



North Yorkshire and York Dementia Strategy

2011 - 2013

Judith Knapton
(Head of Commissioning Adult and Community Services)
NHS North Yorkshire and York Cluster

Pete Dwyer
Director
City of York Council

Seamus Breen
(Assistant Director Health, Reform and Development)
North Yorkshire County Council

Forward

Dementia affects more and more people each year. Many of us already know the impact that dementia can have on the individual and their families. In North Yorkshire and York we have an above average older population and face the demographic challenges of an aging population and with that an increase in the number of people with dementia.

In order to respond to this challenge it is imperative that health and social care, in partnership with other services have a clear strategy to support people with dementia and their carers, now and in the future.

Staff working in statutory, voluntary and independent sector services and people with dementia and their carers were asked for their views on the current services. They told us of the need to improve the early assessment and diagnosis of those with dementia, better support for those with dementia when they have to go in to General Hospitals and better support for their carers. This strategy acknowledges those views and describes our joint approach to improve services and ensure more personalised services and support to help people 'live well' with their dementia.

The publication of the NHS White Paper in July 2010 and the Comprehensive Spending Review means a radical change in health and social care services. This strategy sets out a clear vision underpinned by a commitment to its implementation as these changes take place and beyond.

We would like to thank all those individuals, groups and organisations who have given their views and helped to shape this strategy. By working together on its implementation it will drive forward the changes needed to improve the care and quality of life of people with dementia, their families and carers.

Jayne Brown
Chief Executive NHS North Yorkshire and York
August 2011

Working in partnership:

Pete Dwyer
Director
City of York Council

Seamus Breen
(Assistant Director Health, Reform and Development)
North Yorkshire County Council

1. Introduction and purpose of this document.

The national dementia strategy for England ‘Living Well with Dementia’ was released on 3rd February 2009.

It identifies 17 key objectives which when implemented should result in a significant improvement in the quality of services and promote a greater understanding of the causes and consequences of dementia.

The purpose of the strategy is to:

- Provide a strategic quality framework within which services can deliver quality improvements to dementia services and address health inequalities relating to dementia;
- Provide advice, guidance and support for health and social care commissioners, SHA’s (*Strategic Health Authorities*), local authorities, acute trusts, mental health trusts, PCTs (*Primary Care Trusts*), independent providers and the third sector, and PBC’s (*Practice Based Commissioners*), in the planning, development and monitoring of services,
- And provide a guide to the content of high quality health and social care services for dementia to inform the expectations of those affected by dementia and their families.

The purpose of this local strategy is to outline how partners in North Yorkshire & York have responded to this, describe what we aim to achieve and how we intend to develop services to meet local needs, taking into account the particular characteristics of each locality.

The case for focussing on dementia and the impact dementia has on the person, their families and friends, local health and social care community and the economy are not covered in this document. This has been well documented within the national strategy and many other documents including:

- Everybody’s Business. Department of Health 2005.
- Dementia UK Alzheimer’s Society 2007
- Dementia: Out of the Shadows. Alzheimer’s Society 2008
- Improving Services and Support for People with Dementia. House of Commons Committee of Public Accounts 2008.
- Listening to You – National Dementia Strategy Yorkshire & Humber Listening & Engagement Events Feedback 2008.
- Healthy Ambitions. Department of Health 2008
- My Generation – The Journey of Life (Report on Access to Dementia Services in North Yorkshire. NYCC Care and Independence Overview and Scrutiny Committee. 2009
- North Yorkshire’s Joint Commissioning Framework for Dementia NYCC ACS/NHS NY&Y 2009.
- North Yorkshire and York Mental Health Commissioning Strategy 2010 – 2015 (Draft) 2010.
- The Operating Framework for the NHS in England 2011/12, Department of Health.

The Operating Framework for England 2011/12 expects NHS organisations to make progress on the National Dementia Strategy, including the four priority areas of:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals

- Living well with dementia in care homes
- Reduced use of antipsychotic medication.

2. Aim

The strategic aim is by working with service users and carers and other agencies NHS North Yorkshire and York, City of York Council and North Yorkshire County Council will develop services for people with dementia that:

- Are sensitive to each persons individual circumstances
- support people to live independent, productive, fulfilling and active lives for as long as possible
- encourages people and their carers to be actively involved in the decisions made about their care.
- Support people in negotiating along the care pathway as and when they choose as appropriate
- Provide information in a way that is understood and helps to support the person and their carers in the options available from diagnosis to end of life.
- Are in line with best practice and wherever possible good evidence based practice and are cost effective.

The strategy is intended to secure better mental health for those both under and over the age of 65 who are suspected of having or have a diagnosis of dementia and live within the boundaries of North Yorkshire and York and will also consider those primarily over the age of 65 who have a functional mental health problems (such as depression, anxiety, psychosis).

It should be noted however that older people should be entitled to services irrespective of age and this strategy aims to ensure that the best and most effective mental health care is available to everyone.

3. Dementia in NY&Y

A demographic profile of dementia across the Yorkshire & Humber region commissioned by the Yorkshire & Humber Improvement Partnership showed that for NY&Y the levels of dementia are predicted as:

	2008	Predicted for 2025
Early onset dementia	175	200
Late onset dementia	8,264	13,876

The numbers predicted to have late onset dementia by sub-type within NY&Y

Alzheimer's	5,196
Vascular dementia	1,382
Vascular and Alzheimer's	855
Lewy bodies	333
Fronotemporal	111
Parkinsons dementia	139
Other	248

Source: Dementia UK & POPPI

There are 1344 adults with a Learning Disability known to care management and health services in North Yorkshire and over 550 in York.

Consistent with the national prevalence of the population with Down's syndrome and dementia, the large majority of people with Down's in Yorkshire & Humber region have early on set dementia with 64% aged between 55 and 64 years old and 32% being between 45 to 54 years. This is set to change by 2025 to 67% for 55 to 64 ages while the 45 to 54 years group will increase in absolute terms, the overall proportion will decrease by 2025 to 29%.

(Dementia in Y&H: A demographic profile July 2009)

The Joint Strategic Needs Assessments for York and for North Yorkshire have identified dementia as a priority and concern for the future.

The Independent Review of Health Services in North Yorkshire and York was set up to make recommendations for the future commissioning of services within a sustainable financial framework to ensure future financial balance. The report highlighted a key development being the forecast of the significant increase in the older population. This population makes significant use of health and social care services and states that one of the key priorities should be the care of the growing numbers of people with dementia.

