REPORT TO: **SOCIAL WORK AND HEALTH COMMITTEE - 7 DECEMBER 2009**

REPORT ON: **DUNDEE JOINT DEMENTIA STRATEGY AND COMMISSIONING FRAMEWORK 2010 - 2013**

REPORT BY: **DIRECTOR OF SOCIAL WORK**

REPORT NO: **585-2009**

1.0 PURPOSE OF REPORT

To recommend the approval of the Dundee Joint Dementia Strategy and Commissioning Framework 2010 - 2013.

2.0 RECOMMENDATIONS

It is recommended that the Social Work and Health Committee:

- Endorses the Dundee Joint Strategy and Commissioning Framework.
- Approves the service redesign and commissioning recommendations.

3.0 FINANCIAL IMPLICATIONS

The Joint Dundee Dementia Strategy includes a joint commissioning framework and sets out the remodelling and redesign of current services. The strategy recognises that there is a restricted financial framework at this time and as such a number of changes will be achieved within the current budget. The key financial pressures are detailed in the report.

4.0 MAIN TEXT

4.1 The Multi-agency Inspection of Older People's Services in Tayside (May 2006) identified a requirement for clear joint strategies for older people's services. The Dundee Older People's Strategy 2008 - 2011 (the strategy) was approved by the Social Work and Health Committee and the Community Health Partnership in August 2008. Included within the strategy were a number of actions for the progression of services for older people who have a mental illness, including the development of a strategy for people with dementia.

4.2 The Dundee Joint Dementia Strategic Planning Group includes within its membership a wide range of statutory, non statutory and carer representatives. Throughout the development of the strategy local knowledge was explored and the strategy was cross referenced to other local and national strategies. This ensured that the strategy not only complimented the work undertaken within other disciplines, but also ensured that the specific needs of people with dementia are clearly represented and addressed.

4.3 Two planning guidelines were used to direct the focus of the strategy. Firstly, the Scottish Intercollegiate Guidelines Network (SIGN 86 - Management of Patients with Dementia - a National Clinical Guideline) sets out the expectations for early identification and diagnosis of dementia and post diagnostic care and the strategy recognises further work is required to meet the best practice recommended. Secondly, the document "The Planning, Organisation and Delivery of Joined Up Services for Those with Dementia and Their Carers" (NHS HDL (2004) 44) defines the pathway for people with dementia as pre-diagnosis; diagnosis; post diagnosis; community services; continuing care and co-ordination and care management. Our

strategic promises reflect this pathway. In addition, the delivery of the promises will incorporate any agreed outcomes arising from the development of the Integrated Care Pathway for Dementia.

4.4 The strategy recognises that the consequences of living with dementia are similar regardless of the type of dementia or age of the person with dementia. In developing the strategy it was agreed that the focus of the strategy will be to ensure that people with dementia are offered opportunities to have a fulfilling life, realistic choices throughout the progression of their illness and fair access to services to meet their needs. The strategy therefore addresses the needs of people aged both under 65 years and over 65 years. It has direct relevance to people with organic dementia (Alzheimer's disease, vascular dementia and Lewy Bodies) and indirect relevance to other illness related dementia but who can have needs which will draw on the services to be provided.

5.0 THE STRATEGY

5.1 The strategy follows the structure set out within the Older People's Strategy, defining a set of local promises and a commissioning and redesign framework. An action plan is also included. The joint commissioning framework sets out the service model, the extent to which it will change over time and how the change will be resourced.

5.2 The strategic promises are as follows:

1 We will ensure that dementia services have a clear strategic identity and approach.
2 We will ensure that the professionals you come in contact with will have the knowledge and skills to help you identify and respond to changes in your memory.
3 You will have access to prompt diagnostic services and receive interventions which best meet your lifestyle and condition.
4 We will work with you and your family/friends to promote maintain and improve your health and wellbeing following your diagnosis.
5 You will receive the care and support you require in the setting most appropriate to your needs.
6 Should you require care away from your home we will strive to increase your choices, maximise your independence and keep you free from harm.
7 We will have an integrated approach to the support of individuals living with dementia.

6.0 COMMISIONING INTENTIONS

6.1 The strategy relates to people with dementia who are aged both over and under 65 years of age. The strategy will draw on resources within both adult and older people's services and discussions are ongoing to determine both the structure of services for individuals with dementia and the financial framework which will accompany this. This work overlaps with both the NHS Tayside Mental Health Strategy and the NHS Tayside Older People's Strategy. Until this work concludes, it is unlikely that additional or new funds will be available to support the local Dundee strategy.

6.2 The strategy reflects the current position of dementia services in Dundee and has assessed the relevant areas for development. Some of the development work, such as the commissioning of alternative housing with care overlaps with the Older People's strategy and will be funded as part of this commissioning work. The implementation of the SIGN guidelines and the Integrated Care Pathway for Dementia will be assessed and prioritised annually to ensure available funds are targeted for the greatest impact. Currently an early intervention support service

provided by Alzheimer Scotland is in danger of closing due to external funding difficulties. Securing funding for this service will be a priority over the next few months.

