

Yorkshire & Humber Improvement Partnership Regional Review of Dementia Barnsley Locality Report

**Veronica Brown
Dementia Strategy Lead
Yorkshire & Humber Improvement Partnership**

On behalf of

**Philip Lewer
Deputy Regional Director
Yorkshire & Humber
Social Care and Local Partnerships
Department of Health**

Supported by

**Michael Jackson
Cornsay Research Services**

December 2009

Acknowledgements

The authors of the report would like to thank all those involved in the Barnsley locality review that took place on the 5th November 2009 and in particular the group of carers and people with dementia from the Alzheimer's Society – Circle Dancing club.

The Review Team for the Barnsley locality visit consisted of: -

- Sally Rogers - Yorkshire & Humber Improvement Partnership
- Veronica Brown - Yorkshire & Humber Improvement Partnership
- Peter Ruickbie - Alzheimer's Society
- Sarah Moody - Alzheimer's Society
- Janet Woodhouse - Trainee Nurse Consultant, NHS Humber
- Linda Jarrod - Commissioning Officer NHS Rotherham and RMBC
- Wendy Burn - Mental Health Lead, NHS Humber

The Barnsley team consisted of: -

- Philippa Slevin, Modern Matron, Memory Team, NHS Barnsley (Locality Dementia Lead)
- Tabitha Arulampalam, Partnership Director, Partnership In Action (BMBC & NHS Barnsley)
- Margaret Kitching, Director of Professions, NHS Barnsley
- Bob Revell, Interim Head of Joint Commissioning - Older People, Partnership In Action (BMBC & NHS Barnsley)
- Julie Bowser, Hospital Manager, Mount Vernon Hospital, NHS Barnsley
- Kath Harris, Assistant Executive Director, Vulnerable Adults, Barnsley Social Services Dept
- Eamonn Lynott, Clinical Lead, Community Mental Health Team for Older People, Barnsley Social Services Dept
- Julie Moore, Principle Officer, Self Directed Support, Barnsley Social Services Dept
- Andrew Stones, Consultant Nurse - Memory Services, NHS Barnsley
- Dr Lyn Sutcliffe, Head of Psychological Services to Older People, NHS Barnsley
- Karen Taylor, Director of Operations, Care Services Direct, NHS Barnsley
- Liz Purt, Learning Disabilities Therapy Manager, Barnsley Social Services Dept
- Shirley Atkinson, Professional Development Support Manager, Barnsley Social Services Dept
- Linda Barker, Intermediate Care Services Manager, NHS Barnsley

The staff groups included representatives of: -

- Memory Service - Barnsley
- Inpatient Organic Assessment Ward And Care Navigators
- Inpatient Organic Assessment Ward

The authors of the report would also like to thank the following individuals for their support during this project –

- Philip Lewer Deputy Regional Director Yorkshire & Humber Social Care and Locality Partnerships
- Peter Flanagan - Yorkshire & Humber Improvement Partnership
- Mary Donohoe - Yorkshire & Humber Improvement Partnership
- Lynn Edgar - Review note taker

For Further Information

If you would like further information about this report please contact Veronica Brown who is the Dementia Strategy Lead for the Yorkshire & Humber Improvement Partnership, Telephone 07977577186 : email Veronica.Brown@yhip.org.uk

Michael Jackson is a freelance researcher and can be contacted via Michael.Cornsay@btinternet.com

Please Note

The analysis in this report is based on the material collected during the review process, with notes taken during the visit appraised by the Local Dementia Lead and supplied to the report authors. The submissions to the authors are taken on face value as being materially factual and correct.

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Executive Summary

In August 2009 the Yorkshire & Humber Improvement Partnership developed a dementia peer review programme that would investigate the progress made towards the implementation of the National Dementia Strategy in the fifteen localities in the Yorkshire & Humber region. This report documents these findings for the Barnsley locality, particularly focussing in on the seven priority objectives of the Implementation Plan.

Good quality early diagnosis and intervention for all – around 77% of the population with dementia in Barnsley have a clinical diagnosis and are registered with their GPs. A well-established referral pathway for use by health and social care staff is in place via the GP for new cases and directly to the Memory Service for known cases. The Memory Service operates 3 consultant clinics and 3 non-medical prescribing clinics and the clinics utilise a number of established assessment tools in their work. All new referrals are provided with an extensive pre and post diagnosis counselling service and the details of Care Navigators are provided where appropriate.

Improved community personal support services – a Home Care service is provided for people with dementia through the mainstream in-house service. This provision is currently being reshaped into a Re-enablement service. The memory team provides additional advice and support to community staff when needed through their “single point of entry”. A Resource Allocation System exists in the locality and 36 people use the Individual Budgets scheme that is currently in operation.

Implementing the Carers’ Strategy for people with dementia – a Respite voucher system currently exists that provides access a large choice of Respite options to residential and Home Care support, due to large spare bed capacity. Emergency break contingency planning is also undertaken through the Carer’s Card system that provides support should the main carer be taken ill.

Improved quality of care for people with dementia in general hospitals – a specialist Adult Mental Health Liaison Service does not currently operate across the general hospital any new referrals requiring memory assessment would be followed up in the community. A scoping exercise has been undertaken to assess the needs/gaps in the service provision following the withdrawal of the previous service. Named leads for dementia have been identified in the acute trust.

Living well with dementia in Care Homes – all Care Homes have informal links with the memory team, but plans do exist to implement a Care Home Liaison Service. No specific quality incentive programme exists for Care Homes in the locality, but a fair pricing review has recently been undertaken.

An informed and effective workforce for people with dementia/carerer training and awareness – an e-learning package on dementia awareness is available for all staff groups in NHS Barnsley, all social care staff and for all carers, with the training for social care staff forming part of the Workforce Development Strategy. A number of formal qualifications are available to both health and social care staff groups that include dementia care and the memory team are planning to run training sessions for carers in the near future.

A joint commissioning strategy for dementia – the responsibility for the commissioning of dementia services sits within the joint commissioning arrangements that oversees the management and discharge of pooled resources across a number of shared interests. Commissioners are confident that services have the necessary capabilities for the future, but capacity issues are anticipated. Some current services are being reshaped i.e. Home Care service and other investigations are examining how greater efficiencies can be achieved in the present service configuration e.g. greater use of Telecare services.

1 Introduction

The National Dementia Strategy¹ was published in February 2009 following an extensive public consultation process. The Strategy is ambitious; its aim is that all people with dementia and their carers should live well with dementia. The Strategy also defined the framework for implementation, which is now published as *Living Well With Dementia: National Dementia Strategy Implementation Plan*². It sets out the task ahead to deliver the aspirations of the National Dementia Strategy and identifies seven³ priority objectives that will help provide the foundations for successful implementation, leading to improvements in the quality of the lives of people affected by dementia.

The implementation plan also specifies *that by 31st March 2010, Deputy Regional Directors (DRD)*⁴ *and their regional teams will have completed a baseline review of dementia across their locality measuring against the objectives identified in the strategy and will ensure there is a jointly owned action plan for each locality that key partners have co-produced and co-own.*

In response to this requirement, in August 2009 the Yorkshire & Humber Improvement Partnership, led by the Dementia Strategy Lead, developed a dementia peer review programme that would investigate the progress made towards the implementation of the Strategy in the fifteen localities in the Yorkshire & Humber region.

This report documents the findings of the Barnsley locality review, focussing primarily on progress made towards implementation of the seven priority objectives, although the report does contain details of the remaining objectives in the report appendices. The findings of the review are presented in three main sections in the report and are structured in the following way –

- *Implementation Plan Priorities* – analysis of the responses submitted to the Review Team in relation to the seven priority objectives.

¹ Living with dementia: A National Dementia Strategy - Department of Health – February 2009

² www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103136.pdf

³ Good quality and early diagnostic support services (objective 2); Improved community personal support services (objective 6); Implementing the Carers' Strategy (objective 7); Improved quality of care for people with dementia in general hospitals (objective 8); Living well with dementia in Care Homes (objective 11); An informed and effective workforce for people with dementia/carer training and awareness (objective 13); A joint commissioning strategy for dementia (objective 14)

⁴ Deputy Regional Director for Social Care and Local Partnerships

- *Service Users & Carer Perspectives* – collation of the responses provided by service users and carers of their experiences of dementia services to date.
- *Good Practice, Priorities and Areas for Improvement* – a summary of the responses provided by participants as to current strengths of the service provision and areas where further development is required.

