City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Dementia Strategy Group to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 1 March 2018

AD

Subject:

Post Diagnosis Support for People with Dementia

Summary statement:

This report, as requested at Health and Social Care Overview and Scrutiny Committee in January 2017, is an annual update report from the Bradford District Dementia Strategy Group focusing on the services provided in the District to support people with dementia and their carers post diagnosis.

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Portfolio:

Overview & Scrutiny Area: Health and Social Care

1. SUMMARY

The following report is an update from the Local Dementia Strategy Group on the services available in the District for people with dementia and their carers. The services described are funded by both or either the Local Authority and the NHS and are provided by a wide range of organisations including specialist acute setting support through to community based services.

2. BACKGROUND

2.1 The realisation of the impact of dementia on society, on individual and on families has resulted in increasing Government and public pressure to improve services from health, social care, and voluntary sector and community perspectives.

2.2 Since the inception of the National Dementia Strategy in 2009 policy has focussed on the following issues;

- Improve detection & diagnosis rates
- Dementia-friendly' communities
- Integrated health & social care
- Reduce acute hospital admissions
- Minimise sedative psychiatric medications
- Improve post-diagnostic support
- Better carer support

2.3 The Bradford Dementia Strategy and Action Plan 2015-20 was presented to Health and Social Care Overview and scrutiny in Autumn 2014 and was launched across the District at a launch event in June 2015.

2.4 The Dementia Strategy Group updated Health and Social Care Scrutiny in January 2017 on progress on the Local Strategy and Action Plan. The Committee noted the progress and asked for a further update on Post Diagnosis Support for People with Dementia and their Carers.

2.5 In November 2017 the Bradford Dementia Strategy and Action Plan 2015-20 was refreshed to focus local areas for action and align on-going working into The Well Pathway set out in the 2016 Challenge on Dementia 2020: implementation plan and used in the NHSE Transformation Framework. This has created a comprehensive action plan to focus the current and future work of the Dementia Strategy Group. See Appendix 1

3. REPORT ISSUES

3.1 Locally it is estimated that there are more than 5000 people aged over 65 with dementia in the District. Approximately 4000 of those people have a diagnosis with 1000 remaining undiagnosed. Local diagnostic rates in 2017 are over 80% across the district meaning they are the highest in the region, feeding demand for post-diagnostic services. These high rates have been maintained despite pressures on Primary Care and demonstrate the local commitment to supporting Dementia. In 2016-17 there were 1400 referrals for memory assessments with approximately 700 newly diagnosed people. The number of people with dementia is likely to rise to 6000 by 2020.

3.2 Bradford continues to have a focus on improving diagnosis rates in harder to reach groups: a Multi-Disciplinary Team has been set up between the BTHFT and BDCFT to support the diagnosis of Dementia in patients with complex neurological disorders (e.g. Parkinson's/ Multiple Sclerosis). The DiADeM tool to support diagnosing Dementia in the Care Home setting has also been developed by local clinicians and has now been adopted nationally. Other key issues that need to be considered are that national estimates indicate that 25% of hospital beds are taken up by people with dementia, 80% of residents in care homes are people with dementia however it is estimated that 66% of people with dementia still live at home.

3.3 Receiving a diagnosis of dementia can be a difficult and emotional time. It can be hard to come to terms with it and know what to do next. Some people might even feel a sense of relief from knowing what is wrong and what steps to take. Support after a diagnosis is very important. A diagnosis of dementia shouldn't stop people being in control of their lives or doing many of the things they enjoy. They should be supported to remain independent, active and engaged, and fully involved in making decisions and choices for themselves, for as long as they can.

3.4 Post diagnosis services range from general to highly specialised support. When a person needs a diagnosis they are referred to a memory clinic. There are 14 Memory Clinics per week in 14 different GP surgeries.

3.5 Four key elements of post-diagnostic support include:

1) **Dementia Adviser** (2 weeks after referral)

•Providing information about diagnosis & treatment, Carers Needs, Community Support, Local Services, Benefits & Legal Advice.

The Dementia Adviser service is an assigned worker service with the Dementia Advisers and Dementia Support Workers working together from diagnosis and throughout the dementia journey. This is run by the Alzheimer's Society and funded by both the Local Authority and the CCGs and also subsidised with voluntary income. Over 50% of people estimated to have dementia in Bradford District have had now had contact with the service based on electronic records which began in 2014. This is higher than the national average, 2016/2017 there were 663 new referrals to the service. With 16/17 demonstrating a plateauing in new diagnoses and the Alzheimer's society have seen increasing numbers of people already diagnosed coming back to the service either through self-referral or contact with their other teams in the District.

2) **Nurse review** (3 months after diagnosis)

•Physical Health, Social Needs, Practical Support, Medication, Other Mental Health Issues, Sign-posting, Onward Referral

3) **GP review** (every 12-15 months)

•Physical health, changes in memory, medication, advanced care planning, Community Matron support. People with Dementia from Bradford Face it Together group have helped design the advance care planning template with clinicians in Bradford and this is now being used as a base for a regional

template and is quoted as good practice in the National Care Planning guidance.

