Plymouth
Dementia Strategy
2009 - 2013

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Executive Summary

NHS Plymouth and Plymouth City Council Adult Social Care Services have been working together on the development of a Dementia Strategy for Plymouth, in parallel with the launch of the National Dementia Strategy published in February 2009.

Services currently provided by specialist and non-specialist staff for people diagnosed with dementia are of good quality. However, it is acknowledged that there is a significant number of older people living in our communities with dementia who have not had the benefit of a specialist assessment and early intervention and therefore have not had their care needs identified, or met. In addition, as people live longer, we can expect the number of people with dementia to rise significantly, which will place an additional burden on local services. There is no option or desire to stand still on this pressing demographic need.

In 2008 NHS Plymouth and Plymouth City Council Adult Social Care provided support to only one third of the estimated 2904 people with dementia. *Our joint strategy is to significantly increase this provision such that by 2012 we will be providing support to the MAJORITY of the estimated 3,107 people with dementia in our area.* This will be challenging due to resource constraints, but we believe it is vitally important due to ever-increasing demographic need.

2008	**Plymouth City Council**	**NHS Plymouth**	**Total**
Estimated total of people with dementia			**2904**
People with dementia known to services	938	148	**1086 (37.3%)**
Cost of care supplied	£1.24m	£2.5m	**£3.74m**
Hours of care supplied per annum (est.)	83,000	*751	**83,751**

* patients who had an open episode of care in 2008. This information was provided by the Business Intelligence Unit, NHS Plymouth

2012	Plymouth City Council	NHS Plymouth	Total
Estimated total of people with dementia			**3107**
People with dementia known to services	1369	216	**1585 (51%)**
Cost of care supplied (est. at 2008 rates)	£1.81m	£3.65m	**£5.46m**
Hours of care supplied (est.)	121,136	1096	**122,232**

We can assume from this that the remaining populations of older people are in the health and social care system without a diagnosis, or may be in the early stages of dementia and supported by relatives and carers. By 2012 we will have to find £1.72m of new funding if we do not reorganize the way services are delivered. However, through this strategy we intend to develop early interventions and support through primary care in order to delay admissions to care home settings.

We will ensure that all people with a dementia will be supported on the dementia pathway through:

- Primary and pre-primary care pathways and early intervention
- Care and support commissioned jointly through adult social care and health.

Adult Social Care and NHS Plymouth have already undertaken a baseline review of current services which identified gaps in provision and areas for improvement. Health, Adult Social Care and the Community and Voluntary Sector have, over the past six months, invested a huge amount of time and energy in shaping and redesigning their services aiming to ensure they are fit for purpose and that people with dementia in Plymouth will be able to access the highest quality care available.

Currently we provide the following services:

- Specialist dementia and enabling domiciliary care provision managed by Adult Social Care.
- A Community Older Peoples Mental Health Team (OPMH) which includes occupational therapists, physiotherapists, community psychiatric nurses and social workers.
- The Community and Voluntary Sector provides preventative befriending services and lunch clubs
- Prospective dementia screening for all adults with Down's Syndrome in Plymouth, and assessment and intervention for all adults with learning disabilities with dementia, provided by the Learning Disability Partnership.
- Plymouth has the only specialist Extra Care Housing for people with dementia in the region.
- Short Break (Respite) services with the Independent, Community and Voluntary sector.
- Over 10,000 hours per week of independent sector domiciliary care per week with 80% of this provision supporting older people.
- Specialist Independent Care Home provision across the city.
- Additional support is available through community social work teams and district nursing provision.

- Partnership working with the Community and Voluntary Sector for befriending services and support through the Alzheimer's Society.

This is the strategy for Plymouth which will be subject to consultation. It outlines a vision for services that will enable agencies and communities to make significant progress in addressing the delivery of effective, person-centred services for older people with dementia and their carers, within available resources. It will also guide decision making by commissioners about needs and resource allocation over the longer term.

THIS STRATEGY WILL PROVIDE:

- A robust analysis of the needs of people with dementia in Plymouth to inform commissioning
- A "whole system" focus across health and social care for service improvement
- A commissioning framework for Plymouth City Council and NHS Plymouth
- Coherence with other related health and social care commissioning strategies, including the "All our Futures" Strategy for people over 50, the Extra Care Housing Strategy, the Carers' Strategy, the End of Life Care Strategy, Plymouth's Health and Social Care and Wellbeing Strategy 2008-2020 and Plymouth's Mental Health Commissioning Strategy (currently in draft) and the Putting People First "concordat" .

THE OVERARCHING COMMISSIONING AIMS OF THIS STRATEGY, WITHIN AVAILABLE RESOURCES, ARE:

- For Plymouth to be a **regional or national leader** in dementia care service provision.
- To provide services to the majority of people needing them.
- To secure services and support that deliver holistic, person-centred health and care and low level support to address mental as well as physical health needs, with dignity and respect.
- To secure services that are flexible and able to change in line with people's unique circumstances, enabling and supporting independence and choice.
- To secure a comprehensive city wide Community Memory Service as part of a fully integrated pathway of care.
- To promote equity of access to services and support based on individual and population needs.
- To ensure that treatment, care and support is based on the best available evidence of effectiveness.
- To ensure that wide ranging resources and services in the community respond to the needs of people, particularly those in the early stages of dementia.
- The city-wide Community Memory Service is delivered in partnership with Plymouth City Council, and consists of both Health and Social Care Staff working in integrated teams. The strategy proposes that the Community Memory service will be expanded so that referrals will be accepted directly from individuals, carers and other professionals.

THE PRINCIPLES UNDERPINNING THE STRATEGY ARE:

- Service users and carers are involved in the development of services and care pathways.
- Person-centred assessment and care planning.
- Service users and carers feel they are in control of the services and support they receive.
- Services and support are provided as near to home as possible.
- Access to services is simple and timely.
- All people with a diagnosis of dementia in Plymouth will be able to access appropriate care and support.

PROCESS FOR DEVELOPING THE STRATEGY

A project group of the main agencies has been involved in the development of the strategy. This group includes NHS Plymouth and Adult Social Care Commissioners, Older Peoples' Mental Health Services, the Learning Disability Partnership and the Community and Voluntary Sector. The strategy reflects Plymouth's response to the National Dementia Consultation and listening events co-coordinated by CSIP (Care Services Improvement Partnership) plus the priorities of older people, carers and people with dementia themselves.

The work programme to support production of this strategy has included:

- A baseline assessment of current provision using the service directory and commissioning checklist in "Everybody's Business"
- National and local demographic evidence commissioned by the Alzheimer's Society in London
- Evidence from wider consultation with older people and carers including specific research commissioned by Adult Social Care from Plymouth University
- Development of a care pathway for dementia by specialist staff across Health and Adult Social Care
- Four service user and carer consultation sessions
- Stakeholder events involving the Community and Voluntary Sector
- Support from Adult Health and Social Care portfolio holder Councillor Dr David Salter who chairs the Health and Social Care Integration Board and has had longstanding involvement with dementia services.

STRATEGIC PRIORITIES IDENTIFIED FOR WIDER CONSULTATION

Improved Awareness

- Plymouth City Council Adult Health & Social Care will develop a comprehensive joint communication strategy together with NHS Plymouth to raise public awareness of dementia and help dispel myths surrounding it. This will include access to good quality information and advice.

Early Diagnosis and Intervention

- Provide an integrated city wide Community Memory Service which includes Health and Social Care staff to provide accurate and rapid diagnosis and improve the outcomes for people accessing services.
- Ensure that Intermediate Care is available and accessible for people with dementia.
- Commission a pre-primary Dementia Advice service based within each integrated locality team which will reach out into the local community, raise awareness of dementia and provide low level support and signposting to people not otherwise known to the service. These individuals would act as a single point of contact for their community.
- Commission a "one stop shop "in the city centre to enable people to get information, advice and access assessment for services.
- Work in partnership with the community and voluntary sector and housing providers to increase low level befriending services available for older people with dementia and their carers and to develop more innovative models of housing support.
- Commission preventative and supportive services through the Community and Voluntary Sector which will be co-located with the Memory Service and provide support on diagnosis.
- Work with primary care to develop a validated dementia toolkit for use in primary care for people with early signs of dementia.

Support for Carers

- Commission a range of flexible and responsive specialist short break (respite) services for carers within care home settings and within the persons own home.

Improved Quality of Care

- Improving the quality of care in Plymouth's Derriford Hospital by reviewing the hospital psychiatric liaison service to ensure that there are enough resources to facilitate referral to specialist services, ensure appropriate discharge arrangements are in place and raise awareness and competency around dementia care within an acute environment.
- Develop a joint Health and Adult Social Care workforce development plan which will support improvements in care and support services across independent, Community and Voluntary Sector Specialist and Housing services. This will include setting up a Dignity in Care Forum to share good practice and support independent sector providers improve standards.