Chapter 4 of this report contains an action plan template for key partners in each locality to complete in light of the review findings. In addition to the above chapters of this report, a number of appendices also exist that contain the response data collected during the review process. These appendices are –

- Appendix 1 - containing the descriptive evidence collected in section 4 of the Metrics Proforma in support of progress made with the seven priority objectives of the Strategy.
- Appendix 2 - containing the descriptive evidence collected in section 4 of the Metrics Proforma for the remaining objectives of the Strategy. This evidence has been included in this report for completeness, but has not contributed to the analysis provided.
- Appendix 3 – containing the detailed responses to section 3 of the Metrics Proforma relating to strategic questions about the locality.
- Appendix 4 – containing the quantitative evidence about dementia in the locality and collected through section 2 of the Metrics Framework.

Material presented in Appendices 1-3 has been extracted from the data collection proformas and where appropriate, have been collated to reflect the triangulation of responses from the participating groups visited as part of the review process.

2 Review Methodology

The methodology used in this review process incorporated a number of research techniques including surveys and semi structured interviews. The collection of data was coordinated around the *Metrics Framework* that contained four key sections that are listed below with further details in Appendix 5 -

- Section 1: Local Service Description
- Section 2: Quantitative Metrics
- Section 3: Strategic Issues
- Section 4: Descriptive Evidence

The Local Services Description section of the above Metrics Framework was completed by the Dementia Strategy Lead and forwarded to the Locality Dementia Lead, along with the Quantitative Metrics section of the document, for review and completion prior to the Review Team visit. The Review Team visits were co-ordinated by the Dementia Strategy Lead, with the Locality Dementia Lead for each area organising the locality visit programme, incorporating opportunities for the Review Team to meet and interview the following groups of partners and stakeholders⁵ -

- Chief Officers and Senior Officers from the local health and social care organisations.
- Primary Care Trust, Adult Social Care commissioners and Third sector partners
- Up to three care pathway staff groups which could include memory clinics, secondary care services, community teams, primary care teams, specialist services, Home Care providers, Care Home providers and third sector provider organisations
- Carers and people with dementia.

Notes of the locality visits were recorded by a dedicated member of the Review Team and were circulated to the Locality Dementia Lead for verification as an accurate record of the discussions had during the visit. The evidence gathered here for section 3 and 4 of the Metric Framework was collated with the evidence gathered in section 1 and 2 of the framework, and is presented and analysed for the locality in this report.

⁵ The choice of groups being interviewed by the Review Team reflected the local service configurations and as no two localities are identical, the types of group participated varied from locality to locality.

3 Findings of the Review Team in the Barnsley Locality

3.1 Implementation Plan Priorities

This section of the report contains a summary of the evidence collected in Section 2: Quantitative Metrics and Section 4: Descriptive Evidence of the data collection proforma, relating to the seven priority objectives of the National Dementia Strategy Implementation Plan. Full details of the questions posed and responses given for this locality are recorded in Appendix 1.

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.

The baseline data submitted to the Review Team for the Barnsley locality in relation to Section 2: Quantitative Metrics are outlined in Table 1.

Table 1: Good quality early diagnosis and intervention for all	2009 Baseline
Number of patients currently registered with GPs as having dementia	1,908
Registered patients as percentage estimated total population with dementia aged 65 years and over	77%
New referrals to Memory Assessment Services per year Apr 2008 – Mar 2009	750
Apr 2009 – Review visit	409
Average wait time from receipt of referral to first (face to face) contact with Memory Service (weeks)	
CT/MRI brain scans for clarification of dementia diagnosis: Average waiting time from referral to CT/MRI scan date over last 12 months (weeks)	CT Scan is 3 weeks MRI Scan is 5 weeks
Minimum and maximum waiting time from referral to scan date over last 12 months (weeks)	2- 8 weeks based on routine referral.

In Barnsley it is estimated that around 77% of the population with dementia have a diagnosis and are registered with their GPs. The proportion in the locality is twice the regional rate of 39% and two and a half times the national rate of 33%.

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) –

- A well-established referral pathway between health and social care staff is in place via the GP for new cases. This approach is encouraged to eliminate physical health problems prior to assessment by the Memory Service. Once a person is known to the service, re-referrals can be made directly to the clinics from health sector staff.
- The Memory Service operates 3 consultant clinics and 3 non-medical prescribing clinics. The consultant clinics see new referrals as well as reviews, while the non-medical prescribing clinics only support review cases. The Memory Service staff utilise a number of established assessment tools in their work.
- All new referrals to the Memory Service are provided with pre and post diagnosis counselling service, which covers an extensive range of topics such as information/treatment/prognosis as well as information relating to finances/wills etc. and can include information on local services, third sector organisations, statutory and non-statutory organisations. Referral for therapeutic intervention is also available. Details of the Care Navigators will also be provided where appropriate.

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, people who pay for their care privately, through personal budgets, or through local authority-arranged services.

The baseline data submitted to the Review Team for the Barnsley locality in relation to Section 2: Quantitative Metrics are outlined in the Table 2.

Table 2: Improved community personal support services	2009 Baseline
How many hours of specialist Home Care for people with dementia are currently offered per year?	Information not available
Number of people with dementia currently in receipt of individual budgets?	36

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) -

- Provision of Home Care service is provided for people with dementia through the mainstream in-house service. Future plans include the re-shaping of this service in to a Re-enablement Service which would be a time limited service connecting the recipient to the required intermediate care and existing pathways of care.
- The approach in Barnsley is to engage with suppliers through a strategic training programme that aims to develop them, their workforce and their business commissioning policy/framework. Through building this relationship performance and improvement are monitored.
- Good referral and networking arrangements exist in the locality for community staff, with information and contact details available via a website. The memory teams also provide additional advice and support to community staff when needed through their “single point of entry”.
- A Resource Allocation System exists in the locality and support for the use of Individual Budgets is provided by a number of professional groups across the locality.

Objective 7: Implementing the Carers' Strategy for people with dementia. 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.

The baseline data submitted to the Review Team for the Barnsley locality in relation to Section 2: Quantitative Metrics are outlined in the Table 3.

Table 3: Implementing the Carers' Strategy for people with dementia.	2009 Baseline
Number of Carer Assessments carried out for Carers of people with dementia Apr 2008 – Mar 2009	109
Apr 2009 – Review visit	Information not available.
Number of people with dementia in receipt of short breaks Apr 2008 – Mar 2009	81
Apr 2009 – Review visit	Information not available.

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) –

- A voucher system is currently being operated for Respite in the locality that provides access to residential and Home Care support. The use of Individual Budgets for carers is expected to increase the choice of support available.
- Currently a large choice of Respite options exist in the locality due to spare bed capacity in the locality.
- A Carer's Card system is currently operated in Barnsley that provides a contingency plan for an emergency break or a secondary carer should the main carer be taken ill.

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.

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) –

- A specialist Adult Mental Health Liaison Service does not currently operate in Barnsley, however interim arrangements do exist, but mainly for known cases. New referrals requiring memory assessment would be followed up in the community. A scoping exercise has been undertaken to assess the needs/gaps in the service provision following the withdrawal of the previous service.
- Named leads for dementia have been identified in the acute trust.

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

The baseline data submitted to the Review Team for the Barnsley locality in relation to Section 2: Quantitative Metrics are outlined in the Table 4.

Table 4: Living well with dementia in Care Homes		2009 Baseline	
Number of registered beds in residential and nursing care in your community for dementia		849 dementia beds	
If possible, indicate what percentage this is of the total provision of residential and nursing care beds		51%	
Number of Care Homes in your community with 4/3/2/1 star rated by CSCI/CQC.		Number	Percentage
4* rating		5	7%
3* rating		41	59%
2* rating		13	19%
1* rating		3	4%
0* rating		0	0%
Not rated*		8	11%

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) -

- No specific quality incentive programme exists in the locality, but a fair pricing review has recently been undertaken. Additional costs associated with care for specific conditions are discussed with suppliers as and when required.
- All Care Homes will have informal links with the memory team, but plans do exist to implement a Care Home Liaison Service to provide an in-reach service to all Care Homes and link it to the current Memory Service configuration.

Objective 13: An informed and effective workforce for people with dementia/carer training and awareness

All 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.

The baseline data submitted to the Review Team for the Barnsley locality in relation to Section 2: Quantitative Metrics are outlined in the Table 5.