4. Local services

North Yorkshire and York the Community Mental Health services have recently undergone the national process of Transforming Community Services. The new providers of Older Peoples Mental Health services are:

Leeds Partnership NHS Foundation Trust has been awarded a three year contract to provide services in York, Selby and Tadcaster.

The proposed date of transfer of services to Leeds Partnership NHS Foundation Trust has been agreed as 1 October 2011.

Tees Esk and Wear Valleys NHS Foundation Trust has been awarded a three year contract to provide services in Harrogate district with outreach in to Craven where appropriate; Hambleton and Richmondshire, Scarborough, Whitby and Ryedale.

The proposed date of transfer of services has been agreed as 1 June 2011.

There are two Councils with Social Services responsibilities - North Yorkshire County Council and City of York Council and seven District Councils. Social Care staff in North Yorkshire were previously integrated in with Community and Mental Health Teams however this is no longer the case. Services have not historically been integrated in the York area.

There are five main district hospitals:

Airedale NHS Trust (covers the Craven area)

Harrogate District Foundation Trust (covers the Harrogate, Knaresborough Ripon and district)

South Tees Hospital (covers the Hambleton and Richmondshire area)

Scarborough Hospital (Covers Scarborough, Whitby and Ryedale)

And York (covers Selby and York).

There are a variety of voluntary sector and independent organisations that provide a range of primary and secondary prevention services that play an important role in supporting people with dementia and their carers. Investment in many of these organisations has been made by City of York Council (CYC), North Yorkshire County Council (NYCC) and NHS North Yorkshire and York. However the commissioning of these services is inequitable across the area.

NHS North Yorkshire currently have joint commissioning arrangements with both City of York Council (CYC) and North Yorkshire County Council (NYCC) and see dementia and the implementation of the new strategy as a priority area of work.

A mapping exercise was carried out to review the existing services against the objectives in the National Strategy. The discussions took place with key stakeholders in each geographical area and they were asked what they felt the priorities should be for that area (appendix 3). The areas were:

- Craven
- Harrogate, Ripon and Nidderdale
- Hambleton & Richmondshire
- Scarborough, Whitby and Ryedale
- Selby
- York

As would be expected there are many similarities across the different geographical areas but it also shows the gaps in service that relate specifically to an area.

5. Mapping of services and Peer Review

5.1 Mapping of services against the national strategy.

The table below shows the objectives from the national strategy, each area identified as a priority (those ticked) for the people they provide services for.

All areas identified objective 2 Early diagnosis and treatment and Objective 8 Care in General Hospitals as priorities.

Area	Objective												
	1 Raise awareness	2 Early diagnosis	3 Infor- mation	4 Access to care after diagnosis	5 Peer support	6 Community Personal support	7 Carers strategy	8 General Hospitals	9 Inter- mediate care	10. Housing support	11 Care homes	12 End of life	13 Workforce
Craven	√	√					√	√					√
Harrogate / Ripon		√				√		√			√		√
Ham & Rich		√				√		√	√		√		
SWR		√						√			√		√
Selby		√				√	√	√	√		√		
York		√					√	√	√				
Learning Disabilities							√	√				√	

5. Mapping of services and Peer Review - continued

The mapping exercise identified two objectives all areas felt are priorities for action:

- Objective 2 Good quality early diagnosis and intervention for all

There was felt to be a lack of support for people in the early stages of dementia and in particular the period between first raising concerns with services and eventually confirming a diagnosis. It is acknowledged that it can be very difficult in the early stages to make a diagnosis but more needs to be done in providing support to people at this time.

The importance of a multi disciplinary integrated approach was stressed by all and a need to ensure services are personalised.

- Objective 9 Improved quality of care for people with dementia in general hospitals

Real concerns were expressed by staff and service users and carers about the experiences of people in general hospitals who have dementia and their carers.

Issues raised include:

- Lack of knowledge and understanding by staff for those with dementia
- Lack of dignity and respect for patients and their carers
- Lack of systems in place to facilitate effective flow through the hospital and appropriate discharge to the appropriate place

Both of these objectives have been identified for early action in the implementation of the strategy.

Other issues raised as major concerns in all areas were:

- The lack of an integrated care pathway. Staff and services users and carers commented on the impact removal of social care staff has had on service delivery.
- Inconsistent and inequitable provision by the third sector in providing services for people with dementia and their carers.
- Capacity of services to deal with the increase in numbers of people with dementia as the elderly population grows at a time when the funding of public sector services is being reduced.

An issue that was raised in all areas was the benefits of different agencies and service users and carers coming together to share ideas and listen to each other. Many felt the previous Dementia Collaborative (a national initiative that came to an end in 2007) had many benefits and staff stated they would welcome something similar being set up.

5.2 The Yorkshire and Humber Health Improvement Partnership (YHIP) Peer Review.

YHIP carried out two Peer Reviews. One for North Yorkshire services and one for York services. This involved a small team (including health and social care commissioners and providers; Alzheimers Society Representatives and Strategic Health Authority representatives) visiting the area and meeting staff (commissioners and providers), service users and carers and a visit to a service. Set questions were asked that relate to the objectives in the national strategy.

Feedback from the review teams highlighted the following:

What is working well?

- Commitment from stakeholders to improve services for people with dementia and their carers

In each (sub) locality there are many individuals and organisations committed to improving the experience of those suspected of and having dementia. The partnership working in this initial planning phase was considered very positive.

- Once in the 'system' people generally get a good service

The services provided by the Community Mental Health Teams in particular were considered to be working well for those with moderate to severe dementia, with good links to other services.

- Involvement of the third sector
The range of services provided across the North Yorkshire and York was seen as very positive. However the provision is not consistent across the area.

What needs improving?

- A whole system care pathway is needed with greater integration

The Peer Review team commented that social care staff integrated within community mental health teams is considered to be good practice. However this is not the situation within North Yorkshire or York.

The role of the third sector also needs to be clarified and supported to provide services that are equitable.

- Inequity of provision across North Yorkshire and York

The current provision of services is largely based on historic commissioning of services when there were four Primary Care Trusts. This has resulted in inequity across the Trust in what and how services are provided and not necessarily addressing health inequalities.