Improved Dementia Pathway

- There will be a single point of access. Specialist staff will support the proposed integrated community teams across the city and will also provide a rapid response service for those patients in crisis or at risk of admission.

Enhanced Community Memory Service

- To pilot a Dementia Advisor outreach service in a locality in Plymouth with a view to roll out over the next 1-2 years.
- To develop a validated dementia toolkit for use in primary care for people with early signs of dementia.
- Commission a Community and Voluntary Sector service to link into the Memory Service and provide support on diagnosis.
- Ensure that Intermediate Care is available for people with dementia.

1.Background and drivers for change

1.1 What do we know about dementia?

Dementia is a progressive and largely irreversible clinical syndrome that is characterized by a widespread impairment of mental function. It is estimated that there are 700,000 cases of dementia in the UK and approximately one million people caring for people with dementia. (National Institute for Clinical Excellence November 2006)

It is a disease of uncertain duration but which, on average, lasts 10 years from diagnosis to death. It is a journey ultimately affecting all levels of functioning, making demands on families, local support networks and communities. Services and professionals supporting the person with a dementia need to be flexible and fit round the person as the journey takes it own course.

The demographic trend indicating the increasing population of the very old (85 yrs+) means that dementia is often linked with progressive frailty and physical illness and is often first recognised during a hospital admission when there has been a disruption to routine and a change in the person's physical and mental resources. A dementia is a diagnosis of last resort which means that for some people there may be a period of extended assessment. Individuals present at varying stages of the disease and need to be able to access appropriate assessment and support at each entry point. Good practice for dementia will have much in common with the guidelines for enduring illness.

A useful way of viewing dementia is to see the journey as having 3 phases, of uncertain duration but driven by common changes in cognition and ability to carry out daily living tasks. The person and their supporters are likely to need different resources at each stage, usually in combination. No one profession or service has all the answers for the individual and their family but working in trusting professional and service collaboration we can provide a first class service for the people of Plymouth and for the most vulnerable individuals.

It is estimated that only a third to a half of older people with dementia receive a diagnosis and yet older people with a mental health need account for a significant proportion of those who use health and social care services

NICE (National Institute for Clinical Excellence) guidance 2006 offers good practice advice on the care of people with dementia, underpinned by the principles of person-centred care. This strategy will aim to incorporate these principles throughout to ensure that services are responsive to the needs of carers and people with dementia in Plymouth. The principles assert:

- The human value of people with dementia, regardless of age or cognitive impairment, and those who care for them
- The individuality of people with dementia with their unique personality and life experience among the influences on their response to dementia
- The importance of the perspective of the person with dementia
- The importance of the relationship and interactions with others to the person with dementia and their potential for promoting well-being.

1.2 Why do we need a strategy?

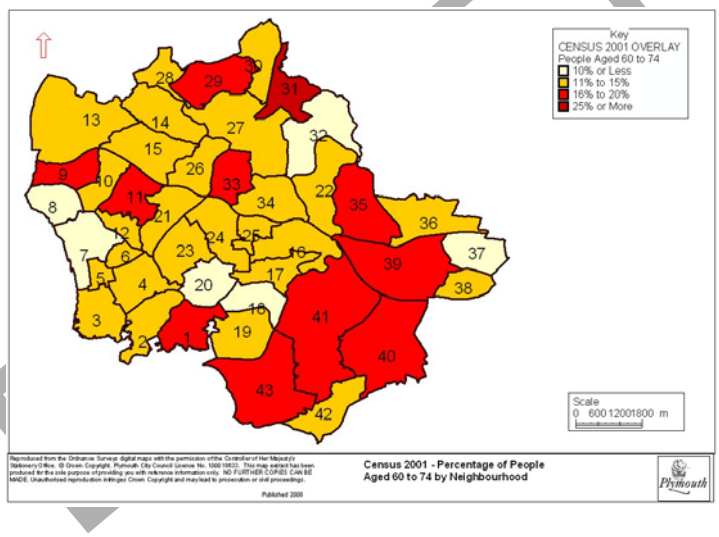
Currently, there is a high level of need relating to services for older people with dementia with a significant increase in demand anticipated in the next 5 – 10 years. There are 38,500 people in Plymouth over the age of 65 years and it is likely that about 10% of men and 15% of women will have some form of dementia or memory loss.

Comment [j1]: Could insert prevalance for Down Syndrome and LD here.

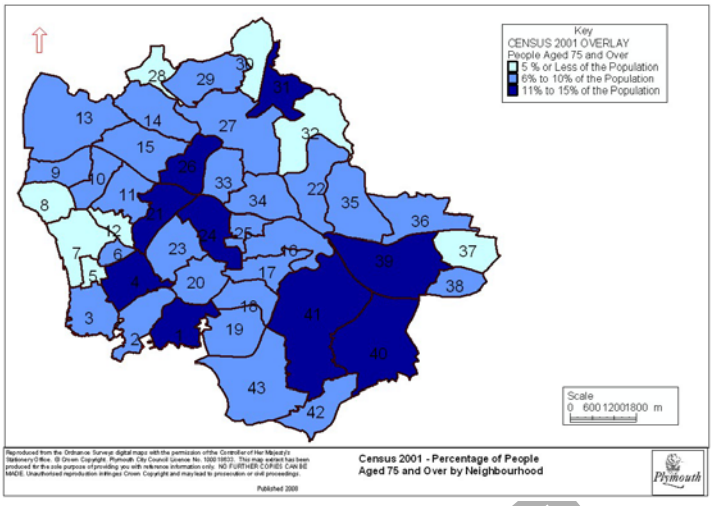
In terms of population changes, growing demand for older people's mental health services and pressure on resources means that we have to continually review the way we do things and consider new ways of working that will improve the care we deliver to people with a dementia related need and their carers. This strategy sets out a joint direction of travel for NHS Plymouth and Adult Social Care for the next 5 years and includes other funding streams e.g. Supporting People, organisations and individuals involved in older people's mental health services. The strategy reflects national good practice guidance around dementia which will, we believe, improve outcomes for older people, at all stages of their dementia, and their carers.

1.3 Current Issues

The information mapped below is taken from the Census 2001 displaying the percentage of people Aged 60 to 74 by neighbourhood area.



The information mapped below is taken from the Census 2001 displaying the percentage of people Aged 75 and over by neighbourhood area.



GP surgeries are required to keep a register of all the people registered with their practice who have a diagnosis of dementia. The table below shows the number of people on the dementia registers of GP practices in the different areas of Plymouth.

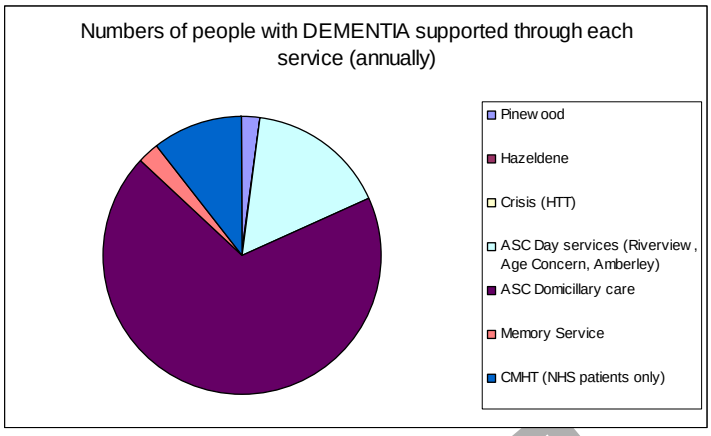
Area of Plymouth	Number on dementia register	Area of Plymouth	Number on dementia register
Ernesettle	17	Hartley	19
Plympton	181	Devonport	3
Honicknowle	15	Keyham	2
St Judes	63	Lipson	7
Estover	23	Mount Gould	5
Plymstock	113	Stonehouse	3
Milehouse	19	Efford	6
North Road West	45	Prince Rock	29
St Budeaux	25	Western Approach	7
Southway	6	Crownhill	29
Roborough	57	Mutley	70
Mannamead	59	Peverell	31
Stoke	125	West Hoe	16
Whitleigh	7	**TOTAL**	**982**

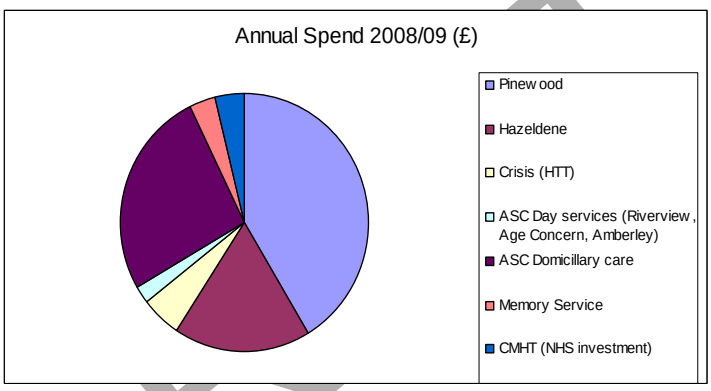
Source: www.ic.nhs.uk

The total number of people registered with dementia at GP practices in Plymouth is lower than what is projected by the Mental Health Observatory below. Living Well with Dementia: A National Strategy states that “currently only a third of people with dementia receive a formal diagnosis or have contact with specialist services at anytime in their illness”. The difference in the number of people projected to have dementia in Plymouth and the number of people with a formal diagnosis reflects this situation.