Table 5: An informed and effective workforce for people with dementia/carer training and awareness	2009 Baseline
Number of dementia awareness courses available for mainstream staff per year	12 Courses ran. 12 Courses running. More to be added as per demand.
Number of mainstream staff having attended dementia awareness courses Apr 2008 – Mar 2009	120 Delegates attended. Mixture of both internal staff and independent sector carers.
Apr 2009 – Review visit	30 Delegates attended so far. 6 courses still to run.
Number of dementia awareness courses available for Carers per year	12 Courses ran. Course brochure is circulated every year to all voluntary/ independent support groups for service users and carers. 12 Courses running. More to be added as per demand.
Number of Carers having attended dementia awareness courses Apr 2008 – Mar 2009	Take up from informal carers on any course is sporadic but the figures in 18 above cover internal, independent sector, shared lives carers and personal assistants.
Apr 2009 – Review visit	Take up from informal carers on any course is sporadic but the figures in 18 above cover internal, independent sector, shared lives carers and personal assistants.

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) -

- An e-learning package on dementia awareness is available for all staff groups in NHS Barnsley, all social care staff and carers in the locality. Dementia awareness training for all social care staff groups forms part of the Workforce Development Strategy.

- Access to a number of formal qualifications that include dementia care is available to both health and social care staff groups.
- Training for carers and people with dementia is planned through the memory team. The training programme has been developed with the involvement of carers and people with 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 should be informed by the World Class Commissioning guidance developed to support the Strategy.

Progress reported in descriptive evidence in the Barnsley locality (Section 4 of proforma) -

- Responsibility for the implementation of the dementia strategy in terms of commissioning requirements sits within the joint commissioning arrangements through the Joint Action Group. The approach that is being developed in the Barnsley locality is where the local NHS and local authority have agreed to the management and discharge of pooled resources across a number of shared interests.
- A joint contract monitoring system is also in place with a senior clinical and management team undertaking quality reviews, which are reported to the Joint Action Group.
- Commissioners are confident that the local services have the capabilities for the future demand of dementia, but there are concerns that there are limits to the services capacity to address the increasing numbers of older people in the locality. Some services are being reviewed for reshaping e.g. Home Care service.
- Further investigations are being undertaken to see where the management of current systems could be improved to provide resources to invest in dementia care. It is anticipated that greater efficiencies can be achieved through the greater use of Telecare services.

3.2 Perspectives of Carers & People with Dementia

An integral part of the region review of dementia was to obtain the views of both people with dementia and carers with regard to their experiences of dementia in the locality. During the Review Team visits, the Locality Dementia Leads arranged sessions with both groups of individuals, posing the questions - *what's good about your experience with dementia in the locality?* and - *what's not so good about your experiences with dementia?* The notes generated during the session are reported below.

What's good about your experience with dementia in Barnsley?

- The Alzheimer's Society cafes and dances were very well received. Carers and people with dementia generally felt that they liked the inclusive friendly social side of attending and the circle dancing was also therapeutic and really enjoyable. Although access to Care Navigators was provided, carers and people with dementia reported that they felt that they found out more information from each other.
- Carers and people with dementia praised the Telecare service in Barnsley.

What's not so good about your experience with dementia in Barnsley?

- It was stated that more information was needed about what support and services were available and in particular the provision of support for carers regarding respite.
- A younger persons day service is available through Moorland Court, but two of the people with dementia at the group stated they did not attend the day centre because there were no relevant activities – they found it boring.
- Issues about the acute services were raised in particular the care of older people with dementia. It was suggested that hospital staff refuse to put information on the hospital records that a person has dementia, thus every time there is a hospital admission the carer has to continually explain about the dementia to staff.
- A sitting service was identified as a useful service addition that could be flexible to their needs.

3.3 Good Practice, Immediate Priorities and Areas for Improvement

During the Review Team visit to the localities, sessions with Chief Officers and Senior Service and Providers were arranged to explore the strategic issues facing the locality in terms of dementia care. Officers present were requested to provide examples of good practice, immediate priorities and areas for improvement for their locality, as detailed in Section 3: Strategic Issues of the data collection proforma and documented in Appendix 3.

The evidence collected in the above sessions was then supplemented with additional material gathered in the more detailed interviews with locality commissioners and staff groups. The following are the combined views on the locality.

Examples of Good Practice in the Barnsley Locality

- Care Navigators in dementia care.
- A “self directed care” focus providing services in the homes of people. Initially developed with dementia services, with success being illustrated through the number of people with Individual Budgets (36). Approach to be extended to other services in the locality.
- Joint working across the health and social care sectors, in particular joint commissioning groups.
- Carer’s Card system with planned approach to contingencies for crisis support.

Immediate Priorities and Areas for Improvement

- Liaison links with Care Homes and acute providers.
- To grow the Rapid Exit/Rapid Response Service to be able to keep more people in their own home and to avoid hospital admissions.
- Investing further in the Individual Budget scheme.
- Further development of the Care Navigator model.

Positioning of the Locality to Meet the Objectives of the National Dementia Strategy

In terms of preparedness to meet the National Dementia Strategy the Barnsley team estimated they were a 7 on a scale of (1 – 10).

4 Jointly Owned Action Plan Template for the Implementation of the National Dementia Strategy

This chapter of the report contains a Jointly Owned Action Plan Template for use by key partners in the locality to create a co-produced and jointly owned plan for the implementation of the objectives of the National Dementia Strategy to be produced by 31st March 2010,

The following template is based on the model used in the National Dementia Strategy Implementation Plan and published by the Department of Health.

Action Plan for the Barnsley Locality			
NDS Objective	Action	Lead Person/ Organisation	Target Date
Good quality early diagnosis and intervention for all			
Improved community personal support services			
Implementing the Carers' Strategy for people with dementia			
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/carer training and awareness			
A joint commissioning strategy for dementia			

Appendix 1:

Detailed Findings Relative to the Priority Objectives of the National Dementia Strategy

The questions in Section 4: Descriptive Evidence of the data collection proforma are based around thirteen of the seventeen objectives of the national strategy. Appendix 1 documents the recorded responses given by the relevant groups involved in the local review to the seven key priority objectives of the National Dementia Strategy Implementation Plan.

National Dementia Strategy 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.

How this can be delivered

- The commissioning of a good-quality service, available locally, for early diagnosis and intervention in dementia, which has the capacity to assess all new cases occurring in that area.

Is there a local procedure or protocol for social care staff (social workers and Home Care staff) or primary care staff (e.g. district nurses, health visitors etc) to refer onto other agencies if they suspect dementia?

Commissioners -

- Yes referral is via a Single Point of Entry (SPE) for Memory Services based at the Oaks Building Kendray Hospital. This was adopted as a point of entry for Memory Services in January 2008 and following this we saw a rapid increase in referral rates. Whilst active involvement by the memory team may not always be necessary for clients, they remain open to the Memory Service following initial referral.
- New referrals to the service from primary care staff including district nurses, health visitors, and community matrons will be accepted via the GP. This is usually following any primary investigations/screening but will be initiated by the primary care staff member.
- Referrals for clients who are already known to the service, but not having active involvement, can be made by any individual back to the team usually via the Single Assessment Process (SAP).

Staff Group 1 -

- Other agencies to have as much information as possible including GP screening
- SAP is an acceptable form of referral
- Preferred methods is referral from GP so that there is information about medical history generally
- Accept other professional's requests for referral
- Will see people on non-active caseloads

Is there a single system or single point of access for referrals to Memory Assessment Clinics from primary and social care? If yes how effective is it?

Commissioners -

- As above, referral is via a Single Point of Entry (SPE) for memory services based at the Oaks Building Kendray Hospital
- Referrals are accepted via GP and Secondary Care staff once other physical causes have been discounted

Is there a single system or single point of access for referrals to specialist services for people with dementia from primary and social care? If yes how effective is it?

Commissioners –

- This is a point we need to develop. Social Care can refer to Memory Service but we ask them to go through GP in first instance to check for physical symptoms – this process is currently necessary but needs to be streamlined and the time reduced. We need to keep the GP in the loop. There are 800 referrals in one 12-month period. There is a new slot capacity for 240 new referrals in Memory Service. Of the 800 some people do not want a diagnosis and are managed by their GPs, of those that want to see Consultants there is capacity for 240 within Memory Service. The shortfall is managed by attendance outside clinic, extended wait and DV's. Again referral is via a Single Point of Entry (SPE) for memory services based at the Oaks Building Kendray Hospital. Whilst active involvement by the memory team may not always be necessary for clients, they remain open to the Memory Service following initial referral.
- Referrals for clients who are already known to the service, but not having active involvement, can be made by any individual back to the team usually via the Single Assessment Process (SAP).
- If the client is not known to the service then referral should be made via GP in order for their assessment and treatment of possible underlying physical causes prior to referral.
- Referral to social services is via Single Assessment Process (SAP).
- Care Navigation Project: Now based in 9 GP practices across the district within the project and reaching more than 40% of population. At the end of the project, Care Navigators will be absorbed into the memory services undertaking existing roles and responsibilities and some of those highlighted within the role of the Dementia Advisor.
- Since Care Navigators in the pilot project have been involved with GPs we have seen a reduction in referrals from GPs and also Acute Teams. In Primary Care there has on occasion been an increase in the number of GP contacts where Care Navigators have been involved however, this has been more focussed and condition driven.

