

# **Yorkshire & Humber Improvement Partnership Regional Review of Dementia Calderdale Locality Report**

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On behalf of

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- CMHT for Calderdale
- Higgins Day Centre in Calderdale
- Acute Hospital Team and Intensive Support Team
- Beechdale Ward Acute Mental Health Hospital

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- Peter Flanagan - Yorkshire & Humber Improvement Partnership
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### 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 Calderdale locality, particularly focussing in on the seven priority objectives of the Implementation Plan.

**Good quality early diagnosis and intervention for all** – currently 39% of people with dementia in the Calderdale locality have a clinical diagnosis of dementia and are registered with their GPs. Referral protocols are in operation for health and social care groups through a single point of access referral mechanism via a telephone help-line. Clear pathways have also been developed to the voluntary sector organisations. The Memory Assessment Service also utilises a number of core assessment tools in the dementia assessment process.

**Improved community personal support services** – a new specialised Home Care service is due to be launched in Spring 2010 for people with dementia which will also offer a daytime home-based Respite provision. A Resource Allocation System for people with dementia is currently piloted in Calderdale and the Individual Budget scheme is still under development.

**Implementing the Carers' Strategy for people with dementia** - a number of short breaks are available for carers, varying from day care services, 'sitting in' services, overnight facilities for service users, residential breaks for carers etc. The new specialised Home Care service is also due to offer daytime home-based Respite provision.

**Improved quality of care for people with dementia in general hospitals** - a Liaison Service provides support to the ward staff at the general hospitals with dementia care. The service supports an assessment and treatment function for older people admitted to the general hospitals and regular education sessions for hospital staff groups. A named lead for dementia has been identified in the acute trust.

**Living well with dementia in Care Homes** – a Care Home Liaison Service operates in the locality providing education, assessment and treatment for people with mental health care issues in all Care Homes in Calderdale. Commissioners reward Care Homes in the locality with quality payments that achieve good or excellent quality ratings.

**An informed and effective workforce for people with dementia/carer training and awareness** – a number of training opportunities are available to hospital and Care Home staff groups within the locality. However commissioners do recognise that the coordination of training could be improved.

**A joint commissioning strategy for dementia** – a local joint dementia strategy for commissioning is under development and will be supported by the appointment of a joint project manager. The project manager, once in post, will investigate capacity and capability issues of local services in relation to future predicted demand.

# 1 Introduction

The National Dementia Strategy<sup>1</sup> 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*<sup>2</sup>. It sets out the task ahead to deliver the aspirations of the National Dementia Strategy and identifies seven<sup>3</sup> 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 31<sup>st</sup> March 2010, Deputy Regional Directors (DRD)*<sup>4</sup> *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 Calderdale 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 two 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.

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

<sup>2</sup> [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_103136.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103136.pdf)

<sup>3</sup> 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)

<sup>4</sup> Deputy Regional Director for Social Care and Local Partnerships

- *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 stakeholders<sup>5</sup> -

- 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.<sup>6</sup>

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.

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<sup>5</sup> 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.

<sup>6</sup> No interviews with carers or people with dementia were arranged during the Review visit to Calderdale.

### 3 Findings of the Review Team in the Calderdale 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 Calderdale locality in relation to Section 2: Quantitative Metrics are outlined in Table 1.

<b>Table 1: Good quality early diagnosis and intervention for all</b>	<b>2009 Baseline</b>
Number of patients currently registered with GPs as having dementia	878
Registered patients as percentage estimated total population with dementia aged 65 years and over	39%
New referrals to Memory Assessment Services per year Apr 2008 – Mar 2009	177
Apr 2009 – Review visit	106
Average wait time from receipt of referral to first (face to face) contact with Memory Service (weeks)	2.9 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 – 5 weeks MRI – 10 weeks
Minimum and maximum waiting time from referral to scan date over last 12 months (weeks)	4-12 weeks

In Calderdale it is estimated that around 39% of the population with dementia have a diagnosis and are registered with their GPs. The proportion in the locality is identical to the regional rate of 39% and one-fifth higher than the national rate of 33%.