1.3.1 Spend Analysis

Comment [j2]: Could add LD figures to this?





1.3.2 Costs to Carers

There are six million carers in the UK who provide unpaid care by looking after an ill, frail or disabled family member, friend or partner of which 1.25 million provide over 50 hours of care per week. The support they provide is estimated at £57 billion per year.

Many older carers do not qualify for Carer's Allowance and lack of funding of social care – from equipment to practical help – places an additional financial strain on carers, often resulting in carers undertaking more tasks themselves.

In Plymouth there are approximately 24,000 people who have identified themselves as unpaid carers, with over 8000 stating that they provide more than 20 hours per week care to someone. Plymouth supports fewer than 2000 carers with direct services and advice and information .This strategy will be reflecting carer's views and will influence new developments to support carers of people with dementia.

1.3.3 Prevalence of dementia

One in 20 people over 65 years has a form of dementia. The prevalence increases with age**,** doubling with every 5 year increase across the age range. In 'cost of illness' studies, the direct costs of Alzheimer's Disease alone exceed the combined costs of stroke, cancer and heart disease.

Forecast of the Prevalence of Dementia in older people over the next 10 years and beyond

UK prevalence rates for dementia are as follows
(Source initiatives in Care 2005 / Alzheimer's Society 2004):

Age 40 – 64	1 in 1000
Age 65 – 69	1 in 50
Age 70 – 79	1 in 20
Age 80 +	1 in 5

In May 2008 the Mental Health Observatory projected the numbers of people with dementia over the next 10 years in each local authority area. The following table shows the figures they predict for Plymouth.

YEAR	65-69		70-74		75-79		80-84		85-89		90-94		95-99		**TOTAL**
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
2008	80	58	136	125	179	299	235	479	211	574	97	289	25	117	**2904**
2010	86	60	143	130	184	299	245	479	216	574	113	314	28	121	**2992**
2015	102	74	161	137	199	319	286	505	236	562	156	382	37	129	**3285**
2020	92	68	192	168	230	338	316	559	281	602	197	410	60	173	**3686**
2025	102	73	174	154	281	423	367	599	332	682	253	475	87	214	**4216**

Source: http://www.nepho.org.uk/mho/briefs#b3

There are subsets of the population who are at greater risk of developing dementia - these include people with alcohol dependency issues, Down's Syndrome and some racial groups. Many older people with dementia will also have another long-term condition which will worsen their prognosis. For these people, costs are six times higher than for those with only one condition.

In the general hospital setting, the presence of dementia is an independent predictor of poor outcome in terms of increased mortality and length of stay, loss of independent function and increased likelihood of transfer to long-term placement. It is also associated with increases in hospital acquired complications, increased likelihood of readmission and use of health and social care services. It should also be noted that an acute illness often leads to a cognitive deterioration in a patient with dementia.

Dementia can also be part of a complex set of illnesses, leading to fragmented care across a range of agencies and the needs of the person with dementia being obscured. 29% of people over the age of 85 will have dementia as co-morbidity and a hospital admission is likely to be twice as long as a person with just one condition. A diagnosis of dementia can adversely affect the patient pathway – for example, a diagnosis for a resident in a care home can necessitate a transfer to another home registered for dementia care. This may lead to a diagnosis being resisted by the family and the original care home.

In the community, the presence of dementia in people living alone will significantly increase their risk of entry into long-term residential / nursing care.

1.4 Key drivers for change

1.4.1 National drivers

This strategy is being developed in the context of national legislation and guidance, including the **National Strategy for Dementia,** published in February 2009, which cover the themes of improved

awareness, early diagnosis and intervention and improving the quality of care, especially through better education and training. In addition other key documents include:

- The White Paper, “Our Health, Our Care, Our Say”, which gives a clear direction for planners of NHS services to ensure health services are based in community settings, linked to primary care and with pathways into specialist hospital settings
- National Service Frameworks, particularly those for Older People, Mental Health and Long Term Conditions, which support the development of more accessible, community based services and including A New Ambition for Old Age, The Next Steps in Implementing the National Service Framework for Older People
- Everybody’s Business - integrated mental health services for older adults
- Clinical practice guidelines from the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence
- Extension of the national Dignity in Care campaign to cover mental health services
- ‘Progress with Dementia’ – a paper published in August 07 by the National Council for Palliative Care which highlighted the lack of coordinated services for meeting both the physical and mental health needs of the patient as they enter the end of life phase of their illness

1.4.2 Meeting national targets and standards

An integral part of this strategy is aimed at improving the overall performance of health and social care services by:

- Improving the mental health and quality of life for service users and their carers.
- Improving the effectiveness and efficiency of health and social care services, enabling resources to be freed up for reinvestment.
- Delivering on national priorities to:
    - Reduce the number of avoidable hospital admissions
    - Enable safe and timely discharge from hospital
    - Increase the number of people supported in their own homes for longer
    - Increase the number of people entering sheltered accommodation, as an alternative to residential and nursing home placements
    - Increase the range and availability of services closer to people’s own homes
    - Provide integrated services

    - Themes of recent policy include:
    - Promoting social inclusion and well-being
    - Embedding service user and carer involvement into the planning and delivery of services
    - Empowering citizens to have greater influence over services through a stronger “voice” and greater choice and control
    - Developing community resources
    - Responding to people on the basis of need, not age
    - Delivering holistic, person-centred health and social care services
    - Opportunities for joint commissioning across local authorities, NHS and other agencies, including the voluntary sector and independent providers of services
    - Enabling cooperation across statutory agencies, improving coordination and communication at all levels.

1.4.3 Local drivers

As part of the national review led by Lord Darzi, a Draft Strategic Framework for Improving Health in the South West 2008/09 has been developed by the Southwest SHA. This sets out a vision and ambition for transforming health locally over the next few years and includes local targets for NHS Plymouth, namely:

- Improving access for service users – 8 weeks by March 2009 and 4 weeks by March 2011
- Improving access for carers – carer's assessment and care plan completed within 4 weeks of the newly referred service user assessment by March 2010
- All diagnosed people with dementia to have a care plan within 4 weeks of diagnosis by March 2010

In addition, there is clear guidance on caring for people with long term conditions which includes the provision of care alternatives closer to home and reducing the length of stay in hospital, both of which are very relevant for people with dementia.

Plymouth has a corporate strategy around supporting people over 50 to remain independent and active citizens. "All Our Futures "prioritises key areas identified by older people themselves.

Other local drivers for change include:

- The opportunity to become a regional or national leader in dementia care service provision
- Increasing financial pressures
- Expected increase in demand for services
- Remodelling of Older Peoples' Mental Health Services is currently in progress, providing an opportunity to develop new and innovative pathways of care for dementia patients
- The need to accelerate joint working between Health and Social Care agencies in order to improve communication between services and thus provide better co-ordination of care.
- Addressing the gaps in service provision and areas of concern identified in the baseline assessment and service mapping exercise

1.4.4 Achieving value for money

The priority for NHS Plymouth and Adult Social Care is to be in a position to respond to demographic pressures. It will be a major financial challenge to meet the significant increase in demand outlined above and both organisations recognize that there will be a significant financial burden in the future if they do nothing to address these issues now.

