnosed with dementia and their carers.</li> </ul>
<p><b>Objective 14:</b> A joint commissioning strategy for dementia</p>	<p>This document sets out the overarching strategy for Halton B.C., St Helens B.C. and NHS Halton and St Helens</p>		<p>Sue Wallace-Bonner HBC, Rob Vickers StHBC and</p>	<p>Document to be agreed through Management Executive Team,</p>	<ul style="list-style-type: none"> <li>• The strategy aims to deliver more capacity and higher quality of service provision</li> </ul>

Continued: Theme: **Delivering the Strategy**

			Janet Dunn NHS H&StH	Senior Management Team and Executive Members by the end of November	
<b>Objective 15:</b> Improved assessment and regulation of health and care services	The Department of Health is progressing this Objective			On going	
<b>Objective 16:</b> A clear picture of research evidence and needs	The Department of Health is progressing this Objective			On going	
<b>Objective 17:</b> Effective national and regional support for implementation of the Strategy	The Department of Health is progressing this Objective			On going	

## Appendix 6

### Halton and St Helens Joint Commissioning Strategy for Dementia



# Implementation Plan

## St Helens

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## Halton and St Helens Joint Commissioning Strategy for Dementia

### Implementation Plan – St Helens

Objectives	Implementation Plan Priority	Actions	Tasks	Lead	Progress to date
<b>Theme: Raising Awareness and Understanding</b>					
<p><b>Objective1:</b> Improving public and professional awareness and understanding of dementia</p>		<p>1. A Public Health programme to support the prevention of dementia should be developed and progressed</p> <p>2. A strategy for community engagement should be drawn up</p> <p>3. A local public information programme should be developed drawing on, and aligned with the national campaign and will include awareness of the risks of developing dementia at a younger age</p> <p>4. Information should be made available to key local employers to help them to ensure that staff can give helpful advice and information and can signpost people appropriately</p> <p>5. Joint work should be undertaken with Children's Services to ensure that they are aware of the National Dementia Strategy and are provided with suitable information for inclusion in PSHE and Citizenship Education</p>		<p>NHS HStH - Public Health</p>	

Theme: Early Diagnosis and Support					
<b>Objective 2:</b> Good-quality early diagnosis and intervention for all	Yes	Early Assessment, Care and Treatment Services (ACTS) for all people with dementia (irrespective of age) and their carers should be commissioned for Halton and for St Helens	<ul style="list-style-type: none"> <li>Investment to be approved</li> <li>Tender exercise – NHS H&amp;StH</li> <li>Approve provider</li> <li>Implementation plan led by a Project Manager overseen by a Steering Group</li> </ul>	HBC, St H C, and NHS HStH	Specifications for ACTS completed & business cases progressing through commissioner approval processes. It will then be subject to a tendering exercise
<b>Objective 3:</b> Good-quality information for those with diagnosed dementia and their carers		ACTS should be given responsibility for ensuring that there is locally tailored, good quality information on dementia and on the 'options for planning ahead' available to be provided to everyone in the borough that is diagnosed with dementia, and to their carers	ACTS service provider to produce appropriate information Commissioners should assess outcomes through the performance monitoring process	ACTS service provider  NHS HStH	See 2 above
<b>Objective 4:</b> Enabling easy access to care, support and advice following diagnosis		A Dementia Care Adviser will be commissioned as part of the development of an early assessment, care and treatment service		HBC & St H C commissioners	See 2 above. The development of the DCA post will need to be timed to fit with the ACTS implementation time-table
<b>Objective 5:</b> Development of structured peer support and learning networks		A Dementia Network Project will be commissioned through Age Concern Mid Mersey and the Local Alzheimer's Society to develop Peer Support and Learning Networks.	Applications will be made to St Helens Adult Social Care & Health for funding for the Project	St HBC	
Theme: Living Well with Dementia					
<b>Objective 6:</b> Improved community personal support services  <i>An additional mapping and</i>	Yes	Professional and vocational training will be developed to support continuing professional development. People with dementia will be		5 BP Trust, St.HBC, NHS H& St.Helens	



<i>gap analysis of the needs of younger adults with dementia, and their carers, will be completed.</i>		supported to remain independent in their own homes through inclusion in the health and social care personalisation developments			
<b>Objective 7:</b> Implementing the Carers' Strategy	Yes	The specific needs of carers of people diagnosed with dementia are addressed in the Carers Commissioning Strategy		NHS H& St. H, St.HBC	This Objective has been addressed in the current Carers Commissioning Strategy
<b>Objective 8:</b> Improved quality of care for people with dementia in general hospitals	Yes	A specific lead will be identified for dementia in the general hospital		StH&K	A specific lead has already been identified in StH&K Trust
<b>Objective 9:</b> Improved intermediate care for people with dementia		Professional and vocational training will be developed to support continuing professional development, linked to the capacity and specialisms in each team			
<b>Objective 10:</b> Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers		Use of virtual sensor and lifestyle monitoring technology will be progressed Joint HBC / NHS H&StH action on telehealth will be considered			
<b>Theme: Living Well with Dementia</b>					

<b>Objective 11:</b> Living well with dementia in care homes	Yes	ACTS will provide an in-reach support service for people with dementia in care homes and contribute to the training of staff A new service specification for residential and nursing homes will be developed that includes the dignity charter The action plan for the dignity coordinator will be implemented A lead for dementia in the hospital will be identified	ACTS provider's operational policy will include details of the in-reach service arrangements Commissioners will assess outcomes through the performance monitoring process	ACTS provider	See 2 above
<b>Objective 12:</b> Improved end of life care for people with dementia		A multi-agency end of life strategy for people who have dementia including support for their families/carers will be developed.			
<b>Theme: Delivering the Strategy</b>					
<b>Objective 13:</b> An informed and effective workforce for people with dementia	Yes	Commissioners in Halton and St Helens boroughs and in NHS Halton and St Helens will work together to ensure that effective local arrangements are established for dementia training and education			
<b>Objective 14:</b> A joint commissioning strategy for dementia	Yes	This document sets out the overarching strategy for Halton B.C., St Helens B.C. and NHS Halton and St Helens		Sue Wallace-Bonner HBC, Rob Vickers StHBC and Janet Dunn NHS H&StH	
<b>Objective 15:</b> Improved assessment and regulation of health and care services		The Department of Health is progressing this Objective			
<b>Objective 16:</b> A clear picture of research evidence and needs		The Department of Health is progressing this Objective			
<b>Objective 17:</b> Effective national and regional support for implementation of the Strategy		The Department of Health is progressing this Objective			