6.3 Our future commissioning intentions are to:

- Prioritise and resource the gaps arising from the implementation of the Integrated Care Pathway for Dementia. Costs to be determined.
- Prioritise and resource implementation of SIGN 86 guidelines. Costs to be determined.
- Maintain an outreach support worker service for early intervention. Cost £30,000.
- Increase the range and choice of psychosocial interventions. Costs to be determined.
- Commission 100 Housing with Care units by 2010-2011 (as detailed in the Older Peoples Strategy 2008 - 2011), some of which will include provision for people with dementia.
- Seek capital investment to deliver Psychiatry of Old Age In-patient and Day Hospital services and co-locate with the Department of Medicine for the Elderly. Costs to be determined.

6.4 In addition to the commissioning intentions, the Strategy will be supported by service redesign and remodelling. We will:

- Finalise and agree the Integrated Care Pathway for Dementia, identify gaps in current service provision and redesign service.
- Develop an open referral system to access diagnostic services.
- Review the role of the Dundee Memory Clinic.
- Review current service criteria and take appropriate action.
- Explore the options for providing a range of respite care for people with dementia and their families.
- Consider the option of a Short Breaks Bureau.
- Develop the range of supports for people with dementia across the city.
- Increase use of assistive technologies.
- Carry out service reviews.
- Introduce the Liverpool Care Pathway in relation to palliative care.
- Introduce robust system for transition of care between settings.
- Introduce the Long Term Conditions approach to case management.

7.0 CONSULTATION AND PUBLICATION

7.1 The draft strategy was widely consulted on and comments included in the final document. Consultation included people with dementia, carers, statutory and non-statutory bodies.

8.0 POLICY IMPLICATIONS

There are no major issues.

9.0 CONSULTATIONS

The Chief Executive, Depute Chief Executive (Support Services) and Director of Finance have been consulted in preparation of this report.

10.0 BACKGROUND PAPERS

None.

Alan G Baird
Director of Social Work

DATE: 19 November 2009

DUNDEE
JOINT DEMENTIA STRATEGY
AND
COMMISSIONING FRAMEWORK
20010 – 2013

Art Work created through the THAT Arts & Dementia Project held at Ward 19, Benvie House, Royal Dundee Liff Hospital

DUNDEE JOINT DEMENTIA STRATEGY
AND COMMISSIONING FRAMEWORK
2010 -2013

CONTENTS

INTRODUCTION

Dementia impacts on both the person with the illness and those who care for / support that individual. Dementia is a progressive, long-term condition with many challenges, gradually affecting memory, thinking and behaviour - it can eventually affect all aspects of everyday living. However, with access to appropriate information, treatment and support we believe it is possible for people to maintain their dignity and achieve a good quality of life.

Getting the right mix, quality and scale of services will not only meet the wishes and best interests of people with dementia but will also meet the national and local policy intention of rebalancing care between community and institutional services. These include social care, health care, housing and both acute hospital services and care home/NHS continuing care provision. Our strategy for people with dementia is based on a whole systems understanding of the inter-relationship between the services and support that people with dementia receive.

STRATEGIC DIRECTION

The Joint Commissioning Framework outlined in this strategy will help us to fulfil our strategic objectives for community care, which are to:

1 support, protect and improve health and promote wellbeing;
2 shift the balance of care across the whole system of health and social care;
3 provide access to a wide range of care and support;
4 prevent inappropriate admissions to hospital;
5 facilitate timely discharge from hospital; and
6 enable people to keep control over their own lives.

These strategic objectives link to the local and national outcomes which form the basis of our local Single Outcome Agreement.

RESOURCE FRAMEWORK

The costs of some of these services will be met through resource transfer from existing institutional services. Specifically, we will redesign in-patient services, reduce continuing care beds and reduce care home placements. We will redirect funding to increase intensive home care packages, respite services and accommodation with care.

We will continue to work closely with our voluntary service providers to develop a range of service options by accessing a wide range of funding streams. We will provide business cases for the future development of dementia services and seek to redesign current provided and commissioned services to make best use of the available resources. More generally health and social care resources for people with dementia are aligned and financial performance is jointly monitored.

DEVELOPING THE STRATEGY

The Dundee Joint Dementia Strategic Planning Group includes within its membership a wide range of statutory, non statutory and carer representatives. Throughout the development of the strategy we have drawn on local knowledge to inform our understanding of what works well and what does not. We have looked at the work undertaken by other agencies working with people living with dementia and drawn on their strategic approaches. We have sought out good practice examples and will incorporate these into our service development. Throughout the strategy development we have cross referenced our work to other local and national strategies to ensure that the strategy not only complements the work undertaken within other disciplines, but also to ensure that the specific needs of people with dementia are clearly represented and addressed.

Specifically, we have endorsed and agreed to prioritise the adoption of the best practice outlined in the Scottish Intercollegiate Guidelines Network (SIGN 86 - Management of Patients with Dementia - a National Clinical Guideline). The guideline sets out the expectations for early identification and diagnosis of dementia and post diagnostic care. In addition, the delivery of the promises will incorporate any agreed outcomes arising from the development of the Integrated Care Pathway for Dementia.

The Scottish Government's publications related to dementia care have set out a framework for the assessment of dementia services. We have followed the template within the document "The Planning, Organisation and Delivery of Joined Up Services for Those with Dementia and Their Carers" (NHS HDL (2004) 44) to develop our strategy. This document defines the pathway for people with dementia as pre-diagnosis; diagnosis; post diagnosis; community services; continuing care and co-ordination and care management. Our strategic promises reflect this pathway.