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

- Referral protocols are in operation for health and social care groups to access both the Memory Assessment Service and advice on dementia issues. The referral mechanism is a single point of access via a telephone help-line with the necessary information inputted into an electronic administration system.
- Clear pathways have also been developed from the Memory Assessment Service and the voluntary sector, while a counselling service is provided for individuals newly diagnosed with dementia.
- The Memory Assessment Service utilise a number of core assessment tools in the dementia assessment process.

**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 Calderdale locality in relation to Section 2: Quantitative Metrics are outlined in the Table 2.

<b>Table 2: Improved community personal support services</b>	<b>2009 Baseline</b>
How many hours of specialist home care for people with dementia are currently offered per year?	At present, there are no specialist services for people with dementia; this service is in development and is expected to be completed Spring 2010
Number of people with dementia currently in receipt of individual budgets?	3

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

- A specialised Home Care service is due to be launched in Spring 2010 for people with dementia where there are difficulties in providing the service through the

mainstream service. The new service will also offer a daytime home-based Respite provision.

- The local authority is currently piloting a Resource Allocation System for people with dementia that is currently being used across all service user groups.
- An Individual Budget scheme is still under development in 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 Calderdale locality in relation to Section 2: Quantitative Metrics are outlined in the Table 3.

<b>Table 3: Implementing the Carers' Strategy for people with dementia.</b>	<b>2009 Baseline</b>
Number of Carer Assessments carried out for Carers of people with dementia Apr 2008 – Mar 2009	Approximate 75
Apr 2009 – Review visit	Approximate 37
Number of people with dementia in receipt of short breaks Apr 2008 – Mar 2009	Approximately 48 There are 4 residential respite beds commissioned for people with dementia and 2 nursing short breaks, although the majority of people with dementia requiring short breaks are supported within mainstream provision including Calderdale Shared Lives (Adult Placement) scheme. Currently Shared Lives support up to 10 service users and carers with dementia. Specialist dementia day care support has now been integrated into day care provision supporting people to access services in their own localities. Independent day service providers also support people with low-level dementia. Calderdale's Carers Project is currently supporting 249 carers who have been identified as being a dementia carer.
Apr 2009 – Review visit	Approximately 27

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

- A number of short breaks are available for carers, including dementia carers varying from day care services, 'sitting in' services, overnight facilities for service users, residential breaks for carers etc.
- The new specialised Home Care service is due to offer daytime home-based Respite provision.

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 Calderdale locality (Section 4 of proforma) –

- A Liaison Service provides support to the ward staff at the general hospitals with dementia care and is operated by a team of mental health nurses and consultant psychiatrists. The service supports an assessment and treatment function for older people admitted to the general hospital. The team also provide regular educational sessions for hospital staff groups.
- A named lead for dementia has 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 Calderdale locality in relation to Section 2: Quantitative Metrics are outlined in the Table 4.

<b>Table 4: Living well with dementia in Care Homes</b>	<b>2009 Baseline</b>	
Number of registered beds in residential and nursing care in your community for dementia	291	
If possible, indicate what percentage this is of the total provision of residential and nursing care beds	22%	
Number of Care Homes in your community with 4/3/2/1 star rated by CSCI/CQC.	Number	Percentage
4* rating	2	18%
3* rating	5	44%
2* rating	2	18%
1* rating	2	18%

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

- A Care Home Liaison service operates in the locality providing education, assessment and treatment for people with mental health care issues in all Care Homes in Calderdale.
- Care Homes in the locality are rewarded with quality payments if good or excellent ratings are obtained. However commissioners will suspend placements with Care Homes if poor performance is reported, until demonstrable improvements have been achieved.

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 Calderdale locality in relation to Section 2: Quantitative Metrics are outlined in the Table 5.

<b>Table 5: An informed and effective workforce for people with dementia/carer training and awareness</b>	<b>2009 Baseline</b>
Number of dementia awareness courses available for mainstream staff per year	This data is not available. Our main mental health provider offer mental health training but this is not specific to dementia although it does cover dementia.
Number of mainstream staff having attended dementia awareness courses Apr 2008 – Mar 2009	Information not available.
Apr 2009 – Review visit	Information not available.
Number of dementia awareness courses available for Carers per year	Information not available.
Number of Carers having attended dementia awareness courses Apr 2008 – Mar 2009	Information not available.
Apr 2009 – Review visit	Information not available.