1.4.5 Mental Capacity Act 2005

This Act, fully implemented from Oct 2007, provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions.
Guiding principles include:

- A presumption of capacity – unless it is evidenced otherwise
- Individuals being supported to make their own decisions
- Unwise decisions – does not mean an individual is lacking capacity to make that decision
- Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests
- Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

1.4.6 Other key drivers for change

Promoting independence and choice – Putting People First – Transformation of Adult Social Care

Increasingly, service users expect to have their needs met in a person centred way, retaining autonomy and independence and choosing how services will be provided to meet their needs. For many, the decision to move into residential or nursing care is one of last resort. Despite becoming increasingly frail, many fiercely hold on to their independence. Different responses will be required in the future and services need to change to reflect this. There is a need:

- To give people more control over their own care and support arrangements
- To provide services that respect dignity and privacy
- To provide services which are convenient and closer to home, wherever possible, enabling people to remain in their own home
- To provide services that help people maintain the links and activities that both structure their day and lead to continued independence and social well-being
- Ensure the workforce in mainstream services for older people is well-trained and has the flexibility to provide understanding, support and effective signposting for people experiencing dementia problems
- For a wider range of providers and provision that is more innovative, offering services better tailored to people's need
- To focus, wherever possible, on enabling people to do things for themselves
- To enable commissioning of services not only at local authority and health level, but also at individual (direct payments, individual budgets) and general practice level
- For people who do move into a care home setting ensure that they are able to make supported decisions wherever possible and choices about everyday activities

Carers

Carers play a vital role in providing largely unpaid care for a spouse, relative, partner or friend who, due to their illness, cannot manage without help. Many carers need help and support to continue in this role, especially as many will be old themselves.

The demands of caring can have a negative impact on the carer – emotionally, physically and financially. All carers have the right to an assessment of their own needs and all agencies supporting the patient should play a key role in supporting the carer, perhaps through health promotional activities, support groups and a range of respite care. It is estimated that there are approximately 6000 carers in Plymouth.

Plymouth's Carers Strategy will be reviewed in 2008/09 and will reflect priorities identified in this strategy.

Promotion of health and well-being

Currently, statutory services focus heavily on illness services and crisis management. Plymouth's Health, Social Care and Well Being Strategy 2008-2020 identifies priorities areas for action to manage the challenge of an ageing population and increasing numbers of people living with dementia. If we are to improve the effectiveness of provision and tackle the predicted increase in demand, it is essential to focus on promotion of health, well-being and independence and the development of preventative and early intervention services. Running in parallel to this should be a supportive framework for carers.

The five themes highlighted in The Mental Health Foundation Inquiry into Mental Health and Well-being in Later Life refer to older people across the board but are worth mentioning at this point because they seem to have a particular relevance for people with dementia:

- Public attitudes
- Staying active
- Social networks
- Standards of living
- Physical health

Certain transition points may challenge older people's resilience and coping mechanisms, for example, retirement, moving home and going into hospital, and life events involving change and loss, such as bereavement and illness. The cumulative effects of day-to-day problems can also challenge the mental health of older people. Low-level preventative services, such as housing and tenancy support, help with housework, gardening, laundry, befriending and home maintenance and repairs, can help improve people's quality of life and maintain their independence.

Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Older people may suffer from isolation from a variety of causes such as bereavement, dispersed family, lack of occupation, insufficient financial resources, poor transport services and the impact of poor health. A recent 'quality of life' survey identified that 22% of older people thought their quality of life was neither good nor poor and a further 26% thought it was poor or very poor.

Other groups at risk of dementia

There is an increased risk of dementia in people with Down's Syndrome from the age of 40, for whom there is a genetic risk of early onset. Some 50% of those aged 50 and above will have Alzheimer's.

Comment [j3]: Need to add info here: about the numbers and the services in place via the LDP.

People who have spent years misusing drugs and/or alcohol are also at higher risk of developing dementia and OPMH services will be ensuring that local substance misuse services are part of the 'network of care' receiving specialist support when needed.

It is widely reported that black and ethnic minority communities experience social exclusion and often fail to seek out or access local services.

Barriers include language, culture, knowledge of what services are available, and the attitudes and practices of some service providers. Ensuring services become more visible – for example, the development of the open access one-stop shop in a central location within the city - will encourage individuals to seek help and information.

As OPMH services are redesigned, specialist staff will be working differently, providing opportunities to develop new skills and pursue areas of interest. It is the intention to gain a detailed understanding of the local population, its demographic demand needs and priorities, and to provide a service that is sensitive to this and issues relating to diversity.

2.Current Position

2.1 Current services – what you have told us

The Plymouth Joint Strategic Needs Analysis on the local needs of older people was reviewed and supplemented with feedback from the older people's reference group made up of representatives from organisations working with older people as well as older people themselves a process which identified the following desires from service users:

- Better awareness of services available
- Improved transport especially in outlying areas
- More community 'energisers' or volunteers encouraging social inclusion
- Services closer to home
- Opportunities to engage in volunteering, leisure activities, access to computers

More explicitly, from the work we have done in mapping health and social care provision and in listening to what staff, patients and their carers say, we know that:

- Access to some services is based on age not need.
- Access to adaptations and equipment is slow.
- Many are confused about benefits and only realise they can claim after talking to someone else.
- A high quality service is provided for those individuals referred into specialist services but increasing demand will limit their ability to respond in a timely and appropriate way.
- Information is patchy, often difficult to understand and uncoordinated with inconsistent advice.
- There is limited follow up support or counselling post diagnosis.
- Accessing meaningful and stimulating things to do is difficult with an overdependence on traditional services such as day care and domiciliary care.
- Access to flexible services to support carers is limited particularly for people with more challenging needs.
- Carer's services, information and advice is not promoted as routine practice across health teams.
- Knowledge and skills about the needs of older people with dementia amongst mainstream non-specialist mental health staff is poor. There is an increase in the volume of older people being admitted to hospital and half of these have some degree of cognitive impairment. These problems are difficult to manage alongside the acute physical illness. Generic ward staff would welcome more support for the clinical teams from the Psychiatric Liaison Service.
- Carers would welcome more face to contact with the specialist dementia liaison staff in hospital – many express concerns about the level of care or support available on the wards, especially at mealtimes.
- Although the Psychiatric Liaison Team has been extended, it would benefit from additional multi-professional input and Consultant Psychiatrist time.
- There is a lack of support in understanding and coping with patients with challenging behaviours.
- Decisions on long-term care placement are being made too early in the discharge process from hospital. This is borne out by the higher than average number of residential care home places in Plymouth.
- There is a higher use of specialist inpatient beds due to lack of intensive support at home, especially at times of crisis.
- Mainstream community services cannot always meet the needs of a person with dementia.

- General lack of education and training across all agencies.
- Organisational boundaries can limit the ability to work together.
- Poor coordination of care for patients approaching the end of their life.
- More specialist in-reach / outreach services required to support mainstream services with education training and advice e.g. stronger links to community district nursing teams, reablement services and care home settings.
- The current Memory Assessment service for older people operates out of the Heathleigh Unit, Mount Gould Hospital. Its hours of operation are from 9.00am – 5.00pm Mon – Fri. It is supported by a small team of Clinical Psychologists with some clerical support. Most of the referrals into the service are from GPs. Currently there is no self referral policy.

2.2 The benefits of changing how services are delivered

By developing and implementing this strategy, we believe we can start to fill the gaps outlined above, bring services closer to the patient, improve the quality and coordination of care delivered, thus enhancing the quality of life for both the person with dementia and their carer.

Integrated services provided by health and adult social care will be able to offer choice, control and independence and respond to people's needs rather than people fitting into services.

In addition, a national and local shortage of specialist staff means that we have to be more innovative with our thinking – more emphasis on outreach services, creating learning environments where mainstream staff can develop their skills and learn new ones. Long term dependency on specialist staff to deliver services is not sustainable and new partnerships with the Community and Voluntary Sector is essential.

Improved integrated service provision in the community will support Plymouth City Council's plans to reduce the number of people in care home placements in the city although it is recognized that a number of high quality dementia care home placements will still be needed.

Finally, the increasingly difficult financial climate is likely to impact on older people and their ability to eat well, keep themselves warm and maintain social contact outside of the home. There will be a responsibility on all services working with older people to identify problems early and respond accordingly.

3.Our vision for future services

3.1 Strategic Priority One – Increasing and Improving Awareness

3.1.1 Increasing public and professional awareness of dementia by:

- Removing stigma
- Reducing discrimination
- Understanding the benefits of early diagnosis
- Carers and the cared for person getting more help and guidance to understand every stage of the care system and find their way through the "care pathway"

Priority - To develop and implement an action plan to raise public awareness of dementia and to dispel some of the myths associated with it

Good quality information should cover:

- A range of health promotion and leisure activities
- Low level support services such as housework, gardening, home maintenance and repair, transport
- Telecare and other assistive technology or aids/adaptations that might assist in maintaining independence and well-being.
- Financial advice available on pension planning, benefits and other financial issues.
- Advice available on alternative accommodation options, for example, sheltered housing and extra care housing
- Information in different formats, languages and appropriate locations, about all the above.