THE SCOPE OF OUR STRATEGY

The strategy recognises that the consequences of living with dementia are similar regardless of the type of dementia or age of the person. In developing the strategy it was agreed that its focus will be to ensure that people with dementia are offered opportunities to have a fulfilling life, realistic choices throughout the progression of their illness and fair access to services to meet their needs. The strategy therefore addresses the needs of people aged both under 65 years and over 65 years, while acknowledging that at an individual level interests and impact can differ greatly according to age. It has direct relevance to people with “organic” dementia (Alzheimer's disease, vascular dementia and dementia with Lewy Bodies) and indirect relevance to other people with illness related dementia(s), for example adults with a learning disability, but who can have needs which will draw on the services to be provided.

OUR STRATEGIC PROMISES

1 We will ensure that dementia services have a clear strategic identity and approach.

2 We will ensure that the professionals you come in contact with will have the knowledge and skills to help you identify and respond to changes in your memory.

3 You will have access to prompt diagnostic services and receive interventions which best meet your lifestyle and condition.

4 We will work with you and your family/friends to promote, maintain and improve your health and wellbeing following your diagnosis.

5 You will receive the care and support you require in the setting most appropriate to your needs.

6 Should you require care away from your home we will strive to increase your choices, maximise your independence and keep you free from harm.

7 We will have an integrated approach to the support of individuals living with dementia.

OUR OVERALL AIM

People with dementia and their carers' needs can be met by a number of complementary local strategies. To ensure that people with dementia and their carers have their needs recognised and supported we will work with all relevant professionals across the various strategies to ensure that the Dundee Joint Dementia Strategy not only reflects these other relevant priorities but also provides a specific focus on dementia. A partnership approach will ensure that assessment, planning and delivery of services will engage with people with dementia and/or their carers to contribute their individual needs, views and wishes to develop the support they require.

Our Strategic Promise 1

We will ensure that dementia services have a clear strategic identity and approach.

To achieve this we will:

1. link to other strategies;
2. adopt a palliative approach;
3. adopt the best practice as outlined in the Scottish Intercollegiate Guidelines Network (SIGN 86 – 'Management of Patients with Dementia – a national clinical guideline');
4. develop services based on the defined Integrated Care Pathway for Dementia and align service development on this;
5. work to evidence based practice;
6. asses all actions within the strategy to ensure issues relating to equality and diversity are taken into account; and
7. ensure you have the opportunity to contribute to the evaluation and development of future strategic and operational service development.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Cross reference and align this strategy with the Dundee Older Peoples Strategy; the Tayside Older Peoples Strategy; the Adult Mental Health Strategy; the Dundee Carers Strategy; Associated Specialists Strategies - College of Physiotherapists, Occupational Therapy Strategy; Palliative Care Strategy; Living and Dying Well Action Plan; Psychological Therapies Strategy; the Dundee Long Term Conditions Strategy and the Tayside -wide HEAT Target Action Plan.
- Identify gaps in current service provision.
- Audit and evaluate current practice against SIGN 86 guidelines.
- Prioritise the implementation of the relevant SIGN 86 guidelines within the current resource and financial framework.

- Finalise and agree the Integrated Care Pathway for Dementia and adopt the outcomes.
- Publish and distribute information explaining the Integrated Care Pathway for Dementia.
- Identify gaps between current service provision and the agreed pathway.
- Develop an action plan to resource and meet identified gaps in service provision.
- Contribute to the work of the Dementia Managed Care Network and use information and research undertaken to inform good practice and innovation.
- Audit one dementia specialist service per year against best practice and amend and improve the service accordingly.
- Include an impact assessment within all new developments and service reviews.
- Access existing networks to consult on future service developments.

PRE-DIAGNOSIS SERVICES

The aims of a pre-diagnosis service are to ensure that dementia is understood as an illness and to recognise that mild cognitive impairment does not necessarily lead to dementia. In addition it should enable individuals to recognise the possible significance of symptoms they may be experiencing. This can be achieved both at a public awareness level and at a clinical level through awareness raising, education and formal assessment.

Our Strategic Promise 2

We will ensure that the professionals you come in contact with have the knowledge and skills to help you identify and respond to changes in your memory.

To achieve this we will:

1. increase general awareness and understanding of dementia;
2. provide a focus on both illness prevention and health promotion;
3. improve early detection of dementia and support of people during this period; and
4. improve the availability of local information.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Develop a strategy to raise awareness of dementia as an illness and reduce stigma among the relevant stakeholders, including members of the public.
- Implement an action plan arising from the awareness raising strategy and identify the cost implications.
- Develop a public health initiative which promotes risk reduction and which includes smoking, alcohol, physical and mental exercise, diabetes and the maintenance of social networks.
- Increase awareness of current health promotion activity and how this might impact on people with dementia (OPEN project/Health Improvement Initiative).
- Develop a protocol for Primary Care which includes primary care liaison.
- Develop an open referral system to access diagnostic services.
- Provide individuals, at the earliest opportunity, with appropriate information about the process of diagnosis.
- Map the current information available and highlight gaps.
- Publish and distribute the criteria and information for services involved in the diagnosis of dementia.