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

- A number of training opportunities are available to hospital and Care Home staff groups within the locality. However commissioners do recognise that the coordination of training could be improved.

**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 Calderdale locality (Section 4 of proforma) -

- A local joint dementia strategy for commissioning is under development and will be supported by the appointment of a joint project manager. The commissioning intentions in this strategy are in line with Transforming Community Services guidance.
- An assessment of the issues relating to the capacity and capability of local services to address the predicted increases in numbers of older people requiring intervention will be investigated by the project manager, once in post.

### **3.2 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 Calderdale Locality**

- Establishing a local dementia network.
- Development of dementia Cafés.
- Joint commissioning of care home between NHS Calderdale and Calderdale Council.

#### **Immediate Priorities and Areas for Improvement**

- Development of the pilot for the specialist Home Care service.
- Ensuring that the right kind of support is made available for people from BME communities.

#### **What could be done better locally?**

- Understanding the potential impact on services of the predicted increase in numbers of people with dementia.
- Public awareness towards dementia.
- Working with carers and people with dementia to develop new services and also improve communication regarding changes in service provision.
- Individual Budgets scheme.

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

In terms of preparedness to meet the National Dementia Strategy Calderdale assessed themselves as 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 31<sup>st</sup> 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.

<b>Action Plan for the Calderdale Locality</b>			
<b>NDS Objective</b>	<b>Action</b>	<b>Lead Person/ Organisation</b>	<b>Target Date</b>
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

**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 –

- Yes there is single point of access. One telephone number and assessed by one person and information passed onto electronic system. From January onwards the Council will have a much stronger user information and advice service.

Staff Group 1 -

- Referral goes through the GP who screens, does physical health checks and does blood tests. Goes to single point of entry and worker allocated depending on East or West Calderdale Team and ensures enough information on the referral.

**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 –

- Yes

**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 –

- MMSE, Bristol ADL

**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 –

- Yes

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

Commissioners –

- Yes

**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 –

- A home care support pilot is due to be launched Spring 2010. The service is intended to be person centred, to support people with dementia living at home where there are difficulties in providing through mainstream providers. The service may also support carers in providing planned home-based respite through core hours of 7am-10pm, not overnight.

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

Commissioners –

- Contracts will be monitored through the joint commissioning approach that covers the Home Support Team and Acute Support.

- There remain issues around about identifying people with complex needs and how to engage with 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, Care Homes, Acute Hospital, Day Care and Community Mental Health Teams all actively engage with mainstream services, but do not record contacts other than formal education sessions.

**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 -

- Calderdale Council is piloting a resource allocation system that is currently used across all service user groups.

**Are people with dementia supported to use Individual Budgets?**

Commissioners -

- Work in progress.

**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 -

- A number of short breaks are available for carers, including dementia carers varying from day care services, 'sitting in' services, overnight facilities for service users, residential breaks for carers etc.

**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 –

- Yes a number of Mental Health Nurses provide a Liaison Service to Calderdale Royal & Huddersfield Royal (CHFT). With support from Consultant Psychiatrists team provides assessment and treatment for any older people admitted to General Hospital with mental health problems. Also provide regular education sessions for hospital staff.

Staff Group 1 -

- Referrals from General Hospital go to the single point of entry. Team Leader and OT – both pathways effective. The team receive around 20/30 referrals a month.
- Shortfalls: Memory Group – They need to have more capacity to meet demands.

Staff Group 2 –

- Yes Liaison nurse within the hospital and contacts us when one of our patients goes into the mainstream care. If we have carried out an assessment they will contact us.

**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 –

- Yes, Jackie Murphy Associate Director for Nursing, CHFT

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

Commissioners –

- No information available.

### **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 continue to use Care Homes that provide a poor service. We work with Care Homes when they have completed the action plan.
- If a home shows evidence of poor practice, as joint commissioners, we suspend placements until the provider can demonstrate that quality has improved to an acceptable standard. We will move to phased admissions, to be sure that the quality continues to improve.
- We provide quality payments to homes that receive Good or Excellent ratings from CQC.