3.1.2 Developing an informed and effective workforce by:

A joint Health and Adult Social Care workforce development strategy which prioritises:

- Good basic training to all staff including independent sector commissioned services
- Ongoing professional and vocational development to aid recruitment and retention

Increased awareness and knowledge about dementia in the community and amongst professionals is a key part of the dementia strategy. Teaching, support and education need to be viewed as core business and valued as such. Currently, this is delivered on an ad hoc basis.
Workforce development programmes will be co-coordinated through a joint workforce development plan and commissioned across community settings including access to the independent sector where training needs have been identified. Incorporated in this should be a competency framework that enables individuals to gain a broader understanding of dementia and the quality of care to be delivered.

Included in the training programme will be the following elements:

- Health promotion – the importance of staying fit and healthy and maintaining social contacts
- Stigma and discrimination around old age and dementia
- Types of dementia and cause – signs, symptoms, early diagnosis
- Co-morbidity of physical ill health and other mental health conditions i.e. depression/anxiety
- Communication – time, space, language, body language, blockages
- Challenging behaviours – recognizing cause, charting, coping strategies

- Risk – wandering, getting lost, driving, suicide, self harm, neglect
- Person-centred care
- Carers' needs – managing stress, information, services
- Issues of consent and capacity
- Continuing Care
- End of Life Care
- Staff values and attitudes

Priority - To develop and implement a Workforce Development Strategy and a training programme tailored to meet the needs of all individuals working with people with, or at risk of developing, dementia

Primary Care – All practice staff will be offered education that will help them to recognise and deal with patients with suspected dementia e.g. those presenting with depression / anxiety / memory problems. In addition, there will be training for GPs, delivered through formal education sessions and, where appropriate, through conversation and reflective practice on individual cases with a link CPN.

GPs would be encouraged to access telephone advice available from the Older Peoples Mental Health Consultant team.

Ward staff in acute hospitals – care of patients with dementia on acute general hospital wards poses a huge problem for ward staff, either due to lack of knowledge around meeting their mental health needs but also lack of time to provide that added support that is often required.

An education programme, similar to that proposed for primary care, will significantly improve the level of knowledge and skills amongst clinicians and generic ward staff.

Dignity in Care Home Settings – this has been highlighted as a priority for improvement by both carers and specialist mental health staff.

It is vital that staff receive training in all aspects of care, not only in identifying people with dementia but in the ongoing management of their care, many of whom have complex needs.

We will support care homes to ensure that training and support is available for care home staff, enabling them to undertake holistic assessments of new residents to identify their likes, dislikes, hobbies and what they can and cannot do.

A Care Home Forum will be established to enable care staff to share good practice and promote the principles of dignity in care settings. It will also provide them with the opportunity to discuss and resolve issues.
There will be a link district nurse and an older person's CPN for each non-nursing care home to offer generalist and specialist advice and guidance when required. In nursing homes, patients with dementia will be allocated a Care Advisor (specialist CPN) to support staff and offer advice.

Priority - To develop Dignity in Care Strategy in partnership with Health, Adult Social Care and the Care Home Sector in Plymouth which will include a Plymouth Care Home

Forum for practitioners to share good practice.

Care closer to home – domiciliary care – it is generally social care staff that have the closest and most regular contact with older people at home. They are more likely to identify a change in behaviour, memory loss or a general deterioration in health. Early recognition of a problem and early intervention will slow down the progression of the disease.
Training sessions alone will not equip staff with all the skills they require, especially for the management of people with difficult and challenging behaviours. Whilst there are significant funding implications for rolling out a training programme, it would be short-sighted to ignore its potential for improving identification of patients with dementia, improving their day to day functioning and, in many cases, reducing hospital admissions and subsequent long term placements.

Priority - To jointly commission good quality domiciliary care provision which will promote choice and control for older people.

3.2 Strategic Priority Two – Early Diagnosis and Intervention

The key priorities in mainstream services are to change attitudes and improve skills in detection and assessment of dementia and to equip staff with guidance on initial management and referral pathways to appropriate services. The 'pre-primary care' service of dementia advisors actively seeking out older people who are showing signs of early stage dementia and signposting them to low level support services will prevent early progression of the disease.

There are messages from consultation that tell us it is sometimes difficult to get a prompt assessment when they have particular symptoms or they are not always referred to the right services in the first instance and that once a diagnosis had been given, there is a need for prompt and timely access to information, advice and sometimes counselling. Carer's consultation has highlighted the need for consistency with the same person to remain in contact with them and to help them to navigate through the system. There should be a clear pathway so that all people diagnosed with dementia will have a care plan and equal opportunity to access appropriate services.

Within Older Peoples' Mental Health Services, care pathways are currently being developed for the care and management of older people with dementia and this will set out expectations for what mainstream services should do in terms of assessment and initial management. There will be less emphasis on referral to specialist services but more collaborative working across all agencies, creating a seamless pathway where patients and carers are able to access the appropriate care at the appropriate time.

3.2.1 Assessment

In the remodelled Community Memory Service –Plus, there will be an 'open door' referral policy, encouraging referrals from all agencies plus self and family referrals. An initial assessment form *'Is your memory a 'real' problem'* will be available to a broad spectrum of community and hospital staff, which could either:

a) act as a guide in assessing the patients' level of memory impairment
b) form the basis of a referral or

c) be offered to families or carers to complete where concerns about memory are being expressed Referrals for assessment will generally be made direct to the Community Memory Service (with a copy to the GP) although some patients may prefer to discuss initially with their GP.

People will receive a robust assessment in their own home or place of choice which will include a range of nursing assessments, risk assessment, daily living functioning and mood. Where appropriate, people will have a brain scan to confirm diagnosis. Feedback of results will be made to the referrer by formal report and a management plan with a copy to the individual if requested. The intention is to 'normalise' the assessment and care process so that the focus is on optimum functioning rather than 'diagnosis' and 'treatment'.

Those people with depression as part of their presentation will receive treatment for their depression through the functional pathway but will be offered reassessment when the depression has been felt to be fully treated.
Patients will be offered a Consultant appointment for clarification of diagnosis and for their prescribing needs where appropriate.

3.2.2 People with learning disabilities and dementia

Numbers expected
Improvements in life expectancy mean that the proportion of people with learning disabilities (LD) over 65 years of age will have doubled by 2020 (Janicki & Dalton, 2000) and that over a third of all people with LD will be over 50 years of age by that time (McConkey *et al,* 2006). Down's syndrome is the most frequent known cause of mild and severe intellectual disability (Minns, 1997) and may account for 15-20% of the LD population (Pulsifier, 1996). Overall, neither the expected nor observed birth prevalence of Down's syndrome in England and Wales is declining (Huang *et al,* 1998).

Local data
There are some 1,700 adults with learning disabilities in the Plymouth PCT area. The Plymouth Learning Disability Partnership (LDP) holds a separate register of all adults with Down's Syndrome (162). All 162 people have received a baseline cognitive assessment at least once, 27 of whom have since received a diagnosis of dementia and 15 of whom have since died. People with DS entering adulthood are added to the register. Of the non–Down's syndrome group there are eight with a diagnosis of dementia and four under investigation.

85% of those with dementia are living in local residential homes for people with LD, compared to 51% of those without dementia. Of those over 40 years, 44% of those with a diagnosis of dementia have had to move home, compared to only 15% of those without dementia. This places pressure on local residential homes and care managers.

Assessment and diagnosis
Due to the risk of early onset dementia in the Down's Syndrome population and the difficulties of arriving at a diagnosis, prospective screening is advantageous as it provides baseline information to compare with future performance. The Plymouth LDP is one of the only services in the UK providing such prospective screening. A register of adults with DS is kept. All are offered a baseline screen in their 20s. Routine screening then takes place bi-annually for those in their 40s and annually for those over 50. The service is run by the Clinical Psychologists in the LDP with the help of unpaid full time undergraduate psychology students. The service is described in McBrien et al (2005).

There is an open referral system in the LDP **and a dementia care pathway for adults with LD has been in use for some six years. A checklist for use by carers and support staff has been developed and researched and is used to alert carers when to refer for a dementia assessment. Use is recommended at the GP annual health check and by social care staff at annual reviews.** All assessments are conducted in people's homes. Anyone suspected of showing early signs of dementia can be referred and receive a comprehensive assessment guided by the Care Pathway. A specialist health screen is conducted by a community nurse, followed by any relevant blood tests to rule out other disorders; then psychological assessment is carried out, followed by any neuro-imaging deemed necessary. The differential diagnosis is made by a psychiatrist in LD. Those receiving a diagnosis of dementia are then treated by the wider multi-disciplinary team. Care packages are adjusted by the social care side of the Partnership.