4) **Dementia Friendly** Communities / Businesses / Services
•GP surgeries, Mosques, Hospitals, WYMAS, BDMC

3.6 In addition to the post-diagnostic pathway of support above additional support is available. This includes:

1) **Social Support**:
   - Time Out (sitting service)
     - 1:1 individual sessions for person with dementia
   - Day Care
     - Social activities and engagement in local centres for older people
     - Young-onset pathways group for people of working age
   - Residential Respite
     - 24 hr care and support for 1-2 weeks at a time
   - Home Care
     - Practical Support with shopping, meal preparation, washing, dressing
   - Care Navigation Service
     - Facilitated sign-posting / access to range of community support Home Care/Day Centres/Sitting Service/Befriending/Memory Tree/Well-Being Cafes / Community & Voluntary Sector groups / Peer Support.
     - A key issue, particularly in regard to community based services is ensuring that there are culturally specific services. There are a number of these services in the District which include services such as Meri Yaadain and Sharing Voices, and Eastern European, South-Asian and African-Caribbean Well-Being Cafes.

2) Highly Specialised Support
   - Specialist Day Care
     - Woodward Court (Allerton), Holmewood Resource Centre (Keighley)
     - Community Hospitals
     - Westbourne Green, Westwood Park, St Luke's Hospital, Castleberg
   - Local Authority Respite & Assessment Units
     - Holmeview & Woodward Court (Bradford), Holmewood (Keighley), Thompson Court (Bingley), Currergate (Steeton)
   - Residential & Nursing Home Care
     - 'EMI' registered facilities
     - Care Home Liaison (Mental Health)
     - Complex Care Team / Community Matron Input
   - Mental Health Hospital Unit
     - Dementia Assessment Unit (Lynfield Mount Hospital)
     - Carers;

3) Community – Based Support
   - Well-Being Café Network
     - 20+ locally-based across the district, for both carers / family / people with dementia to attend. BAME Well-Being Cafés.(http://www.cnet.org.uk/_library/downloads/Well-Being_Cafes_2011_12.pdf)
   - Dementia Support Workers

        - Alzheimer's Society (Bradford, Airedale & Wharfedale), Making Space (Craven), Befriending, Sign-posting to other services, Practical & emotional support
    - Worth Connecting
        - IT project, Minimise social isolation through social networking
    - BAME support
        - Meri Yaadain (out-reach support), Sharing Voices (Bradford), Roshni Ghar (Keighley), Alzheimer's Society BME workers.

4) Carer focussed support

- Carers Resource
    - Carers Welfare Assessments, Sign-posting, Support Groups
- Carers Hub (BDCFT)
    - Sign-posting, Social activities and education
- Alzheimer's Society
    - Carers Education / Family Support Programmes including emotional support and practical support e.g. developing emergency plans
- Relate
    - Relationship counselling for carers / family members
- Care Navigation Service
    - Sign-posting / access to range of community support. Carers are a key source of support to people with dementia, but it is important that they have access to support.
- Rally-round
    - *Details to be added*
- Making Space
    - *Details to be added*
- Young Onset Pathway Group
    - *Details to be added*
- Memory Tree
    - Carers support groups around the District, with parallel activity groups for people with Dementia.

5) Physical and Psychological Support;

To live well with dementia it is important that both physical and psychological needs are addressed. To support this people with dementia can access services where appropriate from the District Nurse Service/ Community Matrons/ Case Managers/MH Physios /Dental Service /Dementia Lead Nurse (BRI) / Complex Care Team/Community Mental Health Teams / Occupational Therapy / Specialist Day Care / Acute Hospital Liaison/ Caring and Sharing (Relate Counselling sessions) and the Piccadilly Project.

6) Self Care

Self care information and guidance are provided by Dementia advisors and include a range of local and nationally developed resources such as carers support guides, living well guides, fact sheets and memory tips. Locally specific and national resources include:

- Local Dementia Self-Care Pack:
    - https://www.bradford.gov.uk/media/1774/dementiaselfcarepack.pdf

- Dementia Services Directories:
  - www.bdct.nhs.uk/support-for-carers
- DementiaCarer.Net
  - www.dementiacarer.net
- National Dementia Helpline:
  - Tel: 0300 222 1122
- Dementia Connect (Alz. Society)
  - https://www.alzheimers.org.uk/dementiaconnect

3.8 A key priority in the National Dementia Strategy is dying well with dementia. Although there isn't a specific end of life service for people with dementia, there is a District wide Palliative Care teams who provide people who have progressive illnesses with help and support throughout progression of their illness.

3.9 Post diagnosis support is a key priority within the Local Dementia Strategy and Action Plan. The vision for people with dementia and their families or carers is to be supported to find, contact and access appropriate, meaningful and local health, social, community and / or voluntary sector support. This needs to be done in an integrated way that ensures that providers of services and people with dementia and their families or carers are aware and can access the wide range of services available at crucial times. The Dementia Strategy Group will be working to ensure that there is that range of services available and continue to support best practice with the coming years with actions shown in Appendix 1.

3.10 The new National Implementation Guide for Dementia advises that all patient should receive a diagnosis and care plan within 6 weeks of referral and have a named care co-coordinator and care plan. An event was recently held in Bradford District & Craven (07/02/2018) bringing together partners from all the local stakeholders, providers and Carer organisations to look at how these challenges can be achieved using the assets we already have and to look for those gaps where investment may be required to ensure a comprehensive service. The outputs from this day will be used to develop an separate targeted action plan to take the work forward.