DIAGNOSIS

Many of us experience memory loss and this can be both frustrating and alarming. For individuals whose lives are affected by memory loss it is essential to know if symptoms are caused by a form of dementia and to seek an appropriate medical response. This will not only confirm the diagnosis but identify the type of dementia. Access to comprehensive diagnostic services, including neuropsychology, is essential to ensure that appropriate advice and availability of local services and support is given to individuals and their carers at an early opportunity.

Our Strategic Promise 3

You will have access to prompt diagnostic services and receive interventions which best meet your lifestyle and condition.

To achieve this we will:

1. encourage equitable access according to need to specialist diagnostic and support services;
2. streamline current diagnostic services and reduce the waiting time for diagnosis;
3. have a wide range of appropriate information available; and
4. work with you and your family/friends to improve health care at the time of diagnosis.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Implement the Fair Access to Care Criteria.
- Develop a 'flag' system for those discharged and/or declining services following diagnosis.
- Review the role of the Dundee Memory Clinic.
- Ensure that as part of the diagnostic process both your cognitive and functional needs are assessed;
- Work with General Practice to agree a process of diagnosis of dementia within primary care settings.
- Explore the development of diagnostic services for people in Acute Hospitals.
- Explore the development of diagnostic services for people in Care Homes.
- Develop a prioritised action plan for the future delivery of diagnostic services.
- Where appropriate, provide a copy of ‘Facing Dementia’ timeously for people who have a diagnosis of dementia.
- Signpost carers to all relevant voluntary and statutory carers support.
- Provide contact numbers for follow up support.

POST-DIAGNOSIS SUPPORT

At the early stages of diagnosis, information and advice will enable the individual and their wider family to put in place a support system which can adjust to the changing needs arising at a level and pace which best meets the needs. Post diagnostic support should enable the person to plan for the future, maintain independence and live with their illness. Every effort will be made to take account of the individual's wishes and personal choices. Where this is no longer achievable, then the appropriate legislation will be applied to ensure that their rights are maintained.

Our Strategic Promise 4

We will work with you and your family/friends to promote, maintain and improve your health and wellbeing following your diagnosis.

To achieve this we will:

1. provide you and your family/friends with person-centred post diagnostic support;
2. build on current early dementia support services;
3. provide you with support to promote your health and wellbeing;
4. ensure your family and friends are supported and involved; and
5. increase the availability of non-pharmacological interventions for dementia using the best available evidence.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Training for staff delivering post diagnostic care to be implemented.
- Review the criteria for services to ensure a diagnosis of dementia, at any age, is not inappropriately used as a barrier to community services or acute hospital services.
- Evaluate the Alzheimer Scotland outreach support service for early intervention and implement recommendations.
- Further develop a long term conditions strategy for people with dementia in line with the North East Seize the Day Alzheimer project.
- Expand the number of individuals with personalised care and support plans which offer opportunities for social interaction, peer support and skill development/maintenance.
- Review the current information available and identify gaps both locally and nationally.
- Signpost the wide range of Alzheimer Scotland information available and ensure access to local information relating to income maximisation and other services is provided.

- Raise awareness of the Alzheimer Scotland ‘Drop in Café’ through the development of information posters and leaflets for professionals and the public.
- Provide opportunities for family/friends affected by dementia to have access to appropriate information, education, support and opportunities to do things together.
- Increase awareness of support services such as advocacy, citizen’s advice and legal support.
- Provide a range and choice of psychosocial interventions which are evidence based and relationship-centred, for example post diagnostic counselling.

COMMUNITY SERVICES

People with dementia should be supported to maintain a normal life, sustaining family and community relationships. This support should be provided in their own home for as long as they wish and is possible. Access to a full range of support services will be provided as and when needed and these services should be tailored to meet the preferences and life choices of the individual. To ensure that informed choice is given, information will be available and professionals will be knowledgeable about the ranges of options available.

Our Strategic Promise 5

You will receive the care and support you require in the setting most appropriate to your needs.

To achieve this we will:

1. provide education for all staff and carers supporting people with dementia;
2. revise criteria for services to ensure equitable access for people with dementia;
3. develop and increase the range and level of community care services aimed at supporting people with dementia and their carers;
4. ensure that information technology is effectively used to support people with dementia and their carers without being intrusive;
5. develop and extend accommodation options which offer alternatives to care home placement;
6. provide appropriate services to people with dementia and their carers at the right time for them to meet their needs;
7. improve the availability of palliative and end of life care services within the community; and
8. improve the standards of community care services and those commissioned or provided by partner agencies.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Collate the information on training which is currently available to staff and carers.
- Develop a learning/training pack which is appropriate to a wide range of staff and carers.
- Ensure that all learning/training opportunities have a personalisation theme running throughout.
- Review the criteria for community services including those which exclude people with dementia.

- Collate or, where required, develop a range of informative information/fact sheets which signpost people to the range of services and supports both at a local and national level.
- Continue to provide Care at Home Services to people with dementia and their carers and review and increase as demands rise.
- Explore the options of providing a range of respite care resources for people with dementia and their carers including the development of a short breaks bureau.
- Develop the range of day supports for people with dementia across the City.
- Monitor the number of people utilising direct payments and seek means to increase this number.
- Ensure that there are sufficient numbers of staff knowledgeable about the range of assistive technologies available and their application and use and the assessment of risk.
- Explore the options to adapt existing housing and/or develop a new housing with care resource specifically designed to support people with dementia and their carers.
- Capture demographic information and analyse to predict future demands.
- Monitor unmet need and waiting times for services.
- Actively seek the views of people who use community services and evaluate their effectiveness.
- Learn from examples of good practice in other areas both locally and nationally.
- Promote and provide palliative care and end of life education for staff providing care to those with dementia who are living in the community.
- Review the current community service provision via an annual review of service level agreements which will include stakeholder consultation and service user involvement.