The LD dementia service is co-ordinated through the Dementia Health Care Programme sub-group. A multi-disciplinary meeting is held on a monthly basis and serves to monitor the individual assessment and treatment of people under investigation, or with a diagnosis of dementia. The meeting also serves to offer CPD for all LD staff. Annual targets are set and progress reported to the Learning Disability Health Programme lead.

Training

One day dementia awareness training is offered to all care providers in the City three times a year. Individualised training is offered to care home staff that has a client who is suspected/is diagnosed with dementia. There are plans to convert our training programmes into an e-learning package.

Research

There are a number of projects completed and underway by the LD dementia service. Research is also underway in conjunction with the University of Plymouth and with the Developmental Disability Research and Education Group (DDREG). The Plymouth work has been reported at local, national and international conferences and in a number of journal articles (McBrien, 2004; McBrien et al 2005; Brown and McBrien, 2008; McBrien, 2009; Whitwham et al, in press; Major and McBrien, in press).

3.2.3 Services for all adults with dementia

The city wide Community Memory Service will remain a service targeted for those people presenting with memory difficulties of no known cause. Those people with neurological or difficulties relating to substance misuse can access the service if it can be demonstrated that assessment will provide a significant help in the care and management of the individual and access the dementia pathway as appropriate.

3.2.4 Keeping people with early stage dementia supported at home

There are a number of low level services that can support patients at home during the early stages of dementia. During our discussions with patients and carers, it was apparent that many were not aware of their existence. There will be a determination to raise their profiles and simplify access to them through improved advice and information on diagnosis and improved links to the community and voluntary sector.

Care and Repair enable those in need of support to maintain their independence in their own home by arranging and assisting with repairs, adaptations and renovations. The services include the following tasks:

General Advice and Information

Casework Services
Repairs Maintenance and Improvements
Major Adaptations
Handypersons Services
Gardening service
Hospital Discharge service

Raising awareness in local communities and developing criteria for access will be an important next step for this service. To minimize anxiety and concerns about workmanship and trust, an accredited suppliers' list is being creating and the possibility of providing badges to accredited sole suppliers is being considered.

Assistive Technology and Telecare
Occupational therapists and social care staff are able to access the following assistive devices to help older people maintain their independence in their own home:
Alarm pendants
Bogus call alert
Carbon monoxide detector
Temperature extreme detector
Smoke detector
Bed occupancy

The equipment is linked to a call centre which will either notify the family if there is a problem or support from the South west Ambulance Service is sent to the home.
Needs are assessed in bands of 'risk to independence'. Presently, only clients at critical or substantial risk can access the scheme and if people live alone there is no physical response. Commissioners will need to look at how this service can be utilized to prevent escalation into more complex care arrangements and develop joined up assistive technology and care partnerships.

Priority - To develop or adopt a locally validated dementia toolkit for use in primary care for people with early signs of dementia.

Befriending and Keeping Active
The Community and Voluntary Sector organizations in Plymouth play a key role in helping older people to maintain social networks and to remain independent for a longer period of time. They will also monitor service users' needs and flag potential problems as they arise. The services they offer include:

- Assistance with bills and accessing benefits
- Assistance with daily living tasks and shopping
- Encouraging social integration with community groups
- Escort to appointments
- Promoting social, emotional, spiritual and intellectual well being.
- Enabling service users to pursue their hobbies and interests
- Support for the carer and low level respite
- Lunch clubs

With the emphasis on Putting People First priorities and promoting independence and choice, commissioners will need to consider additional investment in services such as these and the added value they bring to older peoples' lives.

Priority - Work in partnership with the Community and Voluntary Sector to increase low level preventative befriending services available for older people with dementia and their carers.

Tai Chi at Plymouth Age Concern

Home Care

Domiciliary care is defined to be the provision of personal care and practical support in a service user's own home. It includes the provision of social and emotional support where appropriate; assistance with learning or re-learning of skills and some practical help e.g. cleaning. It will include nursing care that could be given by family carers under the supervision of the primary health care team but excludes nursing care of a type requiring a qualified nurse. Sitting and/or sleeping services might also be provided.

The aim is to increase the number of people being able to remain in their own homes and for longer, to reduce the number of emergency admissions to hospital and to provide care and support on discharge from hospital.

Commissioners will need to find ways of:

- Attracting more staff into domiciliary care services,
- Increasing the number of hours through social care contracts to meet the growing need
- Improving communication between primary care and social care agencies
- Implementing plans to deliver a rolling programme of education and training for all Domiciliary Care providers

The Role of Housing

It is important to ensure that older people have homes that can adapt to future changing need. Good housing is important to health and well-being. Older people are at greater risk of depression if isolated and suffering from chronic illness. Planning of housing for older people with mental health needs and their carers is therefore critical.

Older People may need to:

- Maintain their existing accommodation or move out of homelessness
- Avoid social exclusion
- Access housing, care and support services that maximize independence whether the housing is provided by the state or through self funding
- Move as soon as they can to a suitable home

Planning policy has been influenced by a requirement to build new houses to lifetime homes standards.

Joint planning at a strategic level has progressed the development of Extra Care Housing across the city. Plymouth has one of the only Extra Care Housing schemes in the South West - St Barnabas Court - specifically designed for people with dementia, developed in partnership with Sarsen Housing Association, the Local Authority, Mental Health Services and Dementia Voice.

Care and support services are combined to enable tenants to sustain independence and maintain access to, and involvement in, their local community.

The unit has assisted technology, evaluation is ongoing and will influence future commissioning.

There are allocation policies, which are in place to prioritise the needs of this client group and their carers and a multi disciplinary assessment to identify the needs in relation to the whole person including understanding their life history.

Priority – By 2011 increase the number of extra care tenancies in Plymouth .
To review the role of sheltered housing officers (wardens) so that if required they can be flexible and provide out reach to the local community and provide preventative extended housing support services.

Cookery lessons in Extra Care Housing

3.3 Strategic Priority Three – Support for Service Users and Carers

3.3.1 Good quality information

Local specialist services are currently reviewing the information currently available to patients and carers about dementia. Good information should be particularly prominent in GP surgeries, the local acute hospital and the Local Care Centre. Social Care staff should be able to provide information leaflets for families and carers where they have expressed concerns or suspicions of dementia in their loved ones.

Priority - To update the Older Peoples' Mental Health Service Directory and circulate across all Health, Adult Social Care and Community and Voluntary Sector agencies

The new One-stop Shop will play an important role as a highly visible access point for older peoples' services, providing good quality information about dementia, the range of services available to support patients and their families or carers and both generalist and specialist advice. Each service providing care to people with dementia will need, as a minimum requirement, to develop a leaflet describing their service and the criteria for access.

3.3.2 Practical Advice and Support to Carers

All patients given a diagnosis of dementia at outpatient clinic will be invited, with their carer or family, to a follow up session in 3-4 weeks where they will be offered information and advice and an opportunity to access counselling and a memory strategy group – these are groups for carers and families, providing advice on diet, exercise and coping strategies.

Currently, access to advice and support is patchy. There are a number of excellent carer support groups across the city but they are not co-ordinated.

Priority - To review the carer's strategy and ensure that advice and support is joined up across the city and increase the numbers of carers accessing flexible and responsive care and support

3.3.3 The One-stop Shop and Starting Point Services

Consultation has identified a need to commission a visible presence in the city for older people and carers needing to access services. A One-stop shop will be a facility commissioned in partnership with the Community and Voluntary Sector with linked social care and health staff It will be a generic service for all older people wishing to seek information (about older peoples' services), advice and support plus specific referral for assessment for people with memory problems.

Visitors to the service will be able to:

- Obtain comprehensive information and advice about dementia
- Receive an initial assessment of memory difficulties with referral to the city wide Community Memory Service if appropriate
- Seek expert advice on benefits/financial matters/domiciliary care/direct payments/finding a care home etc
- Be signposted or referred to appropriate services e.g. domiciliary care/day care/day therapy
- Link with patient or carers' groups for support
- Receive a carer's assessment of needs
- Seek low level mental health advice from trained worker with onward referral to specialist services or patient's GP if required.
- Access befriending and advocacy services
- Access to support services.
- Access to education and training through memory strategy groups where carers will be given help with coping strategies and managing challenging behaviours
- Find information about lunch clubs

Priority - To identify and develop further suitable premises close to the city centre that will act as a central information point and gateway to older peoples' services.
To commission a generic and preventative "Starting Point" service for older people through the Community and Voluntary Sector.