4. FINANCIAL & RESOURCE APPRAISAL

None

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

None

6. LEGAL APPRAISAL

None

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

None

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None

10. RECOMMENDATIONS

10.1 The Committee members are asked to comment on the update report.

10.2 That a further update report will be provided in 2019.

11. APPENDICES

Appendix 1: Refreshed Dementia Strategy Group Action Plan: November 2017

Preventing Well				
STRATEGIC ACTIONS	***DELIVERY ACTIONS (What needs to be done)***	***OUTPUT MEASURES (i.e. evidence it has been completed)***	***RESPONSIBLE PERSONS/ ORGANISATIONS***	***WHEN WILL IT BE COMPLETED***
Embed communications around reducing dementia risk into existing relevant health promotion, self-care and early intervention work.	• *Work with Self-Care team to embed dementia prevention into the offer* • *Ensure dementia prevention approaches are embedded into Commissioning and contracting processes through the Healthy Charter.*	• *All new contract and commissioned services are to be Dementia Friendly by benchmarked against the Equality and Diversity checklist by 2020* • *All services will consider the needs of patients and carers of people with dementia* • *Dementia added to Self-Care Programme*	• ***Mary Surr,*** • *Anna Smith* • *Sasha Baht*	*End 2020*
Ensure the public and professionals are aware of the link between cardiovascular risk factors, diabetes and	• *Working with Bradford Healthy Hearts and Bradford Beating Diabetes to improve patient and professional knowledge* • *Develop activity to improve professionals' knowledge of*	• *Embedded in BHH and BDD strategic and operational activity; represented in BHH/BDD literature* • *Organise/deliver educational events for health and social care*	• ***Andrew O'Shaughnessy*** • *Paul Smithson* • *Strategic Clinical Network*	*End 2018*

vascular dementia and are aware of how to use this knowledge to support risk reduction	*the signs and symptoms of Dementia* • *Embed Dementia Prevention into other campaigns for example the Healthy Charter* • *Have a coordinated and joined up approach to using both local and National campaigns and Awareness to develop awareness and support risk reduction*	*professionals* • *Embedded in Healthy Charter* • *Maintain profile and priority of Dementia Awareness Week and co-ordination with University initiatives*		
Have a life course approach to prevention including Care Homes and support for carers around isolation, loneliness, depression and anxiety	• *Availability of appropriate prevention for specific age ranges* • *Work with Self Care team to embed dementia prevention into the offer* • *Work with provider service and the CCGs to increase acceptability and accessibility of IAPT services*	• *Percentage of over 65s accessing IAPT services as measured by the CCG* • *Dementia added to Self-Care Programme* • *ASCOF Indicator 2A: Long-term support needs met by admission to residential and nursing care homes, per 100,000 population*	• ***Andrew O'Shaughnessy*** • *Paul Smithson* • *Sara Humphrey*	*End 2018*
Recognise the contribution of Isolation, Loneliness, Depression and	• *Work with CCGs to reduce loneliness and isolation and input into the Mental Health Strategy*	• *Dementia included in the Mental Health Strategy* • *JSNA MH chapter revised* • *Adult Social Care DMT*	• ***Mary Surr*** • *Sasha Baht* • *Sara Humphrey* • *Simon Baker*	*End 2017*

Anxiety to Dementia	• *Reflect the relationship between Dementia and Isolation in Joint Strategic Needs Assessment* • *Integrate with Adult Social Care loneliness agenda* • *More emphasis on isolation in Care Homes*	*briefed* • *PHOF Indicator 1.18 – Social Isolation* • *Workgroup with Care Homes established*		

Diagnosing Well

STRATEGIC ACTIONS	*DELIVERY ACTIONS (What needs to be done)*	*OUTPUT MEASURE (i.e. evidence it has been completed)*	*RESPONSIBLE PERSONS/ ORGANISATIONS*	*WHEN WILL IT BE COMPLETED*
Reduce inequalities between different demographic groups in diagnosis rates	• *Improve/ access intelligence and coding of the recording of ethnic groups in diagnosis recording data* • *Improve recording of people in Care Homes* • *Map diagnoses by postcode and compare diagnosis rates by age specific ward level data* • *Raise awareness groups known to have lower diagnosis rates* • *Quarterly Report on inequalities to be shared with DSG* • *Ensure when ethnicity data is recorded it is shared*	• *Increase percentage of patient with recorded ethnicity on the dementia register* • *Quarterly report presented at the DSG* • *Use of at risk Data Quality tool to provide a quarterly report of those at risk of Dementia in Bradford and Airedale* • *Lower number of outliers at 18 weeks* • *More people being assessed by six weeks*	• ***Andrew O'Shaughnessy*** • *Public Health Analyst Team* • *Strategic Clinical Network*	*End 2020*
Develop health and social care integrated diagnosis pathways to ensure systems and	• *Develop pathways for those not wishing to pursue a diagnosis* • *Develop pathways for those*	• *Better experience of Diagnosis* • *Less false positive* • *Shorter pathway to*	• ***Sasha Baht*** • *Sara Humphrey* • *Danielle Woods* • *Simon Baker*	*End 2018*

communication are effective and appropriately inclusive to all Communities in the Bradford District	*with additional needs such as learning difficulties or neurological conditions* • *Improve awareness of Dear GP and DIADEM* • *Raise awareness with Health Care Professionals of the importance of blood investigations as part of assessment for diagnosis* • *Develop a well-defined pathway for anyone to be accessible (with a map for how it will work)* • *Map and publicise all pathways including standard pathway*	*diagnosis* • *Increase number of patients having bloods taken as per QoF (NICE id code: NM72)*		
Maximise the use of data and intelligence to identify and predict those most at risk and improve the appropriateness of referrals by GP's	• *Develop data feedback between MATS false positive rates and GP referrals and use of specific screening tools* • *Develop at risk data quality took kit* • *Embed targets and measures into Bradford District Care Trust contracting* • *Develop quality measure into MATS contracting*	• *Improvement in quality measures* • *Increase number people to first assessment in required timeframe* • *Reduction of number people waiting over 18 weeks (reduce outliers)* • *Reductions in Did not attends (DNAs)* • *Reduction in number of people leaving memory*	• ***Sasha Baht*** • *Andrew O'Shaughnessy* • *Sara Humphrey*	*End 2018*