#### **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 –

- Yes, this service is made up of a multi-disciplinary team consisting of Band 7 Nurse, 0.4 Band 6 Nurse, 1.0 Band 5 Nurse, 0.5 Band 7 Dietician and 0.1 Pharmacist.
- The service provides education, assessment and treatment for all Care Homes regarding mental health care. Care management of residents in NHS Calderdale's contracted beds at Claremount Nursing Home.

**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 -

- Acute Hospitals; SWYPFT offer 15 sessions per year with average attendance of 15.
- Care Homes; SWYPFT have offered 7 sessions over last 12 months with 72 staff attending
- Strategy not as joined up as should be. Need to check about what we are doing and what we are not doing.
- Acute team also has the following arrangements: Medic for 6 weeks, GP for 4 months, F2 doctor spent 4 months working within ward environment, Senior training psychologist training with them.
- Local Authority Workforce Development Plan includes training for care staff working with people with dementia. This is provided in partnership with the local Alzheimer's Society. The training is available to all independent sector care providers.

Staff Group 1 –

- Team Leader felt they had good access to training. Care Home Liaison team provide training into independent Care Homes.

Staff Group 2 –

- Just integrating a local Health and Social Care training plan that includes dementia training and awareness. OT is the lead link on the work. Looked at activity type group work – evidence based practice. Now have service users deciding what they would like to do – evaluate it to identify further memory impairment.
- Professionals: Link with Bradford Dementia group – dementia care mapping. The Trust as a whole has been doing dementia care mapping
- Relevant training for Carers: Well-being course. Look after Me Course. Other voluntary courses they can get on and we provide the information.
- Regular Dialogue Meetings. This is quite effective as it is good for carers to meet with managers and discuss any issues on a regular basis. Carers Group very supportive.

**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 –

- A joint project manager has been recruited and is due to commence in November to develop a local joint dementia strategy.
- Commissioning intentions have been developed in line with Transforming Community Services that creates an infrastructure to enhance NHS Calderdale's and Adult Social Care joint commissioning arrangements.

**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 –

- The project manager once in post will carry out a demand and capacity exercise to understand our position.

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

Commissioners –

- To be discussed with the YHIP Lead on our review date.

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

Commissioners –

- Not at present.

## 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 -

- This is being carried out through the Dementia Network.
- Raising professional awareness.
- Training in Care Homes.
- Training with GPs.

**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 –

- No standard information pack shared across the whole system. Information pack and medicines information used at Memory Service but practitioners also use various sources of information depending upon clients needs.
- Need to be sure people have the skills and ability to use the pack.

Staff Group 1 –

- Information is given as appropriate, but is not standardised. Within memory groups carers and people with dementia will be asked what information they want and this becomes a group process.

Staff Group 2 –

- Yes we have information products that pick up the evidence based practice.
- Carer Liaison nurse just reviewing all the information to ensure it is up to date and that people receive the right information.

### **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 –

- Dementia Cafés.
- Alzheimer's Society offer the Carer Education activity.
- Carer Project also run Carer Support Groups.
- Higher Education Group planning for the future.

#### **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 –

- SWYPFT in partnership with Alzheimer's Society offer two 10 week Memory Groups (education regards diagnosis and ongoing care for sufferers and carers) per year with on average 5 couples attending, these are formal time limited groups. The Alzheimer's Society staff complement this with informal ongoing support groups.
- SWYPFT provide 3 Dementia Specific Carer Support Groups that meet every 6-8 weeks in support of the 3 Integrated Day Centres at Halifax, Brighouse and Hebden Bridge with average attendance of 5 at each.
- SWYPFT offer 3 further Carer Support Groups for people of all ages with Mental Health problems including people with Dementia, in Halifax, Todmorden and Brighouse.

**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 –

- Yes, although there are some difficulties with residential beds due to limits in private provision. Working in a pilot project where a nurse carries out a psychiatric nursing informal assessment and then meets with Consultant to review cases seen. Consultant either makes assessments in intermediate care setting or leaves it until later to get a baseline of their dementia. Working in this way works better as it avoids too many assessments and is a good way of providing assessments within an intermediate care setting. Care Homes are not always happy for people with dementia to take up beds.
- 1.6 Mental Health nurses employed by Intermediate Care Team. Supervised by Consultant Psychiatrist.