6. Areas of Good Practice

The mapping exercise and the Peer Review both highlighted areas of good practice across North Yorkshire and York. These include:

Example of good practice	Benefits
<p>Craven Information packs are given out to each person newly diagnosed with dementia. The pack is tailored to the persons specific stage and circumstances.</p>	<p>The person and their carer get supporting information for them to look at their leisure that is specific to their circumstances. Information that backs up the discussions with staff that is enough to help them understand the condition and issues to consider for them, as well as other support available. But not too much to overwhelm them.</p>
<p>Harrogate A Memory And Self Help group (MASH), patients (with carers) work with professionals over 12 weeks. Learn to cope, tips & techniques. Feedback from those who have attended is very positive. Input from Alzheimer's Society, Physiotherapy, Occupational Therapy and Community Mental Health</p>	<p>Supports the person with dementia and the carer to self manage the condition and the impact it has on their lives. It helps them plan for the future and provides peer support.</p>
<p>Hambleton & Richmondshire Completion of the Memory Service National Accreditation Programme by the Older Peoples Mental Health Service</p>	<p>This drives up the standards and quality of care given to people with memory problems, involves service users and carers in the process and identifies areas for improvement.</p>
<p>Scarborough, Whitby & Ryedale Day assessment and support for people with dementia. Community based staff work proactively and collaboratively with assessment colleagues to provide tailored support to people with dementia</p>	<p>The proactive approach helps to reduce social isolation and challenges attitudes that lead to people withdrawing from or being excluded from community based activities, whilst being able to access ongoing medical reviews when required.</p>
<p>York Extended hours of service for Community Mental Health Team to 8pm during the week and from 9am to 5pm at the weekends and Bank Holidays.</p>	<p>The teams are able to step up their support when necessary to enable people to stay at home when their needs increase and prevent the distress of an avoidable admission to acute care.</p>
<p>Selby Use of Assistive Technology to support people with dementia and their carers</p>	<p>Enables people to stay in their homes for longer. Reduces the need for home care and can reduce the anxiety levels of the person with dementia and their carers.</p>

7. Learning Disabilities and Dementia

Within North Yorkshire and York the treatment and care of those with Learning Disabilities (LD) and Dementia is generally managed by the Learning Disability Teams with support from CMHT.

Staff within the LD Teams were consulted to establish what they felt were the issues and areas for improvement.

The results of these discussions highlighted the following:

- Issue of end of life care being provided out of area. Consideration needs to be given to the development of a North Yorkshire & York service for end of life.
- The importance of carers in maintaining people at home and the support needed by them in order to continue providing a caring role, particularly respite, both planned and unplanned.
- Reports of poor experiences by people in general hospitals. Training and education is needed for staff to raise awareness of the issues for those with dementia and LD.

8. Consultation and service user and carer involvement

Both the Overview and Scrutiny Committee reviews and the mapping exercise involved a wide range of key stakeholders including: Members from the Health Scrutiny committees; Adult services from North Yorkshire County Council and City of York Council (both commissioning and providers); PCT commissioners and providers from community, primary and secondary care services; the voluntary and independent sectors and people who have dementia and their carers.

Separate discussions were held with groups of people with dementia and their carers to gain their views on the current services and what they felt could be improved to provide better treatment and care.

The main issues raised were:

- Not knowing who to turn to for support when symptoms cause concern
- Not being listened to particularly in the early stages and particularly by primary care
- Carers not being listened to when the cared for person is having tests or treatment for the dementia or another condition.
- Lack of respite for the carers

9. Services for all

Information on who uses our services is mixed. In North Yorkshire and York the numbers of people from Black and Minority Ethnic (BME) is small compared to the national average.

It is expected that the number of older people with a sensory impairment will increase substantially. Commissioners need to ensure that people from all backgrounds and lifestyles have equal access to services and the services are responsive to their needs. This will have implications for service delivery. For example older people whose first language is not English may revert to speaking their first language as the dementia develops.

10. Values & Principles

During the discussions held for the Health Scrutiny reviews and the mapping against the national strategy a consensus emerged for the values and principles that would underpin good dementia services:

- There should be sufficient capacity within the system, including the third sector for services to respond effectively.
- Service design, planning and delivery should be transparent in the data provided to inform decisions and the process in which decisions are made.
- Services should where ever possible be based in the community and governed by minimum standards that are evidence based and in line with best practice.
- Services should be integrated to ensure close working between the different strands of care.
- Services should be available and easily accessible at every stage of the persons condition without unnecessary delays or repeated referrals to the same service.
- Services should be personalised to meet the individuals needs and circumstances.
- People and their carers should be informed and active partners in the decisions made about their care at all stages of the illness.
- The role of carers should be acknowledged and included as active partners in the care of those with dementia.

The Dementia Declaration was launched in October 2010 by the Dementia Action Alliance. It calls on families, communities and organisations to work together to transform the quality of life of millions of people affected by dementia.

NHS NYY, NYCC and CYC are all signed up to the principles of this declaration to:

- Ensure the work is planned and informed by the views of people with dementia and their carers and evidence this.
- Be an ambassador for the National Dementia Declaration
- Report publicly on progress against the plan to support the delivery of the declaration
- Work in partnership with others to share knowledge about best practice in dementia
- Improve understanding about dementia.

(www.dementiaaction.org.uk, 2010)

11. Prevention

Although the national strategy does not specifically address the issue of prevention it is one that has been raised by a number of people.

There is growing evidence indicating that certain medical conditions - such as high blood pressure, diabetes and obesity - may increase the risk of dementia whereas a healthy lifestyle may reduce the risk.

The dementia strategy will link to the wider public health agenda to promote a healthy lifestyle by the population.

A range of research projects looking at the causes and treatments of dementia are underway nationally. The North Yorkshire and York strategy will take account of any emerging findings and make any amendments that are felt to be advantageous to those at risk of and with dementia.

For those with dementia it is well recognised that activities such as individualised exercise programmes help to maintain the individual's health, independent function and delay the progression of the effects of the condition. (Larson et al 2006).

Secondary prevention methods will be considered to reduce the speed of decline and maintain independence.

12. Action Plan & Future Commissioning

The difficult economic climate and changing demographic profile, means that commissioning new services or new ways of working will become increasingly challenging for all.

The Government's white paper 'Liberating the NHS' (July 2010) sets out the government's long term vision for the future of the NHS. It means that there will be further changes to organisations, management structures and performance measures in the coming months.

The engagement of GPs, as they take on the responsibilities of commissioning services will be vital in ensuring dementia is seen as a priority area of work and ensure high quality and cost effective services are commissioned.

The following Clinical Commissioning Groups will be developed:

- Hambleton, Richmondshire and Whitby
- Vale of York (including Easingwold, Selby, Tadcaster, Kirbymoorside and Pocklington)
- Harrogate Rural and District
- Scarborough (not Rillington)
- Ryedale (including Rillington, Pickering, Malton, Ampleforth and Helmsley)
- Craven are to join Airedale and Wharfedale Alliance
- Bentham to join South Lakes Commissioning Group

Public Health functions will transfer to Local Authorities and Health and Wellbeing Boards will be established to increase public engagement.