CARE IN OTHER SETTINGS

There will be occasions where people with dementia can no longer be cared for within their own home. When this occurs, support will be given to ensure that the ongoing care is provided within the most appropriate setting, be this hospital or care home. We will continue to recognise the important role that carers play and opportunities will be given to enable the continuation of a caring relationship. The quality of care provided is of utmost importance, particularly at the end of life and we will work closely with the care commission and through individual review to ensure this is maintained.

Our Strategic Promise 6

Should you require care away from your home we will strive to increase your choices, maximise your independence and keep you free from harm.

To achieve this we will:

1. increase staff awareness through the provision of education and support for multidisciplinary colleagues in the recognition and behavioural management of people with dementia in care settings;
2. maintain an ongoing program of educational support for professionals caring for people with dementia;
3. ensure packages of care are developed and delivered through direct involvement with carers and the person with dementia;
4. ensure packages of care meet the holistic needs of the individual and carers based on both local and national standards;
5. improve palliative and end of life care for people with dementia;
6. improve communication between formal and informal carers of people with dementia; and
7. ensure the transition of care between various settings is planned and well documented, as well as safe and appropriate.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Provide awareness sessions for multi-disciplinary and multi-agency colleagues within all settings.
- Promote existing recognised and evaluated courses.
- Include dementia in health promotion events in partnership with statutory and non-statutory organisations.
- Liaise with universities and educational providers to raise awareness and influence education.
- Develop educational programmes in partnership with stakeholders, people with dementia and their carers.

- Through multi-disciplinary and multi-agency team meetings/working and involving the carers plus the person with dementia; assess, plan and implement care and evaluate the person's pathway.
- Use information gathering tools, e.g. "Getting To Know You" document.
- Provide easy access to information for staff, the person with dementia and carers regarding: systems, strategies, services, conditions and assistance.
- Work with care home managers and pharmacists to implement the medication recommendations from the 'Remember I'm Still Me' report.
- Promote and provide palliative and end of life care education for staff delivering care to those with dementia.
- Introduce/roll out the use of the Liverpool Care Pathway across all settings.
- Introduce advance(d) statements and care planning.
- Assist in the implementation of the Gold Standards Framework within community based settings.
- Agree communication strategies and expectations between various settings.
- Introduce co-located in-patient hospital services between Psychiatry of Old Age and the Department of Medicine for the Elderly.
- Develop and introduce information packs.
- Develop and introduce a robust system for transition of care between settings.

CO-ORDINATION AND CASE MANAGEMENT

Services provided will be based on individual need, flexibly delivered to take account of changing requirements. A partnership approach will be taken to assessment, monitoring and review, to ensure that people with dementia have their needs assessed and that they receive the services delivered seamlessly regardless of provider. We will make our decision making processes clear and transparent and publish our criteria for services. We will recognise that carers have needs also and a carer's assessment will be offered to all carers. Wherever possible there will be a named worker for each individual with dementia or, where this is not desired, contact routes will be given.

Our Strategic Promise 7

We will have an integrated approach to the support of individuals living with dementia.

To achieve this we will:

1. work within a legal framework with joint clear guidance and procedures;
2. ensure transitions between workers, team and setting will be planned discussed, understood and agreed;
3. develop open access and referral routes for dementia assessment and support services;
4. arrange that risks will be assessed and managed to ensure that your independence is maximised without undue concerns being raised for your safety:
5. have a system of review which ensures the proper level of care and support is provided in response to changing and increased need; and
6. adopt the long-term conditions approach to case management.

What actions are planned?

To address our strategic promises we have agreed the following actions:

- Develop a training programme around mental health legislation including: Adults with Incapacity, Mental Health (Care and Treatment), Adult Support and Protection, Community Care and Carers legislation.
- Review current practices and define local transition process and protocols.
- Define and review good practice during admission and discharge in care settings.
- Develop targeted training for staff at the first point of contact with people showing signs of dementia.
- Evaluate, amend and extend as appropriate the open referral routes into the Community Mental Health Teams (for Older People).

- Develop training/awareness raising for staff around changing needs and risk management.
- Develop agreed multi-agency risk assessment tools and guidance for people with dementia.
- Assess current review systems for people with dementia.
- Support people with dementia to develop their own person centred plans which will support them to continue or start to engage in a range of chosen activities.
- Ensure that people with dementia and their carers are supported to access services at the right time for them.
- Identify and evaluate how the Long Term Conditions case management approach can be effectively used when working with people with dementia and their carers.
- Involve people with dementia in the evaluation of the case management model.

COMMISIONING INTENTIONS

This improvement work will be achieved through a combination of service redesign and remodelling and by commissioning additional services.