Silver Surfers at the East End Resource Centre

3.4 Strategic Priority Four – Improving Quality of Care

If we are to improve the quality of care delivered to people with dementia, we need to be able to identify the different stages in the patient's illness, when re-assessment is appropriate and when palliative care services should be introduced.

3.4.1 Primary and Community Care

In recent years, there has been a significant improvement in the care management of people with long term conditions in the community. We have seen the introduction of community matrons and other specialist nurses who spend an increasing amount of their time seeing patients in their own homes rather than in hospital settings. Many of these patients will also have varying degrees of dementia, some of which will be undiagnosed, so we need to ensure that our plans for rolling out an education and training programme extend beyond the GP surgery to include all community staff. Dementia is a long term condition so patients should experience the same level of care management as those with other conditions.

Historically, there has been reluctance in primary care to make a diagnosis of dementia but this is now changing, especially as practices are now required to record the patient on their dementia register. Furthermore, there will be opportunities for better management of patients' physical care needs as more GPs become involved in their dementia care through shared care arrangements for their prescribing needs.
GPs will need to review patients' physical health on a regular basis.

There has also been a lack of capacity in primary care to provide follow up information and support. It will be important therefore that GPs and other community staff are aware of resources available so that patients and their carers are signposted appropriately.

As the current function of the Community Mental Health Team ceases and staff move into a fully integrated team under the umbrella of the Community Memory Service, we shall be allocating specialist nurses as a link to each of our primary and community care teams. The level of input from this specialist worker will vary from providing an education/advice type role to a rapid response/urgent assessment role for patients in crisis or at risk of admission.

3.4.2 General Hospitals

In our discussions with carers, there were major concerns expressed about the care provided to patients in hospital. They felt that many ward staff were lacking in awareness of the needs of people with dementia and were unable, for whatever reason, to give that extra care that is often needed. Carers were often called upon to bridge the gap between the care the ward staff were able to provide and what the patient needed to maintain stability and keep anxiety and confusion to a minimum.

Once people's physical needs are met in an acute hospital, they may still experience poor care co-ordination and access to dementia services, leading to prolonged lengths of stay. Some people receive a diagnosis of dementia by default so may not be introduced to support services at all. There are concerns that some are excluded from services such as intermediate care and that 24 hour services would enable people with dementia to be discharged more promptly or indeed negate the need for admission in the first place.

The role of the Psychiatric Liaison Service, based within the hospital, is to:

Comment [j4]: What about the LD liaison nurse service?

- Raise awareness of the needs of older people with mental health problems in the hospital setting (ward staff and A&E)
- Educate ward staff in the acquisition of basic skills in mental health assessment, care and treatment
- Assist with the management of complex and possibly severe cases, particularly focusing on assessment and discharge planning

The service is currently staffed by three mental health nurses covering 7 days a week 8.30am – 4.30pm and is supported by a Staff Grade Psychiatrist for 2 sessions per week and a Consultant who will visit on request. We would like to see the service benefit from additional multi-professional input and Consultant Psychiatrist time to support staff to manage these patients more effectively. As more patients are assessed and diagnosed with dementia, those admitted to hospital with an acute illness will have a copy of their dementia care plan forwarded to the ward to ensure that their care is not compromised during their hospital stay.

The Liaison service accepts approximately 750 referrals a year, from all agencies, but their ability to provide a comprehensive service at all levels is limited however it is the intension to develop this service as a priority.

Priority -To expand the Psychiatric Liaison Service so that more support can be offered to ward staff in the management of patients with difficult behaviours and to allow more face to face contact with patients and families.

3.5 Strategic Priority Five – Improving the Dementia Pathway

Comment [j5]: How do we reconcile the LD dementia service in this section? The service is already in place and working well. This text in this section does not apply to LD population/carers.

3.5.1 What should specialist services do differently?

Local specialist Older Peoples Mental Health services have been working with Adult Social Care staff and Community and Voluntary sector agencies to develop a care pathway for people with dementia.

This pathway aims to match the needs of people with dementia and their carers to appropriate services and support. Each phase represents different levels of support, with an assumption that

people with higher phase needs may also require interventions described for preceding phases. Within phases there are choices for people about the type of care that suits them best, the setting of that care and who provides the care.

Even though each individual's experience of dementia will be different, it is a progressive disease and it is likely that, over time, the level of support a person needs will increase. This does not mean, however, that those who support people with dementia need increasingly high levels of specialist skill and knowledge as the disease progresses.

There are certain points along the dementia pathway when more highly skilled assistance may become necessary but these points may happen at different stages in the journey for different people and are not necessarily inevitable for all.

Priority - Specialist staff will support the proposed integrated community teams across the city and will also provide a rapid response service for those patients in crisis or at risk of admission.

All those who provide care and support for people with dementia need a sound level of skills and knowledge related to communication, understanding needs and providing care appropriately. Specialist older people's mental health services need to be well integrated with more generic services used by older people to support mainstream delivery of care. It is at times of critical need when the most highly skilled assistance may be required.

The steps in the model are:

Phase 1: Assessment and Early intervention
Phase 2: Enhanced Care and Support
Phase 3: End of Life Care

There is potential for crisis situations to develop at any point along the pathway. Consideration of potential crises and levels of risk should form part of all assessment and care planning activities, and contingency plans should always be developed to identify what interventions and/or support may be required under which foreseeable circumstances. There is always the potential for unforeseen crises but good contingency planning should provide clues for response.

3.6 Enhancing – The Community Memory Service

3.6.1 The Enhanced City Wide Community Memory Service

The Community Memory Service is an important and fundamental part of Plymouth's Integrated Mental Health Service the integrated service will be delivered in partnership with Plymouth City Council, consisting of both Health and Social Care Staff working in joined up integrated teams.

The strategy proposes that the Community Memory service will be expanded so that referrals will be accepted directly from individuals, carers and other professionals. The service will be resourced to deliver the increased referrals.

Described below is the revised patient pathway for people with dementia. Their care as they move along the pathway will be provided by a number of different professionals and community support staff all working within the Community Memory Service – these include:

Community Psychiatric Nurses (CPNs)
Social Workers
Psychiatrists
Occupational Therapists
Clinical Psychologists
Physiotherapists
Community Support Workers
Community Care workers
Carer Support Workers
Specialist Domiciliary Care Support
Representatives from Community and Voluntary Sector agencies including the Alzheimer's Society and Age Concern

Patients moving along this pathway will benefit from better co-ordination of care through an integrated assessment process involving Health and Adult Social Care staff that extends to the Specialist Domiciliary Care Service and ward staff from the inpatient unit. Staff will meet as an integrated team on a weekly basis, not only to discuss assessments of new patients but to plan effective discharge from hospital, the Local Care Centre etc.

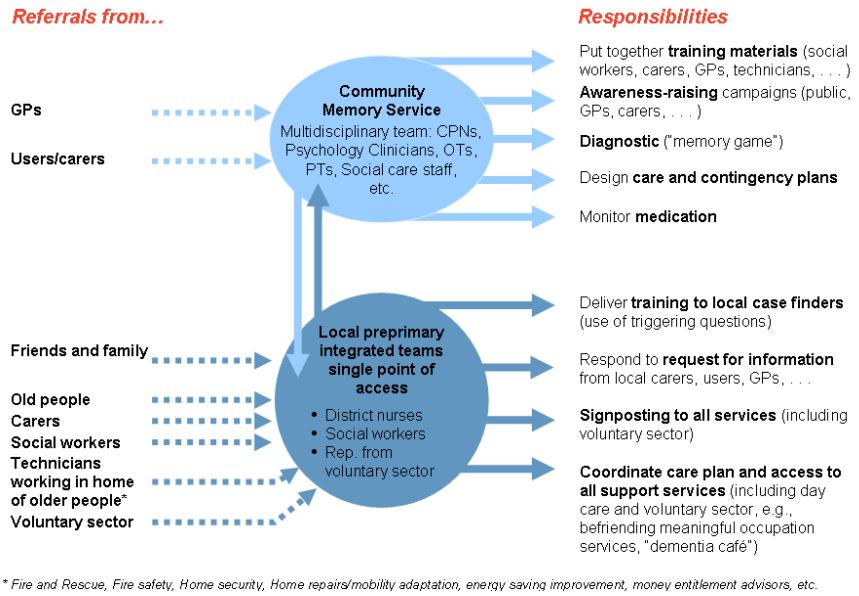
3.6.2 Phase 1: Early Intervention and Assessment

People regularly experiencing difficulties with recalling events, mislaying and losing things, learning and retaining new information. Staff in all settings need to recognise signs of mental health problems and encourage and signpost people to seek help

When family or friends, or indeed the individuals themselves, identify a problem with memory or day to day functioning, they are likely, in the first instance, to make an appointment to see their GP. For individuals living alone, a referral for assessment could be made by any agency – for example, district nurse, domiciliary care worker, care home etc.