Staff Group 1 -

- Memory assessment services see all people with dementia throughout all stages of the illness
- CMHT provision is for Older People Mental Health functional illness

What type of Memory Assessment Service is provided locally? Are there plans to implement a core set of assessment tools? List core set of assessment tools?

Commissioners –

- In Memory Clinics: (based on 40 week/annum) - 3 Consultant clinics/week
 - Total Capacity: - New referrals 240, Follow-ups 480,
 - Non-Medical Prescribing Clinics - 3 Non-medical Prescribing Clinics/week (based on 40 weeks/annum)
 - Follow-ups: 480
 - Numbers of new patients seen (2008/9 pro-rata)
- The memory services use the following assessment tools:
 - MMSE
 - GDRS
 - DEMTEC
 - Relative Stress Survey.
- Training has also been received by the community team for use of the Addenbrooke's Cognitive Examination on first assessment. This is beginning to be rolled out.
- Further in-depth neuropsychological assessment is also available from Psychology, where appropriate, and a core test battery utilising the CAMCOG, various subtests of the Wechsler Memory Test (WMS III) and the Wechsler Adult Intelligence Scale (WAIS III) along with various tests of attention, executive function, verbal function and visuo-spatial ability have been used for some time.

Staff Group 1 -

- All referrals come directly to Memory Team – screened on the day
- If referrals are sent elsewhere they are forwarded to Memory Service
- GP is asked to do bloods, ECG, memory tests
- A senior nurse sees a new patient at first assessment. CT – then seen by a doctor - 12 week wait for this
- Nurse – new appointment 1-2 hours
- Doctor – new appointment 45 minutes
- Nurse – 1 new and 3 follow ups a day
- SPE screened by senior worker and information gathered to determine priority

Are there clear systems/pathways from the Memory Assessment Service on to follow up or voluntary sector services? If yes how effective is it?

Commissioners –

- No response

Do you offer a counselling service (or other support) for individuals newly diagnosed with dementia? If yes how effective is it?

Commissioners –

- All newly diagnosed patients are provided with pre and post diagnostic counselling given by the senior memory worker who first undertook the initial assessment. These functions are built into the initial assessment process and form part of the diagnostic follow-up arrangements.
- The counselling provided is largely driven by the client/carer but will include condition information/treatment/prognosis/information relating to LPA/finances/wills etc. It will also include information regarding local services, third sector organisations, and statutory and non-statutory organisations.

- Referral to Psychology for people with dementia and their carers for therapeutic intervention is also available.
- Details of the Care Navigators will also be provided where appropriate. Care Navigation also provides an information folder.

**National Dementia Strategy 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, people who pay for their care privately, through personal budgets, or through local authority-arranged services.

How this can be delivered

- Implement *Putting People First* personalisation changes for people with dementia, utilising the Transforming Social Care Grant.
- Establish an evidence base for effective specialist services to support people with dementia at home.
- Commissioners to implement best practice models thereafter.

Is there a local specialist Home Care service for people with dementia?

Commissioners –

- We do provide a service for people with dementia and their carers through the mainstream in-house Home Care Service and we particularly communicate the benefits of Telecare as do independent Home Care contractors. There is no specialist named service. We are pushing forward on re-shaping the in – house Home Care service to make it a Re-enablement Service. Need to look at what we do with a very able workforce and look at a very specific Dementia Service. It is necessary to get the balance right – it is a balance between a conventional dementia specific service with a strong model of re-enablement. The re-enablement route would be a time limited service of approximately six weeks that connects to intermediate care and care pathways. Need to look at people with dementia to see if we support or re-enable them. At the end of the six weeks if they connect with intermediate care it will be needs based. People with dementia receive the service until they do not need it or we are sure that they are at the point that further intervention is cost-effective.

What are the local arrangements for contract monitoring of community personal support services, in terms of quality, outcomes, staff competencies?

Commissioners –

- We have a strategic training programme. This is delivered to all sectors, including our supplier’s part of the agenda. Its about how we evaluate people who do not need these standards. Part of this agenda is to work with suppliers to develop them and their workforce and business commissioning policy/framework. We engage with the independent sector in terms of performance and improvement and contribute to development of systems and advice; sometimes we put people in to work alongside them.

In addition to referral routes to specialist services described above, are there clear routes or pathways for mainstream community staff to access advice and information from specialist services for people with dementia?

Commissioners -

- Yes. There is a great deal of local networking with community staff (both health and social care) that takes place with joint visiting being utilised, by our district nurses and social care colleagues, particularly in respect of the more complex cases. There is also information and telephone contact numbers on the internet. We are working with GPs to provide better access for this support within Primary Care. Within secondary care a Single access point (SPE) to dementia services was established in January 2008. In addition existing memory services supports contact for advice and support from other mainstream community staff. The contact numbers and hours of operation are provided on the intranet along with the operational policy of the service.
- There are also reciprocal agreements for psychiatrists to visit Mt Vernon Hospital and other consultants come to Kendray
- Hospital – this is done on an ad hoc basis but works extremely well.

Staff Group 1 -

- Staff will just phone us as a port of call
- SPE offers advice and Andy Stones will also assist in advice giving to other agencies
- Social Services tend to ring for advice.
- Community Matrons use the service as well

Does the Local Authority have a resource allocation system (RAS) that includes older people with dementia? If not, are there plans to introduce this?

Commissioners -

- Yes, the RAS includes older people with dementia – there are currently 36 people with dementia in receipt of self directed care

Are people with dementia supported to use Individual Budgets?

Commissioners -

- People are supported to use Individual Budgets by a range of professionals across Assessment and Care Management, mental health teams and the Memory service.

**National Dementia Strategy Objective 7:
Implementing the Carers' Strategy for people with dementia.**

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.

How this can be delivered

- Ensuring that the needs of carers for people with dementia are included as the strategy is implemented.
- Promoting the development of breaks that benefit people with dementia as well as their carers.

What types of short breaks are provided for dementia carers? What other services are provided for carers?

Commissioners -

- Short Breaks are associated with respite care. For carers in mainstream services vouchers are available for residential and Home Care support. Carers with vouchers are allowed to use any of their suppliers. Currently looking into changing from vouchers scheme to providing cash.
- Individual budgets would be a great help from a carers point of view – as money could be put into a contingency plan so there was a pot of money to use when a break was needed. Individual budgets build short breaks into the assessment.
- There is plenty of spare capacity for respite beds in Barnsley. Reshaping our in-house Home Care Service will reduce the demand for standard care with our suppliers. There are difficulties with the planning to access short breaks. Should you want to book a respite bed say in six months time there is a reluctance on the part of the Care Homes to commit to this.
- The Carers Card is for emergency break rather than a programmed break. Their details are lodged with central call service who would ensure secondary carers should the carer be taken ill etc. This scheme has also been launched across young carers to address emergencies.

**National Dementia 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.

How this can be delivered

- Identification of a senior clinician within the general hospital to take the lead for quality improvement in dementia in the hospital.
- Development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician.
- The gathering and synthesis of existing data on the nature and impacts of specialist liaison older people's mental health teams to work in general hospitals.
- Thereafter, the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

Do you have a specialist older people's mental health liaison service to local acute or community hospitals? If yes how effective is it?

Commissioners –

- See below

Is there a named lead for dementia and a work programme to improve the experience of people with dementia in acute care? If yes please give name(s).

Commissioners –

- Named Lead: Karen Sharp Matron BHNFT and Philippa Slevin - Matron/Manager Memory Services.
- Liaison services until recently were provided by adult mental health that incorporated clients suspected of having a dementia, however this service became unavailable following restructuring of the adult mental health liaison services. Consequently senior staff from the memory service and BHNFT have worked collaboratively to complete an extensive scoping exercise and identified needs/gaps in service provision. This will feed into and inform future developments and where investment should be focused. During the interim period, liaison services for dementia clients has continued, largely where clients are known to the service, on a referral by referral basis.
- Acute liaison and treatment/management advice is provided where necessary by the medical team.
- New referrals requiring memory assessment would be followed-up in the community, recognising the need for assessment in the client's usual place of residence.

Please identify any similar arrangements for any community hospitals in your area?

Commissioners –

- Similar arrangements in place for Liaison at Mount Vernon Hospital
- There is a robust liaison service provided into Mount Vernon Hospital that is reciprocated by our colleagues from Mount Vernon into the older adult mental health and organic assessment wards at Kendray.