Primary Care Trusts are due to cease from 2013 and Commissioning Support Units may provide some of the commissioning functions.

Despite these changes, there is agreement from local stakeholders that the work needed to improve services for people with dementia and their carers must continue while these changes take place.

The assessment of services against the objectives in the national strategy has resulted in the attached action plan for implementation over the next three to five years that will inform the commissioning of services.

It highlights those areas seen as a priority by staff and service users and carers and also indicates the activity that relates to the other objectives in the national strategy.

The Action Plan will be delivered through local area based action plans that will focus on specific priorities for the local area. For example:

- York currently has a Dementia Working Group which is a sub group of the Mental Health Modernisation and Partnership Board for the City.

- Scarborough, Whitby and Ryedale have a Planning and Implementation Group for Older Peoples Mental Health that have been developing and improving local services for people with dementia for many years.

Where required, business cases for the redesign and/or resources needed to implement the strategy will be submitted to the relevant decision making bodies for approval.

13. Sharing learning

Staff across North Yorkshire and York raised the benefits of the previous Dementia Collaborative. This was a national initiative to bring staff, users and carers together to look at improving services. The methodology used was 'Plan, Do, Study, Act' cycle.

Staff felt that it would be useful to set up a network to share learning, prevent duplication, improve communication and understanding between organisations and have a vehicle to engage with commissioners in the planning of services. Staff and other key stakeholders were also keen to play an active role in finding solutions and supporting the implementation of the strategy.

As a result of this, NHS North Yorkshire and York in Partnership with North Yorkshire County Council have set up the North Yorkshire and York Dementia Network. Over one hundred and thirty individuals and groups are on the membership list and three or four meetings are held each year. The feedback has been very positive and the attendances at the meetings are good.

14. Accountability

The implementation of this strategy links directly to the Quality, Innovation, Productivity and Prevention (QIPP) plans for North Yorkshire including 'Shifting Settings of Care and Urgent Care' and 'Best Practice Care pathways for Long Term Conditions'. These will be monitored and progress will be reported to each of the CCG area Locality Programme Boards (which includes PCT/CCG; Local Authorities; Acute Trusts and others). The Locality Programme Boards are supported by the Central Programme Board.

The two Mental Health and Modernisation Partnership Boards for York and North Yorkshire will also monitor progress. In York this group currently reports to the Adult Commissioning Group for the City (Locality Programme Board). In North Yorkshire the Board will report and make recommendations to North Yorkshire County Council Executive Members. In both cases they also report to NHS North Yorkshire Transition and Reform Programme Board.

Where appropriate information on progress will also be put before; both Scrutiny Committees, the Clinical Commissioning Groups via the Transition and Reform Programme Board, and third sector providers via the third sector liaison groups.

Regular updates on progress will also be shared with all who are part of the North Yorkshire and York Dementia Network.

NY&Y Dementia Strategy Action Plan 2011 – 2013

NHS NYY = NHS North Yorkshire and York
CYC = City of York Council

CCG = Clinical Commissioning Group
NYCC = North Yorkshire County Council

To note - Local areas eg York have agreed specific action plans to address local issues.

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
1 - 13	<p>1. To describe an integrated care pathway for dementia and the expected outcomes.</p> <p>To incorporate dementia in to the development of the levels of care initiative to develop more integrated health and social care services.</p>	NHS NY&Y All CCG NYCC	<p>December 2011</p> <p>From April 2011 onwards.</p>	
1-13	<p>2. To develop the relevant service specifications to include the qualitative and quantitative performance measures that will demonstrate the desired outcomes.</p> <p>To reflect the integrated health and social care pathway once approved linked to the Transforming Community Mental Health Services.</p>	NHS NY&Y All CCG CYC NYCC	Ongoing as required.	
1-13	<p>3. To develop robust and effective commissioning of the third sector in order to support the implementation of the care pathway effectively and addresses inequity of provision</p>	NHS NY&Y All CCG NYCC	April – October 2011 and as required	Cuts to public sector spend may impact on third sector provision.
1 – 13	<p>4. To maintain and develop the North Yorkshire and York Dementia Network.</p>	NHS NY&Y NYCC	<p>Meetings held quarterly or as required.</p> <p>Sub groups to meet as required</p>	Capacity to co-ordinate and maintain the network.

Action Plan continued...

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
1. Improving public & professional awareness and understanding	<ul style="list-style-type: none"> - Support National Agenda on raising awareness. - Using local media and websites to market messages on on-going basis - Develop wider public / community engagement. Support for Joseph Rowntree Foundation initiative in York and roll out of learning from it. 	NHS NY&Y All CCG NYCC CYC	April 2011 and ongoing	<p>Network to consider and recommend approach and co-ordination of improving awareness and understanding – in line with national campaign.</p> <p>Local groups to consider implementation at the local level, including support within York for JRF project.</p>

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
2. Good quality early diagnosis and intervention for all.	Describe a community model for early diagnosis and intervention that incorporate health, social care and the voluntary sector to: <ul style="list-style-type: none"> - provide a memory assessment service - Provision of Care plans - Reablement - Sign posting and - Point of contact / advisor role That is accessible to all including those with Young Onset dementia and LD. <ul style="list-style-type: none"> - post diagnosis care to be in line with NICE guidance and include therapies such as cognitive stimulation, cognitive behaviour therapy and others. - telecare to be offered as part of care pathway - services to be available outside usual working hours and at weekends. 	NHS NYY CCG NYCC CYC Vol sector	Model described by October 2011. Evaluation of care navigator role March 2012.	Seen as a priority in all of the 6 areas. Risk - Identification of resources to enable service development and sustainability. Risk of cuts to public sector funding effecting implementation. Risk – lack of consistent agreement from CCG.
	- Negotiate implementation of early diagnosis pathway with providers.	NHSNYY CCG CMH Providers	Sign up to pathway by December 2011.	
	To increase the level of ‘undiagnosed’ dementia through activity such as: <ul style="list-style-type: none"> - engagement with CCG - use of QOF registers - awareness raising reducing stigma - better co-ordination between diagnosis for other conditions and dementia services. 	Network NHS NYY CCG Acute Trusts		
	To promote good practice guidance to primary care for the care and treatment of those with dementia and their carers	NHS NYY CCG		

	<p>To reduce / prevent inappropriate use of antipsychotic drugs to older people with mental health problems:</p> <ul style="list-style-type: none"> - GP's to challenge and reduce repeat prescriptions for anti psychotics - Hospitals to have a policy in place for the use of anti-psychotics and monitor their use. - Undertake antipsychotic audit and assess results 	<p>NHS NYY CCG General Hospital Trusts</p>		
--	---	--	--	--