	process • *Embed partnership working between commissioners and clinical and social care providers to achieve assessment to treatment targets*	*service without a Dementia diagnosis or a MCI*		
Ensure everyone diagnosed receives personalised support, advice and information within three months of receiving a diagnosis	• *Mapping to care coordinators with consideration of need* • *Provide and promote an independent service that provides information and support for people effected by dementia through their journey or are worried about their memory* • *Maximise use of current assets* • *Map existing health and social care assets ant their capacity to deliver named coordinator role and look at capacity/needs gaps*	• *The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (as per QoF NICE id code: NM107)*	• ***Partnership approach to development through DSG***	*End 2020*
Improve awareness of signs, symptoms and benefits of diagnosis	• *Improve knowledge of early signs and symptoms of dementia* • *Develop support resources*	• *Proportion of diagnoses presenting in advanced stages of disease* • *Local diagnosis rates as per*	• ***Andrew O'Shaughnessy*** • *Paul Smithson* • *Strategic*	*End 2018*

for people with Dementia	*around the benefits of seeking support for memory problems and where appropriate seeing a diagnosis of dementia as positive*	*PHOF Indicator 4.16 - Estimated diagnosis rate for people with dementia*	*Network*	

Living and Supporting Well

STRATEGIC ACTIONS	*DELIVERY ACTIONS (What needs to be done)*	*OUTPUT MEASURE (i.e. evidence it has been completed)*	*RESPONSIBLE PERSONS/ ORGANISATIONS*	*WHEN WILL IT BE COMPLETED*
Enhance the Dementia Friendly offer in all providers and the community	• *Define Dementia Friendly provision and consider stepped provision rankings* • *Embed Dementia Friendly training across CCGs, LA and Provider Trust*	• *Output audit report of Dementia Friendly neighbourhoods and businesses* • *Numbers/proportion of CCG/LA/Provider staff in receipt of Dementia Friendly training*	• ***Paul Smithson*** • *Chris North* • *Danielle Woods*	*End 2018*
Develop audience and improved resources for communicating support offers	• *Develop a support pathway for carers* • *Develop a visualised map of support for people with dementia (tube map)* • *Develop activities to review/ reach out to those with an existing diagnosis* • *Develop support offer for rare and young onset dementias*	• *Carer Support Pathway signed off by commissioners/providers* • *Tube Map published* • *Number/proportion of existing dementia patients* • *Support offer for rare/early onset dementias implemented* • *The percentage of patients with dementia with the contact details of a named*	• ***Paul Smithson*** • *Sasha Baht* • *Chris North* • *Danielle Woods*	*End 2019*

		carer on their record as per QoF NICE id code: NM64 • *ASCFP Indicator 3D: The proportion of people who use services and carers who find it easy to find information about services*		
Improve personalisation of care plans through application of evidence based risk assessment tools and increased consideration of carer needs.	• *Maintain the current processes and activity for carers support* • *Recognise different types of carers and their needs to ensure support is suitable and accessible* • *Work with CCGs and Local Authority to refresh the Carers Strategy*	• *Percentage of adult carers who have as much social contact as they like* • *Percentage of carers accessing IAPT* • *Monitor delivery of START* • *Increase use of Caring & Sharing/Relate* • *NHSOF Indicator 2.4 Health-related quality of life for carers*	• ***Sasha Baht*** • *Sara Humphrey* • *Andrew O'Shaughnessy*	*End 2018*
Maximise Potential of Provider Trusts / Hospitals to reduce Morbidity / Mortality	• *Increase number of people with Care Plans in order to reduce unplanned need/demand/crises* • *Reduce length of stay in*	• *Reduced unplanned admissions* • *Reduced Length of Stay in Secondary Care* • *Reduced presentation in*	• ***Danielle Woods*** • *Chris North* • *Paul Smithson*	*End 2020*

and to help Maintain Home Based Care	*hospitals* • *Reduce presentation/admissions in crisis* • *Explore/expand influence of John's Campaign* • *Implementation of delirium care plans*	*crisis* • *Improved recognition and diagnosis of delirium* • *Reduced discharge to residential care* • *Increased discharge to home* • *ASCOF Indicator 2C: Delayed transfers of care from hospital, and those which are attributable to social care or jointly to social care and the NHS, per 100,000 population* • *PHOF Indicator 4.11 – Emergency readmissions within 30 days of discharge from hospital*		
Home First supporting people to live in the place of their choice	• *Deliver Home First Strategy by mapping and maximising community assets* • *Recognition of circumstances requiring new arrangements* • *Maximise availability of adaptations* • *Maximise Carers support* • *Expansion to/support of Dementia Friendly*	• *Number/proportion of people with dementia living at home* • *PHOF Indicator 4.13 – Health-related quality of life for older people* • *ASCOF Indicator 1A: Social care-related quality of life* • *ASCOF Indicator 1H: Proportion of adults in contact with secondary*	• ***Mary Surr*** • *Paul Smithson*	*End 2019*