Pre- Primary Support and Early Intervention

There are, however, many older people who live alone who would not actively seek help. The needs analysis shows that in Plymouth there are under 1000 people with a formal diagnosis of dementia. Our vision for the future is to commission pre-primary outreach workers, or Dementia Advisors, based in integrated teams across the city who would work closely with small communities, local shops etc to identify frail and vulnerable older people who may be showing signs of confusion, memory problems or depression and who might benefit from befriending services or other low level support. There will be an invitation to make contact with the outreach worker, who would make links on their behalf to local support services appropriate to the level of need.



* Fire and Rescue, Fire safety, Home security, Home repairs/mobility adaptation, energy saving improvement, money entitlement advisors, etc.

Priority - To pilot a pre- primary dementia advice outreach service in a locality in Plymouth with a view to roll out over the next 1-2 years to all integrated teams.

Referral
At the GP surgery, a basic validated screening tool and health checks will be used to assess whether a referral to the city wide Community Memory Service is required. Where a referral is not deemed necessary, the individual will be offered an information pack providing advice around diet, exercise, socialising, maintenance of hobbies etc. A review of the patient's physical and mental health needs will be planned at six months.

Priority - To develop a locally validated dementia toolkit for use in primary care for people with early signs of dementia.
Commission a Community and Voluntary Sector service to link into the Memory Service and provide support on diagnosis.

Assessment by the city wide Community Memory Service
The assessment by the CMS will be in the patients' home and will include assessment of risk, daily living functioning and mood. Some patients will be referred for a brain scan to assist diagnosis where appropriate.
Following assessment, patients and their carers or families will be given a clinic appointment where they will be given the results of their assessment. At present, the diagnosis is delivered by a doctor but in the future, there will be psychologist or nurse-led clinics and nurse prescribing. This is likely to reduce the waiting time from referral to diagnosis.
Patients who are ill, in crisis or at risk of hospital admission will be supported by an integrated crisis response service which will incorporate mental health specialist staff, district nurses and social care staff and will reduce the likelihood of hospital admission.

In Care Homes - where patients have been referred by care homes the CMS will carry out the assessment on site so that there is the minimum disruption and distress for the patient. Patients placed on medication will continue to be monitored by the CMS and a copy of the care plan around the management of the patient's memory problems and any challenging behaviours will be shared with the care home. All care homes will have a direct link with a specialist nurse from the CMS who will be available for advice and education.

In hospital - a patient in hospital, suspected of having dementia, will be referred to the Psychiatric Liaison Service in the first instance. The service will undertake an initial assessment and offer advice to ward staff where appropriate. On discharge from hospital, the patient will be referred by the liaison service for a full assessment by the CMS.

Diagnosis
Patients diagnosed with dementia (and their carers) will receive support immediately following the diagnosis and will be linked into Community and Voluntary Sector support .They will be asked to return 3-4 weeks after the diagnosis where they will be given information and advice and offered counselling. The time lapse is to allow the patients and their carers or families to come to terms with the diagnosis and to consider what information and support they might need in the coming months.

All diagnosed patients will be allocated a lead professional, who will be responsible for developing and reviewing the patients' care plan in conjunction with the carer / family.

A newly established carers development worker will be located in the Community Memory Service and will be able to provide information and advice and signpost to other services and carer support groups. This worker will undertake carers' assessments to ensure that their needs are also met.

Patients living alone will have a home-based assessment to ensure they are safe and secure and to identify whether any adaptations or devices are needed to support them in that environment.

GPs will be notified of all patients diagnosed with dementia and will enter the patient's name on their dementia register so that their physical health can be reviewed on a regular basis.

Promoting independence and social inclusion is an important feature of this early phase. Community and Voluntary Sector agencies will play an important role in providing social activities and practical help.

As public and professional awareness around dementia improves, we will need to significantly increase low level support services such as these to prevent early escalation of patients into Phase 2 of their illness which is Enhanced Care and Support.

For this purpose, the Authority plans to develop an enhanced day care service commissioned through the Community and Voluntary Sector. Everybody on this phase of the pathway will have a review at least every six months with the opportunity of a face to face discussion if necessary.

3.6.3 Phase 2: Enhanced Care and Support

Experiencing significant difficulties with memory and comprehension and complex operations. Confused and frequently disoriented, possibly with behavioural issues. The individual and/or carer's life is significantly disrupted by their symptoms. Carers need to feel supported and motivated to continue care

At this stage of the patient's illness, the level of support will need to be increased, especially if the person wishes to remain at home. A re-assessment of their needs will be undertaken by the integrated team with regular monthly contact with the aim of minimising risk of emergency admission and ensuring extra support is delivered in a timely way.

Flexible services and support available to meet the needs of the individual will include:

- Access to telecare and assistive devices which will help to limit risks in the home and to maximise independence.
- Advice and support to explore alternative accommodation options
- Access to meaningful things to do during the day to provide flexible breaks for the carer and person centred activity for the individual.
- Specialist and intermediate care services to maximise physical health and functioning and to minimise any disabling effects of cognitive difficulties. Individuals will be able to benefit from outreach specialist physiotherapy with advice to carers on managing mobility problems.
- A programme of flexible breaks (respite) for carers will be commissioned both within the home, away from home and sometimes together as a couple. Commissioners are planning to identify

3-4 care homes across Plymouth as potential 'centres of excellence' for the care of patients with dementia.

- Assistance with understanding behaviour and developing coping strategies through memory strategy groups
- Some assistance with personal care tasks and maintaining continence through the domiciliary care service
- Advice from specialist mental health staff about care planning for the future
- Specialist domiciliary care provided by Plymouth City Council. There are plans to expand this service which currently provides 800 hours of intensive support per week to enable clients to continue living at home. For the future, this team will be providing an intermediate care service, helping to keep individuals out of hospital
- A review of current levels of in specialist beds will be undertaken .This is because some people are admitted in appropriately because of a lack of alternative provision .Commissioners will be leading on this piece of work and will look to secure a range of support as an alternative to in patient "respite"
- Measures to prevent dementia patients with a physical problem from being admitted to hospital will include interventions by the RITA (Rapid Intervention Team) team which will be supported by a Community Psychiatric Nurse as part of the team
- A review of intermediate care will be undertaken.
- At all stages of a patients' dementia, OPMH staff will be mindful of continuing care needs and whether the patient might meet the criteria and, in those circumstances, staff will undertake a continuing care assessment.
- There is a significant number of people admitted to hospital without a diagnosis. These patients can become disoriented and anxious, often causing disruption on the wards. Their care can also be compromised, particularly around eating, drinking and personal care, causing significant concern for their carers.
- The roll out of the education and training programme will mean that patients will have their dementia diagnosed earlier so that the majority of patients will enter hospital with a care plan in place and agreement with the ward staff to keep the inpatient stay to a minimum.

At all points of the patient journey, patients on the dementia pathway, and their carers, can feel reassured that when a physical problem arises, they will continue to be supported by specialist staff from the Community Memory Service.

Priority - Ensure that Intermediate Care is available for people with dementia.

3.6.4 Phase 3: End of Life Care

24 hour supervision needed

In July 2008, the Department of Health released an End of Life Care Strategy, to promote high quality care for all adults. The aim of this strategy is to "bring about a step change in access to high quality care for all people approaching the end of life. This should be irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic status. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money."
The National Council for Palliative Care has suggested the following indicators where referral to specialist palliative care teams may be appropriate:

Unable to dress or walk unaided
Urinary and faecal incontinence
No consistent, meaningful verbal communication

Plus at least one of the following:

Difficulty in swallowing / eating
Weight loss >10% loss over 6mths
Recurrent urinary and / or respiratory infections
Multiple stage 3 or 4 decubitus ulcers
Symptoms causing distress

Links between specialist dementia services and palliative care teams should be formalised for delivery of high quality care.
As with the dementia strategy, this also promotes a pathway approach to care, with recommended key elements:

- Identification of people approaching the end of life and initiating discussions about preferences for end of life care;
- Care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;
- Coordination of care;
- Delivery of high quality services in all locations;
- Management of the last days of life;
- Care after death; and
- Support for carers, both during a person's illness and after their death.

A local End of Life Care strategy is being developed, looking at the needs of the people of Plymouth but also the care coordination model will help with access to **high quality care** - in a timely fashion.