Objective	Commissioning Action	Lead responsibility Other partners and agencies involved	Time- scales	Notes Resources / Risks
<p>3. Good quality information for those with diagnosed dementia and their carers.</p>	<p>Review of information given to service users and carers and recommend information for each stage of the persons condition and individual situation to provide consistent, accurate, high quality information and advice based on the latest evidence and good practice.</p>	<p>NHS NYY via Dementia Network</p>		

Objective	Commissioning Action	Lead Other partners and agencies involved	Time- scales	Notes Resources / Risks
<p>4. Enabling easy access to care, support and advice following diagnosis.</p>	<p>To consider the role of the dementia advisor as part of the community model for early diagnosis - see objective 2</p>	<p>NHS NYY CCG NYCC CYC</p>		

Objective	Commissioning Action	Lead Other partners and agencies involved	Time- scales	Notes Resources / Risks
5. Development of structured peer support and learning networks	Review current provision against care pathway and commissioning of third sector. Develop effective and robust commissioning of the third sector to support the implementation of the care pathway including the provision of peer support and learning networks.	NHS NY&Y NYCC All CCG CYC		Risk – resources to commission sufficient peer support that provides a personalised service and that is sustainable.

Objective	Commissioning Action	Lead responsibility Other partners and agencies involved	Time- scales	Notes Resources / Risks
6 Improved community personal support services	To incorporate the necessity for staff to have basic dementia training as part of the contract requirement for home care services. To commission services that respond to need rather than work to time slots.	NYCC		
	To review the contract agreement with advocacy services to ensure a consistent level of service is provided across NY&Y. To engage with Healthwatch and Advocacy providers in York to develop a sustainable service for older people	NYCC NHS NYY		Risk – available resources to commission advocacy services in York for Older

				People.
	Ensure the use of assistive technology and telehealth are built in to the care pathway and linked to development of equipment services and housing support.	CYC NYCC NHS NYY		
	To review the provision of flexible and responsive respite and breaks.	NYCC NHS NYY		
	To promote good practice in the review of patients physical health needs to include sight and hearing as part of the annual review by GP practices.	NHS NYY All CCG		
	To consider the needs of those with early onset dementia and develop support mechanisms to meet those needs.	NHS NYY CYC NYCC		Risk – available resources
	To explore feasibility of residential support for women with challenging behaviour	NHS NYY		Risk – resources to develop the service.

Objective	Commissioning Action	Lead responsibility	Time-scales	Notes Resources / Risks
7. Implementing the Carers Strategy.	Refresh both York and North Yorkshire Carers strategies in the light of the changes to the national strategy. Sign off both the Joint strategies between the PCT and CYC and NYCC and other key stakeholders. Implementation of the both action plans.	CYC NYCC NHS NYY	York - Sign off by Nov 2011 NY – Sign off by Feb 2012	

Objective	Commissioning Action	Lead Other partners and agencies involved	Time- scales	Notes Resources / Risks
8. Improved quality of care for people with dementia in general hospitals	a) Identify a lead for dementia in each acute Trust. b) Identify responsibilities of acute care providers in the care of those with dementia in secondary care settings and incorporate it into the contracting process.	a) All acute trusts / NHS NYY CCG b) NHS NYY CCG Acute Trusts	a) April 2011 b) March 2012	Seen as a priority in all of the 6 areas.
	To review the use of anti psychotic drugs in secondary care	Acute Trusts NHS NYY		
	Develop a service specification for liaison services to A&E and the wards within acute care settings and commission service accordingly – to include the submission of a business case to the Transformation and Reform Programme Board as required.	NHS NYY CCG	Draft spec by Sept 2011	Lack of available resources to cover costs

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
9. Improved intermediate care for people with dementia	<p>Ensure that the care pathway and discharge planning for people with dementia includes intermediate care and reablement.</p> <p>To utilise the reablement monies to support training of staff in dementia care.</p> <p>To include this as part Transforming Community Services.</p> <p>Ensure that staff providing reablement services and intermediate care have the skills and competencies for supporting people with dementia.</p> <p>Ensure that all elements of the intermediate care system work together in an integrated way.</p>	<p>NHS NYY Acute Trusts All CCG NYCC CYC</p>	<p>April 2011 To March 2012</p>	

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
10. Considering the potential for housing support, housing related services and telecare to support people with dementia and their carers.	<p>To engage with housing support providers and ensure the needs of those with dementia are considered within the current provision.</p> <p>York – Deliver the Older Peoples Housing Strategy</p>	<p>NYCC NHS NYY</p> <p>CYC</p>		
	<p>To ensure assistive technologies, telecare and telehealth are built in as part of the care pathway for people with dementia at the different stages of the condition.</p>	<p>CYC NYCC NHS NYY</p>	<p>Ongoing</p>	
	<p>To ensure that the design of future extra care housing takes account of the needs of people with dementia, and influence the design of general housing to ensure the needs of those with dementia are considered.</p>	<p>Housing providers NYCC NHS NYY</p>	<p>Ongoing</p>	

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
11. Living well with dementia in care homes	To agree and promote standards of good care and guidance for care homes including: <ul style="list-style-type: none"> - identified named dementia lead in the care homes - appropriate use of medication including antipsychotics - tools and policies that supports people with dementia to undertake meaningful activities 	NHS NYY Network to draft CYC NYCC	Draft by Nov 2011	
	To produce guidance on choosing a home for the general public aimed at self funders	Network to draft	Draft by Nov 2011	
	To consider the development of in reach services to care homes including a liaison service to care homes in the treatment and care of those with dementia. To discuss with providers.	NHS NYY	Nov 2011.	Risk - Lack of available resources
	To monitor the use of anti psychotic drugs given to those with dementia in care homes.	NHS NYY	Ongoing	
	To monitor the number of admissions to hospital from care homes and work with homes who have repeated high levels of admissions to develop an action plan to address the causes.	NHS NYY NYCC CYC	Ongoing	

Objective	Commissioning Action	Lead responsibility Other partners and agencies involved	Timescales	Notes Resources / Risks
12. Improved end of life care	To ensure end of life / advanced directives training is incorporated in to staff training programmes for dementia particularly for health, social care, care home and voluntary sector staff.	All partners Network		

	To support care homes to manage end of life for their residents who have dementia and are dying.	NYCC CYC Network / Independent Care Group		
	To explore feasibility of an in area service for those with LD and dementia.	NHS NYY CCG		Available resources / provider

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
13. An informed and effective workforce for people with dementia.	<p>a) Commission a training programme for staff in North Yorkshire involved in the Enhanced Community Teams that is specific to their role utilising the winter pressures/reablement funding.</p> <p>b) Agree competencies required for level and responsibilities of staff</p> <p>c) Commission a general dementia training programme for the wider health and social care community</p> <p>d) Introduce skills and competencies within service specifications and agreements with commissioned services including health, social care, the voluntary and independent sectors.</p>	<p>a) NHS NYY NYCC</p> <p>b) Network</p> <p>c) NHSNYY NYCC</p> <p>c) NYCC NHS NYY and Provider services.</p>		a) Use of reablement monies to support this.