	Communities • *Work with LA Housing* • *Work with Care Homes to reduce delirium*	*mental health services living independently, with or without support* • *ASCOF Indicator 2B: The proportion of older people (age 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* • *NHSOF Indicator 2.1 Proportion of people feeling supported to manage their condition* • *NHSOF Indicator 3.6.i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services*		
Dementia friendly communities	*Awareness training/education* - *Professionals* - *Society* - *Care homes* • *Grassroots development of dementia friendly awareness* • *Identification of gaps in localities/neighbourhoods*	• *Number of Dementia Friendly Communities, Dementia Friends, Digital Friends and Dementia Champions in the District*	• ***Paul Smithson*** • *Andrew O'Shaughnessy*	*End 2020*

User and Carer Voice implementing and shaping the commissioning process	• *Ensure the commissioning of high quality evidence based support for people affected by dementia providing personalised information support and advice to ensure people affected by dementia can live well.* • *Identify gaps in service and opportunities based on identified need including taking a community asset based approach.* • *Ensure that the Bradford Carers Strategy has strong connections and outcomes relating to the Bradford Dementia Strategy* • *Make sure as many communities across Bradford District as possible are dementia friendly in line with the national recognition standard. This will involve businesses, the health and social care sector (including care homes), local government, the voluntary sector, faith and*	• *Feedback is fed back into re commissioning process* • *People effected by dementia have a voice and impact and are empowered to influence activity in the district* • *ASCOF Indicator 1B: The proportion of people who use services who have control over their daily lives*	• ***Partnership approach to development through DSG***	*End 2020*

	community groups and others. • *Develop a series of Dementia Action Alliances across the District, ensuring that Dementia Friendly Communities and others are in receipt of evidenced learning and outcomes that can inform their practice.* • *Support the co-ordination and delivery of Dementia Friends sessions by volunteers across the Bradford District in order to ensure a better understanding of the issues that people with dementia face in their day to day lives.* • *Develop a network of user involvement groups to enable people affected by dementia shape and influence services and support they receive from providers and from within their communities* • *Use dementia friendly resources to support the*			

	development of dementia friendly communities. • *Identify assets within the community that we can build on and mobilise to improve support for people affected by dementia to live well in their chose tenure.*			

Dying Well

STRATEGIC ACTIONS	*DELIVERY ACTIONS (What needs to be done)*	*OUTPUT MEASURE (i.e. evidence it has been completed)*	*RESPONSIBLE PERSONS/ ORGANISATIONS*	*WHEN WILL IT BE COMPLETED*
Enhance and embed professionals' recognition and use of the Bradford Advanced Care Plan	• *Refresh local resources with view to national guidance* • *Dementia care plan must use softer language re meeting needs now and planning for EOL need*	• *Monitor use and uptake of BACP* • *Reflect EOLC in Dementia in Joint Strategic Needs Assessment* • *Hold BACP educational event for health and social care professionals*	• ***Andrew O'Shaughnessy*** • *Sara Humphrey* • *Mary Surr*	*End 2020*
Improve intelligence and data led feedback on implementation of activities defined in individual's Advanced Care Plans.	• *Develop data linkage between ACPs and place of death data and use to feedback and inform ACP development with relevant teams* • *Better coding of place of death and Death and how we communicate with partnership organisations* • *Better use of data to reduce distress*	• *% of patients where place of death is usual place of residence* • *Reduction in number/% of patients dying at transition* • *Number/% of patients with codes of death & place/time recorded in records*	• ***Andrew O'Shaughnessy*** • *Public Health Analyst Team*	*End 2018*
Improve knowledge of and awareness of	• *Develop knowledge and understanding of*	• *Hold BACP educational event for health and social*	• ***Andrew O'Shaughnessy***	*End 2018*

the last year of life and approaching last days of life	*emotional and faith based perspectives on death* • *Better use of available resources in the third sector within the last year of life* • *Understanding community resources around end of life care and coordinating this including skilling up third sector providers and commissioned carer provision skills* • *Increase use of Gold Standards Framework*	*care professionals* • *Monitor use of 3rd sector in EOLC* • *Reflect EOLC in Dementia in Joint Strategic Needs Assessment* • *NHSOF Indicator 4.6 Bereaved carers' views on the quality of care in the last 3 months of life*	• *Sara Humphrey* • *Mary Surr*	
Improve awareness and importance of end of life care planning with partners, patients and carers	• *Up skilling staff to have these conversations* • *Staff aware to include patients and families to have these conversations* •	• *Record in ACP and monitor specific conversations with patients and carers* • *Bereaved cares views on quality of care in last 3 months of life* • *NHSOF Indicator 4.6 Bereaved carers' views on the quality of care in the last 3 months of life*	• ***Andrew O'Shaughnessy*** • *Sara Humphrey* • *Mary Surr*	*End 2018*
Recognising transitions of care are an opportunity to	• *Improving awareness of this to providers* • *All new patients in care homes will have their plan*	• *Monitor % of transitions where care plan is reviewed*	• ***Andrew O'Shaughnessy*** • *Danielle Woods* • *Chris North*	*End 2018*

review care plans.	*reviewed*			
Improving access to Hospice care for people dying with dementia	• *Access to specialist palliative care* • *Establish a way of recognising people in the last year of life improve professionals' knowledge*	• *% of ACPs where it is noted that last year of life has been entered*	• ***Andrew O'Shaughnessy*** • *Sara Humphrey*	*End 2018*
Understanding the existing issues around end of life care for the frail elderly with dementia	• *Work with DSG to map what is available including third sector to support frail elderly people with dementia* • *Link to Home First Strategy* • *Develop tools for sharing stories with patients /carers*	*That mapping is completed and relevant actions taken forwards*	***Partnership approach to development through DSG***	*End 2018*

Appendix 2: Record of Dementia Strategy Group Member Achievements

Dementia - Reporting achievements to October 2016:V5

Please allocate the achievements below to the relevant Well Pathway Domain. Reminders for each of the domains are below; if you feel very strongly that your achievement fits into more than one of the five domains please rank them 1 being the strongest.