National Dementia Strategy Objective 11: Living well with dementia in Care Homes.

Improved quality of care for people with dementia in Care Homes through the development of explicit leadership for dementia care within Care Homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

How this can be delivered

- Identification of a senior staff member within the Care Home to take the lead for quality improvement in the care of dementia in the Care Home.
- Development of a local strategy for the management and care of people with dementia in the Care Home, led by that senior staff member.
- Only appropriate use of anti-psychotic medication for people with dementia.
- The commissioning of specialist in-reach services from older people's community mental health teams to work in Care Homes.
- The specification and commissioning of other in-reach services such as primary care, pharmacy, dentistry, etc.
- Readily available guidance for Care Home staff on best practice in dementia care.

Do you have policies regarding - contracts to incentivise quality care; how contracts are monitored; continuing to use homes with lowest quality rating?

Commissioners –

- We do not have a quality incentive programme.
- We have been through a fair pricing review to establish an appropriate pricing structure. We amend our prices on a yearly basis – clearly any additional costs associated with improving care to people with dementia will be discussed with our providers and prices amended accordingly. It is a target area to recognise how many people in nursing homes have dementia needs and how we reflect this through our contracts with nursing homes and our expectations.
- Every nursing and residential home will have links with the Memory Team who work with the staff as well as the client. We are very much aware that we need to provide greater support, education and awareness training into residential homes. This provision is ad hoc at the moment and we need to scope it out. One option would be to have a dedicated sub-group within our Memory Team responsible for all the above. Currently looking at the options.
- Looking a developing route for people to raise concerns through safeguarding. Anyone in Care Homes can raise any issues through the safeguarding channel

Do you have a local Care Homes Liaison service that provides specialist support and input to Care Homes? If yes please describe the service? If not do plans exist to implement such a service?

Commissioners –

- All reviews for clients on cognitive enhancers within nursing and residential care have been collated and are now included within the Non-medical prescribing clinic time. Two practitioners on a 6-monthly review basis will service approximately 50 homes. Dependent upon numbers of clients within the homes this will take 2 – 6 hours per home.
- One key priority is to formally establish a nursing and residential home (inclusive of intermediate care) team to provide in-reach to all nursing and residential homes

- Medical input to non-clinic review will be as required.
- Yes plans exist to implement such a service

National Dementia Strategy Objective 13:

An informed and effective workforce for people with dementia/carer training and awareness

All 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.

How this can be delivered

- Commissioners to specify necessary dementia training for service providers.
- Improving continuing staff education in dementia.

Is there a local health and social care education and training plan that includes dementia training and awareness? What is the availability of dementia related training programmes for practitioners for 2008/09 and uptake by sector? What is the availability of dementia related training programme for carers in 2008/9 and uptake?

Commissioners -

- E-Learning Dementia awareness training available to all staff within NHS Barnsley
- Qualified staff undertaking pre and post graduate degrees in Dementia and related studies.
- Unqualified staff undertaking access degrees in dementia care
- Commitment for staff attending regional and national forums/conferences
- Ongoing in-house training delivered by the Nurse Consultant to specific professional groups and into specific learning programmes.
- Peer education sessions within the community memory team
- In Social Care staff can access both taught input and e-learning resources. The taught input ranges from basic awareness for front line carers in all parts of the sector to certificated open learning and advanced qualifications within the Post-Qualifying (PQ) framework. The e-learning resource is open to all in the sector and covers basic awareness. All of the above forms part of the Barnsley Social Care Workforce Development Strategy/Plan and is derived through consultation with all sectors of Social Care and the NHS.
- A total of 25 PCT staff have accessed E-learning in dementia care.
- E-Learning Dementia awareness training available to all social care staff within Barnsley.
- Basic awareness taught input available to all social care staff within Barnsley.
- Modular Open Learning (NCFE) Level 2 qualifications in Dementia Awareness available to all who wish for more in depth learning.
- Option for practitioners to access Post Qualifying (PQ) modules as part of overall PQ awards
- E-Learning Dementia awareness training available to all carers throughout the statutory and independent and voluntary sectors (including personal assistants and informal carers).
- Basic awareness taught input available to all carers (as above) within Barnsley.

- Modular Open Learning (NCFE) Level 2 qualifications in Dementia Awareness available to all who wish for more in depth learning.
- Option for carers, with appropriate prior learning, to access Post Qualifying (PQ) modules as part of overall PQ awards.

Staff Group 1 -

- No training plans at present. Lack of resources has stopped implementation.
- Plans to start training programme – 4 sessions for carers and people with dementia:
 - The brain
 - Lifestyle
 - Assistive technology
 - Finances and legal advice
- The above areas were identified from postcard questionnaire.
 - Sessions in nursing, residential homes and hospice
 - University lecturer role by Nurse Consultant
 - E-learning package for anyone to access (55 minutes – 1.5 hours to complete)
 - Pre and post qualification
 - Health service training
 - Peer education forum – case studies and articles
- People with dementia and carers involved in designing training sessions but not involved in delivering training.

Staff Group 2 -

- We have attended workshops on personalisation in Health and Social Care services. It is about reducing stigma and raising awareness.

Staff Group 3 -

- They had been informed of an e-learning course.
- They were receiving some training from the dietician - as their patients often had difficulty with their diet and eating

**National Dementia Strategy 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 should be informed by the World Class Commissioning guidance developed to support the Strategy.

What are the local arrangements for joint commissioning for dementia, including: -

- **use of JSNA?**
- **involvement of and views from people with dementia and their carers?**
- **links made to sustainable communities?**
- **extent of complementary plans between NHS and adult social care?**
- **policy and progress on recycling savings across organisations?**

Commissioners -

- **Local Arrangements:** I mentioned at the beginning of our discussion the strength of our “Partnership In Action”. In April this year the two statutory sector organisations came to an agreement to implement the management and discharge of the pooled budgets where commissioning continued generally for vulnerable people, in one governance structure, largely by NHS personnel and Lead at the Council. They are ultimately responsible for £97M that sits in the budget and how it is used. Under the Joint Action Group (JAG) there are various partnership arrangements and those partnership bodies are responsible for bringing key stakeholders and partners together for example Mental Health Group and Older Peoples Group. It is within the Older Peoples area partnership arrangements that the Dementia Strategy sits. We took a paper in September to the JAC outlining what we think the affect of the NDS would be for Barnsley and one of the recommendations was that it created a local task group for responding to the Dementia Strategy. We brought a lot of stakeholders together (apart from users and carers who we wanted to involve alongside the Alzheimer’s Society). We found this exercise helpful, as it will provide a platform that we can take away and get the Task Group to “own this”.
- **We do look forward to receiving the comments from the review team on where things can be improved and any benchmarking or good practice we can pick up from elsewhere.** The Task Force will be coming back with a work programme in the next few months and they will be putting in more detail.
- **Governance arrangements around joint conditions:** We have a joint set-up around the contract monitoring process but we also have a senior clinical and management team doing quality reviews in terms of the service that meet monthly and feed into the Contracts Management Team. Agreed through JAG and feeds into the Local Authority and NHS Barnsley. Quality reviews done monthly with each service and covers Older People, Mental Health, Physical and Learning Disabilities.
- **Independent Sector:** we have quarterly monitoring meetings with them but also build into the private sector in terms of Home Care. Systematic review takes place on an annual basis.

Are you confident that local services have the capacity and capability to address the increasing numbers of older people? Are there any particular demographic issues in relation to your own locality?

Commissioners –

- Confident that there is the capability but not sure about the capacity. Excellent work that has been undertaken, cutting edge work by the Care Navigators. There are challenges in terms of capacity in relation to the dementia “time bomb” and within the JSNA there is information in terms of prediction rates for Barnsley that we will be using in our planning over the next few months. One of the areas we have been asked to look at is Older People and Dementia and a predicted planning element for the next three years. JAG is preparing a report that will try to capture some of these challenges and dementia will be one of these using the JSNA information for predictability. The challenge will be the amount of money available and how we shape finances to cover the priorities we want to tackle. Dementia is one of the priorities in Barnsley and our planning process is therefore to see how we can build capacity.
- We are looking at intermediate care stream for Older People in general and fast-forwarding the plans that we had for the Re-enablement Service. We want, through the in-house Home Care service, to look at a re-enablement service that people will be able to access quickly. This means that by shifting some of the service we will have some capacity to put towards dementia needs - looking at how we can manage current systems better. We already have plans in place where we know we can reshape and refocus some of our services and reinvest in dementia.

What existing or future plans do you have for your devolved share of the funding accompanying the strategy for local implementation?