**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 -

- Full range of devices including: property exit sensors, bed/chair occupancy sensors, smoke/CO detectors.
- There are 3 Extra Care Housing developments in Calderdale. Mytholm Meadows in Hebden Bridge, Clement Court in Halifax and Willow Court, in Elland. The latter is opening in November 2009 and people are moving in over a 2-month period. There are a total number of 130 units within these three developments.

**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 –

- Local training around end of life care is based on the care for patients irrespective of their diagnosis, and therefore includes dementia. There is currently no tailored end of life training for dementia patients.
- There is a current gap in our information, as we currently do not know how many people need end of life care, including those with dementia. We are working hard to find ways to identify this. The hospices do not deal with people with dementia or challenging behaviour. Need to identify how we go forward. Process has been in place in Care Homes for a number of years for people living in the home.

**Safeguarding**

**Please describe your local definition/reporting threshold for Safeguarding?**

Commissioners –

- There is a project currently being undertaken going across Calderdale, Kirklees and Wakefield to examine the number of referrals that come through from NHS.
- A well-developed safeguarding board exists in the locality.

**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 –

- A list of Dignity Champions for Calderdale are available via the website.

## Appendix 3:

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

#### What are the top 3 areas of local practice?

Commissioners -

- Establishing a Local Dementia network: It was noted how disengaged some of the local public organisations such as supermarkets and banks were about issues of dementia and we have tried to encourage them meet with us but they did not respond. Trying to develop a sense of the community trying to work together about dementia issues. It was felt very disparate and that there was need for someone to pull all this work together and this has now been achieved in the appointment of the new project manager.
- Dementia Cafés operated by Alzheimer's Society and meets fortnightly. This is a relatively new project and they have met three times so far.
- Joint Commissioning of Care Homes between Local Authority and NHS. Both Health and Social Care work well together trying to focus on outcomes and think about what we are trying to achieve i.e.
  - Better quality service for people and best use of the systems.
  - Being accepted by providers – (better for some than others).
- In terms of Primary Care, we use protocol with GPs for example the over prescribing of anti-psychotic interventions. Document has been drafted for prescribing in Primary Care which focuses on time limited use of anti psychotics (short term). Potentially saving a lot of money. This links with the Care Home team work
- In terms of a joint framework to get the users and carers voices heard from “doorstep” to chief officers there is the Dementia Network and Partnership Board. The Dementia Strategy will not just be informed with stakeholders but also the wider community. The LSP for Older People has all the key senior partners on it. The Health and Social Care Partnership Board brings together the non-executives members from the PCT and key members from across the area. They provide the commissioning focus for the two major commissioning organisations (Local Authority and Health). Decisions are taken either to the NHS board or Council Members for approval. As a result of this we are moving towards a joint commissioning approach so that all commissioning activity by Local Authority and Health will be aligned around a programme structure. Not quite there yet.

Staff Group 4 –

- Hospital Liaison and Care Home Liaison Teams.
- Memory Assessment Services and function was good.
- Single point of access was very beneficial.

#### What are the immediate top 3 areas of Development?

Commissioners –

- Understanding the potential impact on services of the predicted increase in numbers of people with dementia both in older people's mental health services and the Learning Disabilities service.
- Working with carers and people with dementia to develop new services but also improve communication regarding changes in service provision.
- Increase public awareness towards dementia. Work with supermarkets and banks have yet to be fruitful.

- Ensuring that the right kind of support is made available for people from BME communities.

### **What do you think you could do better?**

Commissioners -

- Making sure that the “putting people first” framework is about the transformation and adult social care is applied in the field of dementia. Create opportunities for people to use personalised budgets. Risk that people with dementia “miss out” due to this modernising approach. National issue. Putting people first is the core part of the issue.
- Need to recognise some of the good work that is going on within Calderdale. Need to raise public’s awareness of this work.

Staff Group 1 –

- All workers carry out initial memory assessments.
- Memory nurse – caseload of 200 – managing people on anti-dementia drugs.
- All staff use two IT systems.

Staff Group 2 –

- Look at Telecare and develop throughout the area.