Preventing Well	Diagnosing Well	Living Well	Supporting Well	Dying Well
Risk of developing Dementia is minimised in Bradford's population	Timely ,accurate diagnosis,care plan and review in the first year	People with dementia and their carers have access to safe, high quality health and social care	People with dementia live normally, in safe and accepting communities in Bradford District	People living with dementia die with dignity in the place of their choosing
"I was given information about reducing my personal risk of getting Dementia'	*"I was diagnosed in a timely way"* *"I am able to make decisions and know what to do to help myself and who else can help"*	*"I am treated with dignity & respect"* *"I get treatment and support which are best for my dementia and my life"*	*"I know that those around me are looking after me are supported"* *"I feel included as part of society"*	*"I am confident my end of life wishes will be respected"* *"I can expect a good death"*
STANDARDS: Prevention Risk Reduction Health Information Supporting research	**STANDARDS:** Diagnosis Memory Assessment Concerns Discussed Investigation Providing Information Integrated & Advanced Care Planning	**STANDARDS:** Choice.BPSD Liaison.Advocates Housing Hospital Treatments Technology Health & Social Services Hard to Reach Groups	**STANDARDS:** Integrated Services Supporting Carers Carers Respite Co-ordinated Care Promote independance Relationships Leisure Safe Communities	**STANDARDS:** Palliative care and pain End of Life Preferred Place of Death

PROJECTS	Lead: (Contact /Organisation)	WELL PATHWAY DOMAIN				
		Preventing Well	Diagnosing Well	Supporting Well	Living Well	Dying Well
PARTNERSHIP PROJECTS						
• Improving Diagnosis Rates Working Group	Sara Humphrey, BC/BD CCGs		x			
Quarterly network meeting of all dementia friendly community leads being held to ensure best practice in developing dementia friendly local initiatives is share • Dementia Friendly Communities: o Bradford Royal Infirmary Hospital Wards o 20 Communities in Bradford District o DAA quarterly meetings being held and supported Wards/Localities in Bradford District o Schools in Bradford District (details of which needed) o Bradford Metropolitan District Council o Dementia Action Alliance (DAA) 91 members across district • Dementia Friendly GP practices (WMC,SHC,Cowgill,Saltaire,Idle MC,The Willows,T&D MC)	Danni Woods, BRI Bev Fletcher,Alz Soc Bev Fletcher,Alz Soc Cathy Henwood, Alz Soc Cathy Henwood, Alz Soc Cathy Henwood, Alz Soc Sara Humphrey & C.Henwood				x	
• Dementiacarers.net website	Sara Humphrey & Mick James, BC/BD CCGs				x	
• *"Join Dementia Research"* recruitment programme	Gregor Russell, BDCT	x				

• Delirium training & training resources for Care Homes	Chris North			x		
• DiaDem - protocol to support diagnosis of Advanced dementia in Care Homes	Sara Humphrey & the Dementia CN		x			
• Dementia End of Life Symptom Management on a Page	Sara Humphrey ,Annette Edwards and Dementia CN					x
• NHS England - Dementia in Care Homes training	Sara Humphrey	x	x	x	x	x
• Improving Access and Waiting Times to Memory clinics	Sara Humphrey/Chris North		x			
• Dementia Action Alliance, Bradford	Simon Baker & Paul Smithson, Alz Soc			x		
• PET scanning in memory clinics research study, in collaboration with Nuclear medicine department in Leeds- joint winner of the "Across the Pennines" service development award, from the DAA/SN	Gregor Russell, BDCFT		x			
• Working towards a dementia friendly organisation-ANHSFT	Em Snowdon ANHSFT				x	
• Working with carers Resource within clinical areas	Lynsey Nicholson ANHSFT/Saiuqa Raney, Carers' Resource			x		
All three locality offices of Carers' Resource (Shipley, Skipton and Harrogate) have received the Working Towards Dementia Friendly Award.	Saiuqa Raney, Carers' Resource			x	x	
Working in partnership with BDCFT attending 2 memory clinics per week to support carers (Shipley, Eccleshill)	Saiuqa Raney, Carers' Resource				x	
COMMUNITY PROJECTS:						
• Caring and Sharing - relationship counselling for people with dementia &/or their partners	Sara Humphrey & Gill Croft, Relate				x	

• Memory Bank - resource for reminiscence and life story work	Yorkshire Film Archive				x	
• Alcohol and Dementia-Lifeline Bradford	Faz Hafiz, Piccadilly Project			x		
• Walking Football – Lifeline Bradford	Faz Hafiz, Piccadilly Project				x	
• Herbert Protocol - roll out in Care Homes (details of which needed) - Addition to GP Care Planning templates (SOne)	SY Police / Bev Gallagher Sara Humphrey				x	
• Memory Clubs (Idle, Shipley, Keighley & Low Moor)	E.Milwain, Memory Tree CIC				x	
• Fire Service (need details....)					x	
• Dementia Friendly Swimming Group	Sharing Voices Ishtiaq Ahmed				x	
• Happy Memories, weekly singing group Undercliffe	Alzheimer's Society staff				x	
• Today group –monthly peer support group for people living with dementia	Alzheimer's Society Staff				x	
• Westcliffe Peer support group - monthly meeting	Alzheimer's Society staff				x	
• Coffee plus reminiscence group – monthly group for people living with dementia	Alzheimer's Society staff				x	
• Bradford Evening Social – monthly music evening for people with dementia and carers	Alzheimer's Society staff				x	
• Bradford Face it Together Group (FiT) Support and awareness raising and influencing group for people with a diagnosis of dementia , meeting monthly.	Bradford dementia friendly communities Project				x	