Commissioners –

- We do not expect any increase in our budgets, so we are looking forward to a reduced base-line overall. We are looking at the areas we need to refocus on and dementia is one of these areas. We do have real plans where we know we can draw down some funds to improve the system.

Given the current economic situation, do you have any specific plans linked to improving efficiencies?

Commissioners –

- Telecare Initiative – join integrated approach. Care Navigator scheme was piloted in dementia, as we knew if we could get it right in terms of the risks then it would be very simple to roll out into other services. Independent evaluation of this innovation has resulted in us going into a “roll out” starting in February with the Telecare aspect of it.
- To meet the needs of people with dementia and carers we need to know how best to do this. We believe that we will develop the right service that will be more cost-effective, but there is still work to do. Aim to give people who have dementia and other medical problems a better service. Getting professionals on board will be a challenge.

Appendix 2:

Detailed Findings Relative to the Remaining Objectives of the National Dementia Strategy

The questions in Section 4: Descriptive Evidence of the data collection proforma are based around thirteen of the seventeen objectives of the national strategy. Appendix 2 documents the recorded responses given by the relevant groups involved in the local review to the remaining six objectives of the National Dementia Strategy Implementation Plan.

National Dementia Strategy 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.

How this can be delivered

- Developing and delivering a general public information campaign.
- Inclusion of a strong prevention message that ‘what’s good for your heart is good for your head’.
- Specific complementary local campaigns.
- Targeted campaigns for other specific groups (e.g. utilities, public-facing service employees, schools, and cultural and religious organisations).

What are you doing locally to improve public and professional awareness and understanding of dementia?

Commissioners -

- Work carried out within the Memory Service and linked with Alzheimer’s Society where regular meetings are held to share ideas. We are also involved in raising the profile of dementia and management of people with dementia in residential homes, local education college and going out and about and meet people wherever we can to publicise the Memory Service in Barnsley.
- Leaflets: A raft of leaflets are available that have been produced in conjunction with Alzheimer’s Society.
- Activity Dementia Group – we have moved ahead over the last six months with one of our priorities. Our overarching aim is to make information from the Local Authority and Health available to everyone in Barnsley. The Dementia Strategy Task Group is the vehicle to determine our local priorities and set out appropriate work streams.
- Prevention agenda – there is work going on in NHS Barnsley around social marketing i.e. how do you move people from one behaviour path to another. This approach and development of “Living Well” is high on the agenda for us - when people refer whether there is a diagnosis of dementia or not.
- Starting discussions with GPs about what Primary Care can do in respect of “Living Well”.
- Work around TIAs and vascular dementia has improved.

**National Dementia Strategy Objective 3:
Good quality information for those with a diagnosed dementia diagnosis**

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.

How this can be delivered

- A review of existing relevant information sets.
- The development and distribution of good-quality information sets on dementia and services available, of relevance at diagnosis and throughout the course of care.
- Local tailoring of the service information to make clear local service provision.

Is there a standard information pack offered at dementia diagnosis? If yes at what point is it distributed? How useful is it?

Commissioners -

- We have a post care questionnaire – asking what information carers and people with dementia would like. Rather than put an information pack together that covers everything, what we do with our pre and post diagnosis visits are ask what information they require. Senior workers who initiate the assessments in the community are very much aware of information packs. We feel it is about listening to people and asking them if they want more information.
- Groups in the Acute Hospital are pro-active about what happens and are developing their own leaflets.

Staff Group 1 -

- Pre and post diagnostic counselling – work with clients, senior worker does initial diagnosis
- No standard pack - DOH Booklet 'Who Cares' given out
- Information given on an individual basis
- Various leaflets available including driving

Staff Group 2 -

- Yes. There is a yellow folder. We also have leaflets. We talk to people and explain. We have a booklet if they want it. If they take the pack we emphasise that not everything will apply to them. Some people find it useful and some do not! Feedback is quite positive and they wish they had had the information ages ago. We deal with everyone on an individual basis.

Staff Group 3 -

- There used to be an information pack when the specialist liaison team operated on the wards. The memory team come in instead now.

National Dementia Strategy Objective 5:

Development of structured peer support and learning networks for people with dementia and their carers

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.

How this can be delivered

- 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 also providing a source of information about local needs to inform commissioning decisions.
- Support to third sector services commissioned by health and social care.

What type of peer support and learning networks are offered in your area (e.g. memory cafes, carer support groups, carer education groups)? Who provides them?

Commissioners –

- A local education/support group has been designed for carers and clients but not yet established. This is a six week program but time/cost and a central venue are critical factors to enable this to occur as a 'rolling program'
- The local Alzheimer's Society holds a monthly Dementia Café that is periodically supported by members of the memory service.
- Alzheimer's Society provides information and support throughout the illness to carers and their families.
- Early Onset Group – monthly meeting for carers of those with dementia diagnosed under 65 years old.
- ABC Café – held monthly for carers and people with dementia with an average attendance of 65 people (as many as 90). Alzheimer's Society offers a meeting place 11am – 1:30pm with tea/coffee and a sandwich lunch that is a flagship for the Society. It is often the first event Alzheimer's Society encourages new carers to attend, as it is a buzzing, friendly atmosphere where they are able to meet others in the same position as themselves, staff on hand to give carers support and encouragement to join in with Alzheimer's Society support groups and social events etc. Often health and social care professionals attend the café and we always invite healthcare students to attend when they contact us.
- Alzheimer's Society also holds two very well attended tea dances a year attended by an average 80 carers and people with dementia.
- Alzheimer's Society hold several singing sessions a year for the 'Forget-Me-Not' singers, the local branch choir is made up of carers and people with dementia and these are very well received as the outcomes for some of the people with dementia are amazing, with those no longer able to communicate verbally joining in with gusto. Alzheimer's Society holds weekly Circle Dancing sessions for carers and people with dementia with an average attendance of 16.

Is there consistent provision in your area for these services (are these services provided equitably across the whole area)? If not, what plans are there to develop these functions?

Commissioners –

- Memory service design has taken into account potential disparities of service provision and that current design should enable equity across the memory service domains. Current systems are being developed to further ensure this in relation to capacity and demand issues.

**National Dementia Strategy Objective 9:
Improved intermediate care for people with dementia.**

Intermediate care which is accessible to people with dementia and which meets their needs.

How this can be delivered

- The needs of people with dementia to be explicitly included and addressed in the revision of the Department of Health’s 2001 guidance on intermediate care.

Are local intermediate care & re-enablement services inclusive of people with dementia and other mental health disorders? Please define any specialist mental health provision available within these services, such as medical or community mental health team time?

Commissioners –

- If we can meet the needs we will. We do not have a RMN within Intermediate Care Service. The whole of intermediate care services are acceptable for people with dementia.
- Intermediate care: Mount Vernon Hospital
- There is a reciprocal arrangement between the general intermediate care physicians and the Old Age Psychiatrists where patients are identified and assessed/reviewed on a weekly basis providing specialist advice and management to their respective patients.

**National Dementia Strategy 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.

How this can be delivered

- Monitoring the development of models of housing, including extra care housing, to meet the needs of people with dementia and their carers.
- Staff working within housing and housing-related services to develop skills needed to provide the best quality care and support for people with dementia in the roles and settings where they work.
- A watching brief over the emerging evidence base on assistive technology and telecare to support the needs of people with dementia and their carers to enable implementation once effectiveness is proven.

What types of telecare device are available for people with dementia?

Commissioners -

- There are currently two new homes and two in the process of being built that are Sheltered Extra Care Schemes. The two that are newly built are both 60-bedded homes. The two in the process of being built have a design concept for people with dementia incorporated into them and will reflect best practice.
- Telecare: There are specific packages available through Memory Service designed for people with dementia. This is an open service and promoted across the area. Range of things can be provided. Looking to cluster the packages around particular needs.
- Devices available include: Lifeline, Smoke Detector, Carbon monoxide detector, Gas Detector, CO Detector, Flood Detector, Temperature Extreme Sensor, Property Exit Sensor, Fall Detector, Bed Sensor + Control box, Bogus Caller Button. All of these devices are monitored through the Central Call service that is housed in a “state of the art” call centre.

Ethical side of Telecare: If someone wanders, do you have a set response?

Do you ring primary carers?

Commissioners -

- The Home Care service attends to these issues through the Lifeline Service. We have carried out some work with a software company and this system holds everyone’s data. This system has been designed by Home Carers to capture the information they need and it provides detailed back office information when responding to clients.