Our future commissioning intentions are to:

- Prioritise and resource the gaps identified by the implementation of the Integrated Care Pathway for Dementia.
- Prioritise and resource implementation of SIGN 86 guidelines.
- Maintain an outreach support worker service for early intervention.
- Increase the range and choice of psychosocial interventions.
- Commission 100 Housing with Care units by 2010-2011 (as detailed in the Older Peoples Strategy 2008 - 2011), some of which will include provision for people with dementia.
- Seek capital investment to deliver Psychiatry of Old Age In-patient and Day Hospital services and co-locate with the Department of Medicine for the Elderly;

SERVICE REDESIGN AND REMODELLING

In addition to the commissioning intentions, the Strategy will be supported by service redesign and remodelling. We will:

- Finalise and agree the Integrated Care Pathway for Dementia, identify gaps in current service provision and redesign service.
- Develop an open referral system to access diagnostic services.
- Review the role of the Dundee Memory Clinic.
- Review current service criteria and take appropriate action.
- Explore the options for providing a range of respite care for people with dementia and their families.
- Consider the option of a Short Breaks Bureau.
- Develop the range of supports for people with dementia across the city.
- Increase use of assistive technologies.
- Carry out service reviews.
- Introduce the Liverpool Care Pathway in relation to palliative care.
- Introduce robust system for transition of care between settings.
- Introduce the Long Term Conditions approach to case management.

FINANCIAL FRAMEWORK

The budget which applied to this commissioning strategy is detailed in the Joint Commissioning Financial Framework (to be included in final strategy). The budget reflects the known available finances at the time of the completion of the plan. Where commissioning or service redesign costs are known, the resulting budget is shown. Where developments are yet to be costed, these are not included but will be detailed in subsequent reviews of the strategy. All other developments will be achieved within the allocated baseline budget for older people within Social Work, Housing and Health services.

MONITORING AND REPORTING FRAMEWORK

The Dundee Joint Dementia Strategy and Commissioning Framework are supported by a detailed action plan, which includes details of the actions to be taken with timescales.

The Dundee Joint Strategic Planning and Implementation Group is responsible for ensuring the actions are progressed and the group reports on progress to the Dundee Health and Local Authority Management Group (HALAMG).

DUNDEE DEMENTIA JOINT COMMISSIONING FRAMEWORK

Overall Aim - Promise 1: We will ensure that dementia services have a clear strategic identity and approach.

ACTIVITY	ACTION	TIMESCALE	EXPENDITURE	LEAD OFFICER
1.1 We will link to other strategies.	Cross reference and align the strategy with the: • Older Peoples Strategy Dundee • Older Peoples Strategy Tayside • Adult Mental Health Strategy • Carers Strategy • Associated Specialists Strategy e.g. College of Physiotherapist, Occupational Therapy Strategy. • Tayside Palliative Care Strategy • Psychological Therapies Strategy • Dundee Long Term Conditions Strategy • Tayside HEAT Action Plan.	From commencement of plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.
1.2 We will adopt a palliative approach.	Identify gaps in the current services provision.	Dec 2010	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.
1.3 We will adopt best practice as outlined in SIGN 86.	Audit and evaluate current practice against SIGN 86 guidelines. Prioritise the implementation of the relevant SIGN guidelines within the current resource and financial framework.	Dec 2010	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.

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1.4 We will develop services based on the defined ICP for dementia and align service development.	Finalise and agree Integrated Care Pathway for Dementia and adopt the outcomes. Publish and distribute information explaining the Integrated Care Pathway for Dementia. Identify gaps between current service provision and the agreed pathway. Develop an action plan to resource and meet identified gaps in service provision.	Dec 2010	Costs to be determined	ICP Working Group. Dundee Dementia Forum
1.5 We will work to evidence based practice.	Contribute to the work of the Dementia Managed Care Network and use information and research undertaken to inform good practice and innovation. Audit one specialist service per year and amend and improve service accordingly.	From commencement of plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.
1.6 We will assess all actions within the strategy to ensure issues relating to equality and diversity are taken into account.	Include an impact assessment within all new developments and service reviews.	From commencement of plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.
1.7 We will ensure you have the opportunity to contribute to the evaluation and development of future strategic and operational service development.	Access existing networks to consult on future service developments.	From commencement of plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.

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Pre Diagnosis - Promise 2: We will ensure that the professionals you come in contact with have the knowledge and skills to help you identify and respond to changes in your memory.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
2.1 We will increase general awareness and understanding of dementia.	Develop a strategy to raise awareness and reduce stigma among stakeholders and the public. Implement an awareness raising action plan arising from strategy. Tayside Awareness Raising Group to identify cost implications.	Dec 2011	Within budget	Tayside Awareness Raising Group.
2.2 We will provide a focus on both illness prevention and health promotion.	Develop a public health initiative which promotes risk reduction (smoking, alcohol, physical and mental exercise, diabetes, and the maintenance of social networks). Increase awareness of current public health activity.	From commencement of the plan	Within budget	Public Health.
2.3 We will improve early detection of dementia and support people during this period.	Develop a protocol for Primary Care including primary care liaison. Develop an open referral system to access diagnostic services.	Dec 2011	Within budget	Psychiatry of Old Age Community Services Manager.
2.4 We will improve the availability of local information.	Map current information available & highlight gaps. Publish and distribute criteria and information for services involved in the diagnosis of dementia. Provide individuals, at the earliest opportunity, with appropriate information about the process of diagnosis.	Dec 2010	Within budget	Psychiatry of Old Age Community Services Manager.