• 23 Memory cafes for vulnerable people over 55 including 4 specifically for people with Dementia.	Various community groups, Alzheimer's Society (Dementia cafes)				x	
• Pathways Breaks Group-Monthly support for Younger people living with Dementia and partner/carers. • Pathways Breaks Group - nominated for Queen's Award. Through to second stage. Successful awards due to be presented in June 2017.	Clare Mason and Chris Ireson				xx	
RESEARCH PROJECTS:						
• Bradford University / BDCT joint research projects – South Asian service user experience of Memory Assessment Services – BHiRCH project: preventing avoidable hospital admissions of people with dementia from care homes –	Jan O Murna Downs	x				
• Bradford & Airedale Research Group (BARG), BDCFT and Bradford Primary & Secondary Care	Sara Humphrey & John Hiley	x				
• Dementia Doctoral School, Bradford University	Murna Downs, Jan Oyebode	x				
• Vanguard.... (details needed)						
• Culturally competent adaptation of Addenbrooke's cognitive examination – development and evaluation	Chris north, Gregor Russell, Najma Siddiqi, BDCFT	x	x			
• 'Consent to Contact@ - research Register in Memory Assessment Clinic, BDCFT	Gregor Russell, BDCFT	x				
• Planned Joint Research Day with Dementia CN& Bradford University (Dec 7th 2016)	Murna Downs/Penny Kirk/Sara Humphrey	x				

• Vanguard work project	Rachel Binks ANHSFT					
•						
PRIMARY / SECONDARY CARE PROJECTS:						
• Advanced Care Planning for Dementia in Primary Care – documentation and System One template	Sara Humphrey, BC/BD CCGs					x
• Acute Hospital discharge planning and System One template	Sara Humphrey, Paula Woodrow			x		
• New electronic patient record , incorporating screening for dementia, delirium and depression introduced at BRI	Danni Woods, BRI			x		
• "What Makes a Difference"- Des and QOF resources, care planning templates, reports and FAQs	Sara Humphrey, BC/BD CCGs		3	1	2	
• Daisy Hill Dementia Assessment Unit – opened August 2015 - Gold Award received from Stirling University	Allison Bingham, BDCFT			x		
• John's campaign – a local CQUIN for 2016/17 at BTHFT and BDCFT (carers and family welcomed according to patient's needs)	Danni Woods, BRI Mick James, CCGs			1	2	3
• New liaison model in community hospitals, roll out and evaluation	Chris North, Gregor Russell, BDCFT			x		
• Diagnosis rates in Memory Assessment Clinics – Bradford now 2nd and 3rd highest in the region	Chris North, BDCFT		x			
• Learning Disabilities pathway for assessment & diagnosis • LD networking group	Jackie Armatage, BDCFT		x			
• KPPI Antipsychotics for GPs –System One template and yearly audit	Sara Humphrey, Rick Dawson			x		

• New dementia friendly acute ortho geriatric ward at BRI being built – this will include overnight beds for carers and a dedicated Carer's Room. Jan 2017 opening	Danni Woods, BRI			1	2	3
• Dementia intranet web page developed for staff Intranet at BRI	Danni Woods, BRI			1	2	3
• Dementia Champions in place at BRI, 5 at Marie Curie	Danni Woods, BRI			1	2	3
• Delirium recognition and prevention training, including bespoke training on the wards at BRI	Danni Woods, BRI			1	2	
• "Triple Screening Tool"- Development Implemented at Westbourne Green and Westwood Park Community Hospitals & now under evaluation	Gregor Russell, Chris North, Sara Humphrey		x	x		
• Dementia Quality Toolkit – to support the execution of a dementia coding exercise in primary Care	Sara Humphrey, Paula Woodrow, CN		x			
• Carer's Passport designed	Danni Woods, BRI, Chris North, BDCFT			x		
• Carer's bags – containing a blanket, toiletries, bed socks and ear plugs; designed for any carer who find themselves staying overnight	Danni Woods, BRI			1	2	3
• Carers training (pilot) - looking at health, communication, reducing stress, preparing for a hospital stay and managing different behaviours	Danni Woods, BRI			2	1	
• Review of the Pathway from Referral to Diagnosis in Memory clinics	Chris North & Sara Humphrey		x			
• Clinical Leads 'Top Tips In Dementia' developed for Primary Care	Sara Humphrey		x	x	x	x