**National Dementia Strategy 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.

How this can be delivered

- Initiating demonstration projects, piloting and evaluation of models of service provision prior to implementation, given the current lack of definitive data in this area.
- Developing better end of life care for people across care settings that reflects their preferences and makes full use of the planning tools in the Mental Capacity Act.
- Developing local end of life care pathways for dementia consistent with the Gold Standard framework as identified by the End of Life Care Strategy.
- Ensuring that palliative care networks, developed as part of the End of Life Care Strategy, support the spread of best practice on end of life care in dementia.
- Developing better pain relief and nursing support for people with dementia at the end of life.

**Does End of Life training include the needs of people with dementia and their carers?
Does your local palliative care strategy and services include people with dementia?**

Commissioners –

- Our approach to end of life care training is now focused on competencies needed to deliver end of life care irrespective of diagnosis i.e. assessment, communication, symptom management and advance care planning. So although not specifically addressing dementia patients and their carers the skills needed to meet these patient's needs are included in the courses we run. We have recently considered the development of courses looking specifically at dementia and have included a specific session on dementia within aspects (qualified staff) training and will try to include this for next year. This is a 6-day course run twice per year. We have previously run a session for GPs focused on end of life care in dementia.
- Our working definition of end of life care is taken from the end of life care strategy and therefore, is inclusive of all patients dying from all life threatening illnesses. This includes people with dementia.
- This is reflected by -
 - the involvement of dementia services and commissioners in the strategy group,
 - the recent investment in care and nursing homes – CNS 1 ½ for specialist palliative care for nursing homes and community hospitals and 22 1/2 hour post to develop tools for end of life care in Care Homes it is recognised that many of these patients are suffering from dementia, (newly in post as yet not able to measure number of dementia patients involved)
 - dementia patients with specialist palliative care needs can access the community specialist palliative care team, however, these numbers are small (11 patients April 2008- March 2009 with primary dementia diagnosis but other patients may well have been seen with another primary diagnosis and also have a diagnosis of dementia)
 - Marie Curie/ Supportive care at home also support patients with dementia (these numbers would need to be specifically collated if needed)
 - Yes the palliative care strategy and services include people with dementia.

Safeguarding

Please describe your local definition/reporting threshold for Safeguarding?

Commissioners –

- Across South Yorkshire we have developed a South Yorkshire Regional Safeguarding Protocol that we work to and it is currently actively under review. We are trying to structure our safeguarding board and think we have a lot to learn from the Children's Safeguarding process. The Adult Safeguarding Board has a lead nurse in commissioning, lead nurse in provider services and a lead officer from the Local Authority together with support staff in terms of training and education.
- Safeguarding managed within Local Authority with local development team. There is a safeguarding manager in the General Hospital to ensure DoLs procedures.

Dignity Champions

Do you have Dignity Champions within your dementia services? What sort of initiatives have they been involved with that are specific to the needs of people with dementia and their carers? What outcomes have these initiatives had?

Commissioners –

- Yes, we have good Dignity Champions on the ward. Currently embedded with care. Every member of staff has got a Dignity Workbook and for any new staff it is part of their induction pack. There is a Dignity Champion on the Ward who marks staff workbooks. Looking at introducing a questionnaire prior to discharge to look at people's experiences in terms of dignity.
- Part of the work within the PCT is being carried out by the Palliative Care Team and Long Term Conditions. They are doing a lot of work on "end of life" across all services. Our "end of life" pathway was formulated with medical staff, McMillan nurses and Hospices. Lots of important work being undertaken regarding education in Care Homes to facilitate their understanding of "end of life" care. We use the Liverpool model and have adapted it since its inception 3 year ago.
- The Response Team is set in intermediate care as an admission avoidance team but is not dementia specific and they can go into Care Home to enable people to remain there.

Appendix 3:

Barnsley Locality Responses to Examples of Good Practice, Immediate Priorities and Areas for Improvement

What are the top 3 areas of local practice?

Commissioners -

- Care Navigators for dementia care
- Approach we have taken to the memory clinic/clinical perspective. Slightly different to the way other people work in terms of detail and the clinical approach. It is based on three different sites. Tried to deliver services as close as possible to home and communities.
- Self directed care: This work has been started off in Dementia Services because it was considered an area where we wanted to develop the skills – the results have convinced us that we can roll this approach out to other services. We are learning as we go along and it is a work in progress.
- We put together a pack and put into it stories that were influential in our thinking about people with dementia once we had identified what we can do better i.e. services to people in their own homes. We are convinced that we need to do a mixture of conventional services with the emphasis on self-directed care and individual choice, looking at how we can shape the market.
- Two provider events have been arranged for providers that start on Monday (9th November). The events will look at the way we currently commission services, how it is going to change and move towards more self-directed care.
- The level of integrated work that goes on between Health and Social Care, users and carers. Emphasis on the carers. Some of the evidence around this is the fact that we have 36 people in Barnsley with dementia that have individual budgets. We take a Partnership in Action approach to commissioning and there is a high level of communication between parties. Training is put in alongside this agenda and we continue to carry this out with providers to prepare them for changed way of working.
- National recognition for our Telecare Strategy. Carers' care is embedded within this strategy. We have carried our work with the Memory Team in terms of support for carers.

What are the immediate top 3 areas of Development?

Commissioners -

- Continuing to look at more creative ways i.e. further work on Care Close to Home.
- Liaison links with residential Care Homes and acute providers to ensure we pick people up – not just a placement exercise. Need to look early detection and education, some way to go but trying hard, the partnership working makes it easier for us to achieve objectives. Social Care staff groups are based within teams so things are actioned more quickly. It is about leadership and it goes right down through the organisations. The Chair of the PCT, the Lead on the Council and the two Chief Executives are very committed to partnership working. Stability of personnel has helped this process along, both Chief Executives have been in post for a long time.
- Rapid Exit/ Rapid Response Service: This is an emergency team we have and if we can we will utilise this service. This service is 24/7 and aims to make sure we can provide a quicker service in times of crisis work when people can be coped with and we have the skills. If there are acute needs we may do things differently. We want to grow this to keep more people at home as we know inpatient beds need to decrease. This is part of a better service to prevent people being admitted to acute care. Our delayed discharge rates are very low.

- Priorities for the future: We are looking at what works well now and spreading this across the patch to ensure even coverage in terms of demographics, predicted increase in numbers and given the financial situation over the coming years. Planning going on not just in dementia services but will cover Dementia and Older Peoples services in general. Opportunity to see how we can work better. Investing in Individual Budgets – there is a programme to show that whilst the budgets are ongoing we are also working on block contracts so that in the next year we will know the shift in terms of block funding to individual budgets. These mechanisms are in place and we are confident the building blocks are in place.
- Carers: We have a very good history of working with and supporting carers in terms of dementia, listening to them and facilitating the changes they make us aware of. We want to take this support for carers further in the future.
- Access to the Respite Service is open to all carers in terms of needing to access a service in a hurry. Carers have a card that they carry with them with a phone number to ring in the event of a crisis and they will be supported. Carers will be sent in to cover the carer's absence.
- Our working practices with the Acute Trust are now as joined up as with the Local Authority but we still work hard as a health community. There are always tensions but we try hard to keep the dialogue going. Barnsley is a small area and the Acute Trust is also small – we need to understand what shapes their agenda. General population in Barnsley is very committed to the general hospital.

What do you think you could do better?

Commissioners -

- Care element – spreading it across the area. Plans for the future are based on the Care Navigators model generally not just in dementia so that people can access services through their Care Navigator not just their GPs.
- Early Intervention – if you have a Care Navigator model generally there is a better chance of detecting early signs of dementia. This is a three-year plan.
- Early diagnosis and intervention: We would like to take this forward on the commissioning front.
- Strong voluntary sector in Barnsley and self-directed support model which we would like to grow and spread across the area. Age Concern and Alzheimer's Society are heavily involved in promoting this product. What is happening in terms of dementia will be taken into account in the development of this project. Currently support mechanisms are in place for people with dementia issues to manage their own support. Different methods of support available – it is about them and their families' choice about how they want these delivered.
- Community mapping exercise has been carried out with Age Concern with assistance from their colleagues in other voluntary sector organisations. This is about to be launched on health and social care websites to enable people to identify what activities and needs are going on in their communities so they can identify their needs through this route or with Care Navigators.
- There is a variation in the work we do with GPs. The vision is to grow our "World Class" Commissioning practice working to every shared standard based in world class commissioning. Currently the coverage is about 40% of practices. This is a new way of looking at working with GPs – the idea is that a lot of Care Navigators will be based in these world class-commissioning practices. These practices will be flagships and gateways into quality services. The aim is to have 100% coverage across the district. People will have the information and knowledge to know what they should be getting for

their condition. Care Navigator actually based in the practice. If the practice does not have a Care Navigator then the GP would make a direct referral. Care Navigators fully funded by PCT

- Mostly they deal with the carers, refer them on and facilitate them into the system. This relationship can continue right through a person's illness. There are three planned approaches to care navigation
 - GP Practices
 - Telehub – telephone support service for carers of people with dementia
 - Health and Social Care Service

How well positioned are you locally to meet the objectives of the National Dementia Strategy?