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Diagnosis - Promise 3: You will have access to prompt diagnostic services & receive interventions which best meet your lifestyle & condition.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
3.1 We will encourage equitable access according to need.	Implement the Fair Access to Care Criteria. Develop a 'flag' system for those discharged and/or declining services following diagnosis.	Dec 2011	Within budget	Psychiatry of Old Age Community Services Manager.
3.2 We will streamline current diagnostic services and reduce waiting times for diagnosis.	Review the role of the Dundee Memory Clinic. Ensure both cognitive and functional needs are assessed. Work with General Practice to agree a process of diagnosis of dementia within primary care settings. Explore the development of diagnostic services for people in Acute Hospitals. Explore the development of diagnostic services for people in Care Homes. Develop a prioritised action plan for future development delivery of diagnostic services.	Dec 2011	Additional budget to be identified	Service Manager, Older People's Service, Dundee CHP.
3.3 We will have a wide range of appropriate information available.	Where appropriate, provide a copy of 'Facing Dementia' timeously for people who have a diagnosis of dementia.	Ongoing	Within budget	Managed Care Network for Dementia.

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3.4 We work with you and your family/friends to improve health care at the time of diagnosis.	Signpost carers to all relevant voluntary and statutory support. Provide contact numbers for follow up support.	Dec 2010	Within budget	Psychiatry of Old Age Community Services Manager.

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Post Diagnosis - Promise 4: We will work with you & your family/friends to promote, maintain & improve your health and wellbeing following your diagnosis.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
4.1 We will provide you and your family/friends with person centred post diagnostic support.	Training for staff delivering post diagnostic care to be implemented: CMHTOP health staff Alzheimer Scotland Social Work Staff Acute Care. Review the criteria for services to ensure a diagnosis of dementia at any age, is not inappropriately used as a barrier to community services: social care services, rehabilitation. Review the criteria for services to ensure a diagnosis of dementia at any age, is not inappropriately used as a barrier to acute hospital services i.e. rehabilitation.	Dec 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.
4.2 We will build on current early dementia support services.	Evaluate the Alzheimer Scotland outreach support service for early intervention and implement recommendations. Further develop a long term conditions strategy for people with dementia in line with the North East Seize the Day Alzheimer project.	April 2011	£30,000	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP. Service Manager, Alzheimer Scotland.
4.3 We will provide you with support to promote your health and wellbeing.	Expand the number of individuals with personalised care and support plans which offer opportunities for social interaction, peer support and skill development/maintenance. Review the current information available and identify gaps both locally and nationally. Signpost the wide range of Alzheimer Scotland information available.	April 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work. Service Manager, Older People's Service, Dundee CHP.

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	Ensure access to local information relating to income maximisation and other services. Raise awareness of the Alzheimer Scotland 'Drop in Café' through the development of information posters and leaflets for professionals and the public.			Service Manager, Alzheimer Scotland.
4.4 We will ensure your family and friends are supported and involved.	Provide opportunities for family/friends affected by dementia to have access to appropriate information, education, support and opportunities to do things together. Increase awareness of support services such as advocacy, citizen's advice and legal support.	Ongoing	Within budget	Psychiatry of Old Age Community Services Manager. Team Manager, Social Work. Service Manager, Alzheimer Scotland.
4.5 We will increase the availability of non-pharmacological interventions for dementia using the best available evidence.	Provide a range and choice of psychosocial interventions which are evidence based where possible & relationship-centred.	Dec 2011	Costs to be determined	Psychiatry of Old Age Community Services Manager. Head of Clinical Psychology

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Community Services - Promise 5: You will receive the care and support you require in the setting most appropriate to your needs.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
5.1 We will provide education for staff and carers.	Collate information on training currently available to staff and carers. Develop a learning/training pack appropriate to a wide range of staff and carers. Ensure that all learning/training opportunities have a personalisation theme running throughout it.	Dec 2010	Costing to be identified	Service Manager, Older People's Service, Dundee Social Work.
5.2 We will revise criteria for services to ensure equitable access.	Review criteria for community services including those which exclude people with dementia. Collate or where required develop a range of informative information/fact sheets which signpost people to the range of services and supports both at a local level and national.	April 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work.
5.3 We will develop and increase the range and level of community care services aimed at supporting people with dementia and their carers.	Continue to provide Care at Home Services to people with dementia and their carers and review and increase as demands rise. Explore the options of providing a range of respite care resources for people with dementia and their carers. Consider the option of supporting a Short Breaks Bureau. Develop the range of day supports for people with dementia across the City. Monitor the number of people utilising Direct payments and seek to increase the number.	Dec 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work.

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5.4 We will ensure that information technology is effectively used to support people with dementia and their carers without being intrusive.	Ensure that there are sufficient numbers of staff knowledgeable about the range of assistive technologies available and their application and use. Ensure that risk assessments are carried out as part of the use of assistive technologies.	Dec 2010	Within budget	Service Manager, Older People's Service, Dundee Social Work.
5.5 We will develop and extend accommodation options which offer alternatives to care home placement.	Develop and adapt existing accommodation: sheltered housing, very sheltered housing and individuals' own homes to support people with dementia and their carers. Explore the options to develop a new housing with care resource specifically designed to support people with dementia and their carers.	Dec 2012	Costs to be determined	Service Manager, Older People's Service, Dundee Social Work.
5.6 We will provide appropriate services to people with dementia and their carers at the right time for them to meet their needs.	Capture demographic information and analyse to predict future demands. Monitor unmet need and waiting times for services.	For duration of the plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work.
5.7 We will improve the availability of palliative and end of life care services within the community.	Promote and provide palliative care and end of life education for staff.	Dec 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work.