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
14. A joint commissioning strategy	To draft the Joint strategy with key partners and send out to key stakeholders for comments before amending and producing the final version.	NHS NYY CYC NYCC	Draft by Feb 2010. Sign off by: NHS NYY / CCG	

			CYC NYCC by December 2011.	
--	--	--	----------------------------------	--

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
15. Improved assessment and regulation of health and social care services and of how systems are working for people with dementia and their carers.	<p>Work with Providers to ensure they understand that commissioners only wish to commission good or excellent services for people with dementia. 'Adequate' or 'Poor' will not be acceptable.</p> <p>Ensure quality of services are built in to commissioning of services and the appropriate evidence to ensure outcomes are met.</p>	NYCC NHS NYY		

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
16. A clear picture of research evidence and needs.	<p>a) To look for opportunities for carrying out research to inform best practice.</p> <p>b) To ensure a good evidence base informs service development and commissioning.</p>	All	Ongoing	

Objective	Commissioning Action	Lead Other partners and agencies involved	Timescales	Notes Resources / Risks
17. Effective national and regional support for implementation of the strategy.	<p>a) Attend the Regional Dementia Leads Group and events to share good practice and learning and ensure communication and transfer of information between national, regional and local levels.</p> <p>b) To access any available support from regional or national level and to inform region and national level of progress and any examples of good practice from NY&Y and lessons learnt.</p>	<p>a) NHS NYY</p> <p>b) NHS NYY NYCC</p>	<p>a) Ongoing</p> <p>b) Ongoing</p>	

Appendices

1. Mapping exercise summary by area.
2. Summary of findings from York Overview & Scrutiny Committee.
3. Summary of North Yorkshire Report
4. References

Appendix 1: Results of mapping exercise by area.

1. Priorities for York

CYC Health Scrutiny Committee carried out a review of dementia within secondary care. This highlighted several areas for further work including:

- The role and needs of carers
- Improving overall communication between staff and relatives including written patient information
- The development of a liaison service in partnership between CYC, NYYPCT and YDFT.
- Awareness and training for staff on dementia.

The York Health Group (Practice Based Commissioning Group) were involved in the mapping exercise and highlighted dementia as one of their priorities for service development. The initial group that undertook the mapping exercise have formed in to the York Dementia Working Group and is a sub group of the York Mental Health Modernisation and Partnership Board.

The mapping exercise resulted in the following areas being seen as a priority:

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

Elements of a diagnosis service exist but it was felt that it needed to be improved to provide a more co-ordinated, user friendly and efficient service.

The option of a multidisciplinary 'One Stop Shop' was considered. This would be based in the community linked to practices that would provide:

- Rapid access to early diagnosis
- Relevant information and support appropriate to the individuals circumstances
- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.

- **Objective 7: Implementation of the Carers Strategy.**

Support to carers is a crucial element of supporting those with dementia.

Breaks for carers are seen as inadequate.

Education that provides practical tips on coping with daily living and self management was seen as important. There are several different programmes available and the benefits of each will need to be explored.

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

The main acute provider is York District Foundation Trust.

A recent report by the York Health Scrutiny Committee on the dementia and accessing secondary care highlighted several areas of concern.

The training and education of staff needs to be prioritized and the responsibilities of secondary care need to be made explicit.

The development of a liaison service was identified as a major gap that has existed for some time.

- **Objective 9: Improved intermediate care for people with dementia** – There is currently no dedicated intermediate care service accessible to people with dementia. Currently it is unknown how often someone with dementia is offered the service or offered rehabilitation on discharge from hospital.

2. Priorities for North Yorkshire

The NYCC Care and Independence Overview and Scrutiny Committee also decided to focus on Dementia and carried out a review of services. This has resulted in a report that includes 18 proposals that outline what people feel a good dementia service should look like (appendix 2)

One area all agreed would be useful is the establishment of a Dementia network. This network will:

- provide leadership to the implementation of this local strategy and action plan
- improve communication and co-ordination between agencies
- devise, co-ordinate and ensure common standards and competencies in training and service provision
- ensure the people who use services and their carers are involved in the development, implementation and monitoring of the action plan.

The mapping against the national strategy objectives highlighted the following as priorities for each area:

2.1 Craven:

The main acute provider is Airedale District Hospital. However some patients in the north of the area use Lancaster Acute Trust. The mental health services are provided by Bradford and Airedale Community Mental Health Trust

- **Objective 1: Improving public and professional awareness and understanding**
Some members of the group felt it was important to support people in identifying symptoms and seeking support at an earlier stage. To reduce the stigma of dementia to enable people to feel more comfortable about discussing concerns and seeking help with the confidence they will be listened to and treated with respect.

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

The group discussed the need for greater integration between services particularly mental health and primary care; health and social care and the role of the voluntary sector. This is to reduce duplication of assessment reduce delays and provide more rapid and personalized services. Services should be based in the community linked to practices that would provide:

- Rapid access to early diagnosis
- A point of contact for people with dementia and their carers
- Relevant information and support appropriate to the individuals circumstances

- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.

- **Objective 7: Implementation of the Carers Strategy.**

Support to carers is a crucial element of supporting those with dementia.

Breaks for carers are seen as inadequate.

Education that provides practical tips on coping with daily living and self management needs to be developed.

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

The training and education of staff needs to be prioritized and the responsibilities of secondary care need to be made explicit.

A specialist nurse liaison is commissioned to provide the service but no other staff / resources are commissioned. The development of a more robust liaison service was identified as a priority.

- **Objective 13 – informed and effective workforce** – to develop a learning network to provide opportunities for training and education for staff from all agencies.

2.2 Harrogate, Ripon and Nidderdale:

The main acute provider is Harrogate District Foundation Trust.