Commissioners -

- In terms of preparedness to meet the National Dementia Strategy Barnsley estimated they were a 7 on a scale of (1 – 10).

Appendix 4:

Quantification of the Baseline Position against the National Dementia Strategy

Prior to the Review Team visiting each locality, the Locality Dementia Leads were asked to complete Section 2: Quantitative Metrics of the data collection proforma, providing quantitative evidence about dementia in the locality.

Table 6 illustrates the responses to all the questions posed in the proforma, however in many cases data is not routinely available due to the newness of the need for collection.

Table 6: Baseline Position Against the National Dementia Strategy for the Barnsley Locality

Objectives	Metrics	Position	
Objective 2: Good quality early diagnosis and intervention for all	Number of patients currently registered with GPs as having dementia	1,908	
	Registered patients as percentage estimated total population with dementia aged 65 years and over	77%	
	New referrals to Memory Assessment Services per year Apr 2008 – Mar 2009	750	
		Apr 2009 – Review visit	409
	Average wait time from receipt of referral to first (face to face) contact with Memory Service (weeks)	High Priority: 1 Week Medium Priority: 6 Weeks Routine Priority: 35 Weeks nursing/residential Homes: 32 Weeks Referrals can and are frequently seen sooner dependent upon changing need. Where there is an extended waiting time for routine and nursing/residential homes regular contact is maintained by the team to provide advice and support.	
	CT/MRI brain scans for clarification of dementia diagnosis: Average waiting time from referral to CT/MRI scan date over last 12 months (weeks)	CT Scan is 3 weeks (2 - 4) MRI Scan is 5 weeks (4 - 8) weeks	
	Minimum and maximum waiting time from referral to scan date over last 12 months (weeks)	2- 8 weeks. All based on routine referral.	
Data sourced from the Barnsley Metrics Framework submitted to the Review Team prior to visit on 5th November 2009			

Table 6: Baseline Position Against the National Dementia Strategy for the Barnsley Locality

Objectives		Metrics	Position
Objective 5: Development of structured peer support and learning networks for people with dementia and their Carers.	Number of referrals to peer support and learning networks Apr 2008 – Mar 2009	A local education/support group has been designed for carers and clients but not yet established. This is a six week program but time/cost and a central venue are critical factors to enable this to occur as a 'rolling programme' Apr 2008 - Mar 2009	
	Apr 2009 – Review visit		0
	Total number of individuals currently using peer support and learning networks	From a health perspective and to underpin the existing support and peer learning networks the team are keen to roll out the local programme once a venue is agreed and made available. The intentions are to run the programme at different times of the day to capture as many people as possible. Twice a year AS take 52 carers and people with dementia on a day trip to Harrogate for a luncheon and cabaret experience, which is always over, subscribed. AS currently organise 2 holidays a year for 52 carers and people with dementia that again is always over subscribed. These are particularly important events enabling carers to share a holiday with their loved ones in a friendly, safe, non-judgmental environment along with their peers. Funds permitting, AS also arrange other trips and days out as our feedback tells us that for some carers being able to enjoy social excursions where they interact again as 'a couple' or 'friends' in the knowledge that we are 'all in the same boat' and they are not being judged is, in their words "life saving".	
Objective 6: Improved community personal support services	How many hours of specialist Home Care for people with dementia are currently offered per year?	There are no Dementia specific services however Home Care service provides a range of interventions for people with cognitive impairment. Examples with be In-House Home Care services provides support with medication to approximately 360 who have some degree of cognitive impairment Dementia Support Service is currently in development as part of the reshaping of Home Care services.	
	Number of people with dementia currently in receipt of individual budgets	36	
Data sourced from the Barnsley Metrics Framework submitted to the Review Team prior to visit on 5th November 2009			

Table 6: Baseline Position Against the National Dementia Strategy for the Barnsley Locality

Objectives	Metrics	Position	
Objective 7: Support for Carers	Number of Carer Assessments carried out for Carers of people with dementia Apr 2008 – Mar 2009	109	
	Apr 2009 – Review visit	Not currently available Earlier this year the Local Authority introduced a new user records system. The introduction of this system has delayed the production of performance data in this financial year.	
	Number of people with dementia in receipt of short breaks Apr 2008 – Mar 2009	81	
	Apr 2009 – Review visit	Not currently available	
Objective 10: Housing support, housing-related services and Telecare	Number of people with dementia who are supported to live at home, including in extra care or sheltered accommodation	This is not collected from providers of Supporting People commissioned schemes. If required we can add it onto our quarterly monitoring returns.	
	Number of people with dementia supported at home with a Telecare device.	60 Central Call, the Local Authorities 'lifeline' service provides an extensive range of Telecare devices.	
Objective 11: Living well with dementia in Care Homes	Number of registered beds in residential and nursing care in your community for dementia	849 Both of these figures are somewhat misleading as while registered as dementia services not all beds are used for dementia care.	
	If possible, indicate what percentage this is of the total provision of residential and nursing care beds	51%	
	Number of Care Homes in your community with 4/3/2/1 star rated by CSCI/CQC.	Number	Percentage
	4* rating	5	7%
	3* rating	41	59%
	2* rating	13	19%
	1* rating	3	4%
	0* rating	0	0%
Not rated*	8	11%	
Data sourced from the Barnsley Metrics Framework submitted to the Review Team prior to visit on 5th November 2009			

Table 6: Baseline Position Against the National Dementia Strategy for the Barnsley Locality

Objectives	Metrics	Position
Objective 13: An informed and effective workforce for people with dementia/Carer training and awareness	Number of dementia awareness courses available for mainstream staff per year	12 Courses ran. 12 Courses running. More to be added as per demand.
	Number of mainstream staff having attended dementia awareness courses Apr 2008 – Mar 2009	120 Delegates attended. Mixture of both internal staff and independent sector carers.
	Apr 2009 – Review visit	30 Delegates attended so far. 6 courses still to run.
	Number of dementia awareness courses available for Carers per year	12 Courses ran. Course brochure is circulated every year to all voluntary/ independent support groups for service users and carers. 12 Courses running. More to be added as per demand
	Number of Carers having attended dementia awareness courses Apr 2008 – Mar 2009	Take up from informal carers on any course is sporadic but the figures in 18 above cover internal, independent sector, shared lives carers and personal assistants.
	Apr 2009 – Review visit	Take up from informal carers on any course is sporadic but the figures in 18 above cover internal, independent sector, shared lives carers and personal assistants.
Safeguarding	Number of people over 65 referred to Adult Safeguarding processes Apr 2008 – Mar 2009	194 (255 in total)
	Apr 2009 – Review visit	128 (171 in total)
	Number of people with dementia referred to Adult Safeguarding processes Apr 2008 – Mar 2009	10
	Apr 2009 – Review visit	21
Data sourced from the Barnsley Metrics Framework submitted to the Review Team prior to visit on 5th November 2009		

Appendix 5:

Structure of the Data Collection Proforma used in The Review Process

The data collection proforma used in this review process consisted of four sections, these are: -

Section 1: Local Service Description

- Containing background information on the types of services available in the locality to support carers and people with dementia. The information was compiled from regional and national data sources and was provided to the Locality Dementia Lead for verification.

Section 2: Quantitative Metrics

- Containing the quantitative measures assigned to the objectives of the national strategy e.g. number of referrals to memory clinics etc. The Locality Dementia Lead was required to complete the data trawl prior to the Review Team visit. Response listed in Appendix 4 of this report.

Section 3: Strategic Issues

- Containing questions for Chief Officers and Senior Service Providers, soliciting examples of good practice, immediate priorities and areas for improvement for the locality. The Review Team collected responses to questions in this section during their visit to the locality. Responses listed in Appendix 3 of this report.

Section 4: Descriptive Evidence

- Containing approximately 30 questions investigating the progress made to-date in the locality in implementing the objectives of the National Dementia Strategy. The commissioners in the locality were asked to respond to all the questions in this section of the proforma during their semi-structured interview with the Review Team. Other participating groups were asked only the questions from this section that were deemed relevant to their involvement in dementia in the locality, thus providing additional evidence to that of the commissioners, as well in parts a triangulated insight into the provision and quality of service provided in the locality. Responses listed in Appendix 1&2 of this report.