Staff group 3 –

- Better assessment of need and how to integrate people with dementia.
- Getting Acute Ward staff to accept issues as theirs and how to attend to them.
- More support post diagnosis.
- Better Home Care that would engage and provide active support ourselves “doing for people”.
- Encourage more training.

Staff group 4 –

- No provision for people with early onset dementia
- Individual Budgets take time to set up – difficult for service users to implement. Carers sometimes find it difficult to find care agencies to provide support.

### **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 Calderdale assessed themselves as 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 Calderdale Locality**

<b>Objectives</b>	<b>Metrics</b>	<b>Position</b>
Objective 2: Good quality early diagnosis and intervention for all	Number of patients currently registered with GPs as having dementia	878
	Registered patients as percentage estimated total population with dementia aged 65 years and over	39%
	New referrals to Memory Assessment Services per year Apr 2008 – Mar 2009	177
	Apr 2009 – Review visit	106
	Average wait time from receipt of referral to first (face to face) contact with Memory Service (weeks)	2.9 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 – 5 weeks MRI – 10 weeks
	Minimum and maximum waiting time from referral to scan date over last 12 months (weeks)	4-12 weeks
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 Apr 2009 – Review visit Total number of individuals currently using peer support and learning networks	Peer Support is offered via the Dementia Café that is provided by the Alzheimer’s Society. This actual numbers are not available at present
Data sourced from the Calderdale Metrics Framework submitted to the Review Team prior to visit on 3 <sup>rd</sup> November 2009		

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

Objectives	Metrics	Position
Objective 6: Improved community personal support services	How many hours of specialist home care for people with dementia are currently offered per year?  Number of people with dementia currently in receipt of individual budgets	At present, there are no specialist services for people with dementia; this service is in development and is expected to be completed Spring 2010.  3
Objective 7: Support for Carers	Number of Carer Assessments carried out for Carers of people with dementia Apr 2008 – Mar 2009  Apr 2009 – Review visit  Number of people with dementia in receipt of short breaks Apr 2008 – Mar 2009  Apr 2009 – Review visit	Approximate 75.  Approximate 37. Approximately 48. There are 4 residential respite beds commissioned for people with dementia and 2 nursing short breaks, although the majority of people with dementia requiring short breaks are supported within mainstream provision including Calderdale Shared Lives (Adult Placement) scheme. Currently Shared Lives support up to 10 service users and carers with dementia. Specialist dementia day care support has now been integrated into day care provision supporting people to access services in their own localities. Independent day service providers also support people with low-level dementia. Calderdale's Carer Project is currently supporting 249 carers who have been identified as being a dementia carer.  Approximately 27
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  Number of people with dementia supported at home with a Telecare device.	Information not available.  Information not available.
Data sourced from the Calderdale Metrics Framework submitted to the Review Team prior to visit on 3 <sup>rd</sup> November 2009		

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

Objectives	Metrics	Position
Objective 11: Living well with dementia in Care Homes	Number of registered beds in residential and nursing care in your community for dementia	291
	If possible, indicate what percentage this is of the total provision of residential and nursing care beds	22%
	Number of Care Homes in your community with 4/3/2/1 star rated by CSCI/CQC.	Number      Percentage
	4* rating	2            18%
	3* rating	5            45%
	2* rating	2            18%
	1* rating	2            18%
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	This data is not available. Our main mental health provider offer mental health training but this is not specific to dementia although it does cover dementia.
	Number of mainstream staff having attended dementia awareness courses Apr 2008 – Mar 2009	Information not available.
	Apr 2009 – Review visit	Information not available.
	Number of dementia awareness courses available for Carers per year	Information not available.
	Number of Carers having attended dementia awareness courses Apr 2008 – Mar 2009	Information not available.
	Apr 2009 – Review visit	Information not available.
Safeguarding	Number of people over 65 referred to Adult Safeguarding processes Apr 2008 – Mar 2009	206
	Apr 2009 – Review visit	Information not available
	Number of people with dementia referred to Adult Safeguarding processes Apr 2008 – Mar 2009	58 were identified as Elderly Mentally Infirm
	Apr 2009 – Review visit	
Data sourced from the Calderdale Metrics Framework submitted to the Review Team prior to visit on 3 <sup>rd</sup> 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.