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

The group discussed the option of a multidisciplinary service based in the community linked to practices that would provide:

- A case finding function to detect dementia at an earlier stage
- Integrated team with health and social care
- Rapid access to early diagnosis
- Relevant information and support appropriate to the individuals circumstances
- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.
- To provide a dementia advisor/Admiral nurse function to provide a point of contact, advice and signposting for people through their journey from diagnosis to end of life (including support to carers after death of the cared for person)

- **Objective 6 Improved community personal support services**

The home care support available to people with dementia needs to be improved. There are also gaps in the provision of day activities particularly in the Ripon area.

- **Objective 8 improved quality of care for people with dementia in general hospitals**

Gap in knowledge and skills of ward staff in supporting those with dementia. Training identified as a need. Development of the current nurse led liaison service highlighted as

a priority to provide links between primary/community and secondary care. Important to have both social care and therapy input.

- **Objective 11 Living well with dementia in care homes.**

There are some examples of good practice within the Harrogate & Ripon areas, however there are some that need improvement. Some support is given to care homes currently by CMHT but needs to be improved particularly regarding provision and monitoring of medication. The development of a liaison service to care homes with links to the hospital liaison service would improve both the care for people with dementia and support for the staff.

- **Objective 13 An informed and effective workforce for people with dementia.**

The training of staff in a range of settings is needed to improve the care and quality of life for people with dementia and their carers.

2.3 Hambleton & Richmondshire:

The main acute Trust Provider is South Tees Acute Trust.

- **Objective 2 Good quality early diagnosis and intervention for all.**

The group identified the need for greater integration between services particularly mental health and primary care; health and social care and the role of the voluntary sector. This is to reduce duplication of assessment, reduce delays and provide more rapid and personalized services. Services should be based in the community linked to practices that would provide:

- Rapid access to early diagnosis
- A point of contact for people with dementia and their carers
- Relevant information and support appropriate to the individuals circumstances
- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.

- **Objective 6 Improved community personal support services**

Concerns were expressed at the level of training of staff, reliability and lack of flexibility of personal home care services. This section of the strategy includes a range of home care support and was seen as a priority to raise standards and improve peoples quality of life. The role of the voluntary sector in providing day opportunities was acknowledged as an important part of the care pathway.

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

The main general hospital services are provided by South Tees Acute Trust from the Friarage Hospital site or in Middlesbrough. Services are also provided at the Lambert and Richmond Friary Hospitals.

Gap in knowledge and skills of ward staff in supporting those with dementia. Training identified as a need.

Although the current nurse led liaison service is functioning well it is highlighted as a priority to develop the service to provide greater links between primary/community and secondary care.

- **Objective 9 Improved intermediate care for people with dementia**

There is no intermediate care service that meets the needs of people with dementia.

This should link to the development of the Liaison service between secondary care and the community.

- **Objective 11 Living well with dementia in Care Homes.**

There is no specific liaison service to care homes provided by CMHT. Support is provided by CMHT usually in response to behaviour disturbance or deterioration. A liaison service would greatly improve the quality of life of many of those with dementia in care homes and provide support to staff.

2.4 Scarborough, Whitby and Ryedale:

The main acute trust provider is Scarborough Hospital Trust. The mental health services provider is Tees Esk and Wear Valleys NHS Trust.

- **Objective 2 Good quality early diagnosis and intervention for all.**

Elements of a diagnosis service exist but it was felt that it needed to be improved to provide a more co-ordinated, user friendly and efficient service. Proactive **Case Finding** would identify people sooner and provide the support they need in the early stages of the condition.

The development of a multi agency memory service based in the community that could provide:

- Support to staff to proactively case find
- Rapid access to early diagnosis
- Relevant information and support appropriate to the individuals circumstances
- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.

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

The main general hospital is Scarborough, however some patients also use South Tees Acute Trust in Middlesbrough.

Gap in knowledge and skills of ward staff in supporting those with dementia. Training identified as a need. Development of the current nurse led liaison service highlighted as a priority to provide links between primary/community and secondary care.

- **Objective 11 Living well with dementia in care homes.**

There is no specific liaison service to care homes provided by CMHT. Support is provided by CMHT usually in response to behaviour disturbance or deterioration. A liaison service would greatly improve the quality of life of many of those with dementia in care homes and provide support to staff.

- **Objective 13 Informed and effective workforce**

The training of staff in a range of settings is needed to improve the care and quality of life for people with dementia and their carers

2.5 Selby:

The main acute trust provider is York District Foundation Trust.

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

The group discussed the option of a multidisciplinary based in the community that would provide:

- Rapid access to early diagnosis
- Relevant information and support appropriate to the individuals circumstances
- Signposting to other support and information including voluntary / independent sector support for both the carer and cared for person.
- To provide a dementia advisor/Admiral nurse function to provide a point of contact, advice and signposting for people through their journey from diagnosis to end of life (including support to carers after death of the cared for person)

- **Objective 5,6,7,: Prevention of Crisis: This has links with 5 – Structured Peer support / 6: Improved community personal support / 7: Implementation of the Carers Strategy.**

It was felt that a combination of improved respite for both the person with dementia and the carer is an important element in preventing crisis. Breaks for carers tend to be provided in a crisis – inadequate planned respite available.

The provision of structured peer support that is specific to that individual also limited. Plus no access to crisis team from York for Dementia (can access for functional mental health).

If OOH service required – often no one goes out to the person and they are admitted. General view that staff do not understand the needs of those with dementia.

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

A recent report by the health Scrutiny Committee on the dementia and accessing secondary care highlighted several areas of concern.

The training and education of staff needs to be prioritized and the responsibilities of secondary care need to be made explicit.

The development of a liaison service was identified as a major gap that has existed for some time.

- **Objective 11: Living well with dementia in Care Homes.**

There is no specific liaison service to care homes provided by CMHT. Support is provided by CMHT usually in response to behaviour disturbance or deterioration. A liaison service would greatly improve the quality of life of many of those with dementia in care homes and provide support to staff.

Appendix 2.

Issues highlighted in the York Health Scrutiny Committee Dementia Review regarding care given at YDFT

- Carers and relatives recounted stories of negative experiences in relation to staff attitudes, clinical care and the level of dementia awareness training of staff. There was a recurrent theme of lack of involvement of carers and relatives and the difficult balance between privacy, dignity and confidentiality and the need to support the patient through involvement of a carer.
- Flexibility at meal times and visiting times was raised as carers felt that they were prevented from supporting the patient and should be able to visit outside of normal visiting times.
- Clinic appointments posed problems as clinic staff may not have enough time to realise that the patient has memory problems and often patients presented fairly well but could not remember what they had been told with regard to medication or future treatment plans.
- A consistent theme was an apparent lack of communication between staff with regard to the needs of the patient and poor communication with relatives and carers resulting in lack of continuity.
- Lack of patient information was also highlighted. The Alzheimer's Society have produced a leaflet entitled `This is Me ` which would provide individual information on a patient and they are hoping to introduce this into the hospital
- Lack of progress on the Essence of Care benchmark in relation to mental health was highlighted by hospital staff during the committee visit.
- The need for a psychiatric liaison service was outlined by hospital, NYYPCT and local authority staff. Acknowledgment was given to the work previously carried out to identify the need for the service.