• A level/BTEC student pilot project. Working with patients within community hospital settings, plans to roll out across trust. In partnership with 4 Bradford schools. Bingley G, Beckfoot, Laisterdyke, Carlton Bowling	Danni Woods, BRI			1	2	
• New electronic patient record , incorporating screening for dementia, delirium being rolled out -ANHSFT	Laura Jerwood ANHSFT			x		
• John's campaign being rolled out, this will include Carer's Passport -ANHSFT	Elaine Andrews and Lynsey Nicholson ANHSFT				x	
• Dementia intranet web page (Aireshare) being developed for access by staff -ANHSFT	Elaine Andrews ANHSFT			x		
• The Dignity Room provides provisions/clothes/toiletries etc. for patients and carers-we are progressing "carers bags" –a concept shared with us by Bradford Teaching Hospitals -ANHSFT	Elaine Andrews and Lynsey Nicholson ANHSFT			x		
• Focussed falls work is ongoing in collaboration with the Y&H Improvement Academy-our falls rates are reducing -ANHSFT	Elaine Andrews ANHSFT			x		
Dementia Champions at Carers' Resource	Saiuqa Raney, Carers' Resource				x	
TRAINING DEVELOPED / DELIVERED:						
• Dementia Awareness training for facilities staff at BRI	Danni Woods, BRI			1	2	3
• Dementia Champions training delivered to BRI and Marie Curie staff	Danni Woods, BRI			1	2	3
• Dementia mentoring in Primary Care	Gregor Russell		x	x	x	
• Training events on Care Planning and QOF for GPs, PNs and DNs	Sara Humphrey	x	x	x	x	

• Webinars on Care Planning developed and delivered	Sara Humphrey, CN		x	x	x	
• Webinar on 'The Implementation of John's Campaign at BTHFT' delivered for the Y&H CN	Danni Woods		x			
• Webinar on Assessment of Cardiac Status before Prescribing Acetyl Cholinesterase Inhibitors for Dementia	Sara Humphrey, George Crowther, CN		x			
• 'The Bradford Experience to Achieving 67% Prevalence Rates' webinar to Midlands and now available on Dementia CN Site	Sara Humphrey		x			
• Live well self-care course for people with course piloted in 2015 and schedules to run again October 2016	Bradford Alzheimer's Society Staff				x	
• 2 Live well (self-care for people with a diagnosis sessions)	Bradford Alzheimer's Society Staff				x	
• 3 Carers resource information sessions (CRISP) delivered.	Bradford Alzheimer's Society Staff				x	
• Dementia Friendly Practices and 'Meet the Psychiatrist Q&A' to 8 practices	Sara Humphrey& Gregor Russell		x	x	x	x
• Learning Disabilities & dementia training package for carers	Healthy Living group, Bradford People First			2	1	
Dementia friends sessions (reporting to October 2016) 6,728 dementia friends made • 143 Dementia Champions • 1,970 Digital Friends	Alzheimer's Society Staff				x	
• Dementia Awareness training for all staff together with bespoke training to targeted areas -ANHSFT	Em Snowdon ANHSFT			x		
• Fifteen of our staff attended an accredited course in the University of Bradford and those staff are now rolling out	Em Snowdon and Jane McSharry ANHSFT			x		

sessions regarding patient centred care and patients who live with dementia. -ANHSFT						
Dementia Friends training delivered to all staff at Carers' Resource, included as part of the Induction process for all new staff.	Saiuqa Raney, Carers' Resource				x	
AUDITS, UPDATES & PUBLICATIONS:						
• Dementia Health Needs Assessment and Strategy for Bradford	Andrew O'Shaughnessy, PH	x	x	x	x	x
• Review of Intermediate Care Services	Toni Williams, PH				x	
• Post Diagnostic Support - evidence review and framework	Andrew O'Shaughnessy, PH			x	x	
• Audit of Dementia in Bradford's Care Homes	Bunny McCullough, PH			x	x	
• Antipsychotic Audit 2015	Tracey Gaston, BC/BD CCGs				x	
• Patient and Carer Evaluation of GP Care Planning Template on System One	Alzheimers Soc/Sara Humphrey/Nicola Philis (Dementia CN)				x	
• BDCCG/BCCCG Formal Review of MATS and ACHL Services	Valerie Rhodes		x			
• 'What works well' BRI pilot site. Leeds Beckett and Bradford University	Dani woods, BRI Jan O, Bradford Uni	x				
• National Dementia Audit	Danni Woods, BRI	5	1	2	3	4
• Participated in the national Audit of Dementia-ANHSFT	Elaine Andrews/Lynsey Nicholson ANHSFT			x		
• Undertake Carers audits and submit an annual report to the AWC CCG -ANHSFT	Elaine Andrews/Lynsey Nicholson ANHSFT			x		

• Focussed falls work is ongoing in collaboration with the Y&H Improvement -ANHSFT Academy-our falls rates are reducing	Elaine Andrews ANHSFT				x	
EVENTS:						
• Living with Dementia Today and Tomorrow Event, Dementia Awareness Week	Danni Woods, BRI Chris North, BDCFT				x	
• Dementia Friendly events at 6 GP practices in Bradford	Sara Humphrey			x		
• Dementia Friendly Denholm event	Sara Humphrey& Marylyn Foster			x		
• 'Do Memory Problems Matter' Presentation to 'Rockwell Rocks-Older People Event	Sara Humphrey	1	2			
• 'How to get the most out of the NHS' Presentation to Alzheimer's Face it together Group	Sara Humphrey& Gregor Russell		1	2		
• Carers workshops , Carers support group	Danni Woods, BRI, Sarah Baker, Carers Resource			2	1	3
• Nominated award for BMA patient information award, delirium leaflet , 12th Sept, London	Danni Woods, BRI	1		3	2	
• Bradford Photo-booth challenge , 370 people across Bradford Met signed up to "Challenge Dementia"	Bradford Alzheimer's society staff				x	
• Living with Dementia -Dementia Awareness Week-ANHSFT	Elaine Andrews and Lynsey Nicholson ANHSFT				x	
• Working with Carers Resource -ANHSFT	Lynsey Nicholson ANHSFT and Carers Resource			x	x	

12. BACKGROUND DOCUMENTS

None