Appendix 3

Recommendations from the North Yorkshire Care and Independence Overview and Scrutiny Committee report on Dementia

Proposal 1, Values and Principles. A consensus emerged from the people The Committee spoke to, on the values and principles that might underpin a good dementia service.

Proposal 2, A Dementia Network. Development of an organised network to provide leadership, drive and enthusiasm should be established to make this good dementia service a reality. Partners are therefore invited to re-commission what was known as the Dementia Collaborative on a substantive rather than short term basis.

Proposal 3, National Dementia Strategy. The National Dementia Strategy aims, in a short period, to transform the way people with the illness are cared for. It should be adopted as a strategic framework so that partners can then commit to delivering its aims.

Proposal 4, Education Programme Only by tackling the low level of public and professional awareness of the condition can we begin to tackle the stigma and misapprehension that surrounds it. Much is being done nationally, but there is scope for a local information campaign as part of a joint agency Education Programme

Proposal 5, Community Engagement. These awareness raising initiatives should be deployed with strong community engagement to increase levels of understanding and build supportive social networks. The existing infrastructure of Local Strategic Partnerships the NYSP and our Area Committees can be used to good effect

Proposal 6, Training Programme The case for training is made repeatedly in the National Strategy. To ensure there is an informed and effective workforce for people with dementia. This means providing training for some non social care staff where appropriate, but mandatory, specialist training for professionals who have contact with people with dementia or their carers.

Proposal 7. Diagnosis. Most of the people Members spoke to believe that early diagnosis is helpful. It helps care givers to understand and prepare. People with dementia can plan and make decisions about their affairs. In most instances it can be the only way to gain access to existing effective treatments. Opinions though can differ on how a diagnosis should be arrived at, so a debate is called for.

Proposal 8. Care Pathways. A systematic approach to describing the services and interventions that follows diagnosis is important. The report emphasises the significance of developing common integrated care pathways. This exercise is best carried out by the newly created Dementia Network proposed earlier.

Proposal 9. Data Collection. Getting these care pathways right will depend in part, upon a more rounded and complete picture of local needs and services. Improved information and data collection at the point of diagnosis is suggested, especially if we are to examine claims there is inequity across the county.

Proposal 10. Telecare and Assistive Technology. People like the idea of Telecare and Assistive Technology devices as an enabler, helping people with dementia to live independently in the community.

Proposal 11, Single Focus for Referrals No-one should have to go through dementia alone. For some people there appears to be a care and support vacuum where people have to find their way without support, until needs mount and a crisis occurs. We therefore support the idea of a single focus for referrals from Primary care.

Proposal 12, Information People with dementia and their carers should be provided with good-quality information linked to Care Pathways.

Proposal 13, Support and Advice. Continuous support and advice ought to be provided to help people understand and accept the diagnosis.

Proposal 14, Improving Care and Support. The quality of care provided in general hospitals for people with dementia will be raised by enhanced training, but could also be improved by better discharge planning, dementia care champions on wards and carers having the opportunity to stay in hospital with the person with dementia.

Proposal 15, Home Care Services. There is a case for introducing specialist trained staff in home care services to better meet the needs of the two thirds of people with dementia who live at home.

Proposal 16, Short Breaks and Respite. Short breaks and respite help support families in the caring role in the community. This emerged as a priority in the Committee's consultation. Breaks need to be flexible as people with dementia can live with the condition for a number of years and care needs change over time.

Proposal 17, Joint Commissioning. Joint Commissioning and planning mechanisms should be established to determine the services needed for people with dementia and their carers, and how best to meet their needs.

The report offers comments on the remaining aspects of the strategy which address care in residential settings but Members recognised these were for further study by others.

Proposal 18, Delivering the Strategy. Any action taken by the council in conjunction with partners should be supported by national campaigns and access to the latest information and research. Clear information on the delivery of the National Dementia Strategy is required and additional resources should accompany it.

Proposal 19, One Stop Shop. The Committee would like to champion the notion of a one-stop-shop for people with dementia:

- A recognised holistic service for people with dementia and their families to turn to.
- A place where the diagnosis and ongoing treatment might be carried out away from a clinical environment.
- A place where there is peer support and up to date informed advice.
- This need not be all about a building but also about the 'virtual' team of people focussed on dementia and works to one end.

4. References

- Dementia in Y&H: A demographic profile July 2009
- Living Well With Dementia. Feb 2009. Department of Health
- North Yorkshire's Joint Strategic Needs Assessment 2008 – 2011
North Yorkshire County Council / NHS North Yorkshire and York
- Joint Strategic Needs Assessment York 2008.
City of York Council / NHS North Yorkshire and York
- North Yorkshire Joint Commissioning Framework for Dementia NYCC August 2009
- *My Generation - The Journey of Life*. Jan 2009. NYCC Care and Independence
Overview and Scrutiny.
- Draft report: Implementing the national dementia strategy in York. July 2010. York
Dementia Working Group.
- Draft document: The vision for older people's health and well being in York 2010-
2015. July 2010. City of York; York Health Group; NHS North Yorkshire and York.
- A Review of Services for People with Dementia: The Case for Change Across
Yorkshire & Humber YHIP/DH February 2010.
- Larson et al. Exercise is associated with reduced risk for incident dementia among
persons 65 years of age and older. Jan 2006. Vol144 No 2 p73-81
- Dementia Review (Accessing secondary care) Report by City of York Council Health
Overview and Scrutiny Committee, November 2008
- Everybody's Business. Department of Health 2005.
- Dementia UK Alzheimer's Society 2007
- Dementia: Out of the Shadows. Alzheimer's Society 2008
- Improving Services and Support for People with Dementia. House of Commons
Committee of Public Accounts 2008.
- Listening to You – National Dementia Strategy Yorkshire & Humber Listening &
Engagement Events Feedback 2008.
- Healthy Ambitions. Department of Health 2008
- North Yorkshire and York Mental Health Commissioning Strategy 2010 – 2015
(Draft) 2010.
- The Operating Framework for the NHS in England 2011/12, Department of Health.
- Independent Review of Health Services in North Yorkshire and York. Report of the
Independent Commission August 2011.