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5.7 We will improve the standards of community care services and those commissioned or provided by partner agencies.	Actively seek the views of people who use services and evaluate their effectiveness. Learn from examples of good practice in other areas both locally and nationally. Review the current community service provision via an annual review of service level agreement which include stakeholder consultation and service user involvement.	For duration of the plan.	Within budget	Service Manager, Older People's Service, Dundee Social Work.

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Care in Other Settings - Promise 6: Should you require care away from your home we will strive to increase your choices, maximise your independence and keep you free from harm.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
6.1 We will increase staff awareness through the provision of education and support in the recognition and behavioural management of people with dementia in care settings.	Provide awareness sessions for multi-disciplinary and multi-agency colleagues within all settings. Promote existing recognised and evaluated courses. Include dementia in health promotion events in partnership with statutory and non-statutory organisations.	For duration of the plan.	Within budget	Dementia Nurse Consultant.
6.2 We will maintain an ongoing program of educational support.	Liaise with universities and educational providers to raise awareness and influence education. Develop educational programmes in partnership with stakeholders, people with dementia and their carers.	For duration of the plan.	Within budget	Dementia Nurse Consultant.
6.3 We will ensure packages of care are developed and delivered through direct involvement with carers and the person with dementia.	Through multi-disciplinary and multi-agency team meetings/working and involving their carers and person with dementia assess, plan, implement care and evaluate the person's pathway. Use information gathering tools, e.g. "Getting To Know You" document	Dec 2010	Within budget	Speciality Manager, Dundee CHP. Service Manager, Older People's Service, Dundee Social Work.

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6.4 We will ensure packages of care meet the holistic needs of the individual and carers based on both local and national standards.	Provide easy access to information for staff, the person with dementia and their carers regarding: ➢ Systems ➢ Strategies ➢ Services ➢ Conditions ➢ Assistance Work with Care Home Managers and Pharmacists to implement the medication recommendations from the 'Remember I'm Still Me report.'	Dec 2011	Within budget	Speciality Manager, Dundee CHP. Service Manager, Older People's Service, Dundee Social Work.
6.5 We will improve palliative and end of life care for people with dementia.	Promote and provide palliative and end of life care education for staff providing palliative care. Introduce/roll out the use of the Liverpool Care Pathway across all settings. Introduce advance(d) statements and care planning Assist in the implementation of Gold Standards Framework within community based settings	Dec 2011	Within budget	Speciality Manager, Dundee CHP. Service Manager, Older People's Service, Dundee Social Work.
6.6 We will improve communication between formal and informal carers of people with dementia.	Agree communication strategies between various settings. Agree expectations between various settings	Dec 2011	Within budget	Speciality Manager, Dundee CHP. Service Manager, Older People's Service, Dundee Social Work.
6.7 We will ensure the transition of care between various settings is planned and well documented, as well as safe and appropriate.	Introduce co-located in-patient hospital services between Psychiatry of Old Age and the Department of Medicine for the Elderly. Develop and introduce information packs. Develop and introduce a robust system for transition of care between settings which would include: ➢ Protocols ➢ Documentation ➢ Risk assessments ➢ Expectations	Dec 2012	Costs to be determined	Service Manager, Older People's Service, Dundee CHP.

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Co-ordination and Case Management - Promise 7: We will have an integrated approach to the support of individuals living with dementia.				
ACTIVITY	**ACTION**	**TIMESCALE**	**EXPENDITURE**	**LEAD OFFICER**
7.1 We will work within a legal framework with joint clear guidance and procedures.	Develop a multi-disciplinary training programme around mental health legislation including: -Adults with Incapacity -Mental Health (Care and Treatment) -Adult Support and Protection -Community Care and -Carers Legislation	Dec 2010	Within budget	Psychiatry of Old Age Community Services Manager. Team Manager, Social Work.
7.2 We will ensure transitions between workers, team and setting will be planned, discussed and understood and agreed.	Review current practices and define local transition process and protocols. Define and review good practice during admission and discharge in care settings. Develop targeted training for staff at the first point of contact with people showing signs of dementia.	Oct 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work. Team Manager, Social Work.
7.3 We will develop open access and referral routes for dementia assessment and support services.	Evaluate, amend and extend as appropriate the open referral routes into the Community Mental Health Teams for Older People	Dec 2010	Within budget	Psychiatry of Old Age Community Services Manager. Team Manager, Social Work. Clinical Director Dundee CHP
7.3 We will assess and manage your risks to ensure that your independence is maximised without any undue concerns being raised for your safety.	Develop training/awareness raising for staff around changing needs and risk management. Develop agreed multi-agency risk assessment tools and guidance for people with dementia.	Oct 2011	Within budget	Service Manager, Older People's Service, Dundee Social Work. Team Manager, Social Work.

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7.4 We will have a system of review which ensures the proper level of care and support is provided in response to changing and increased need.	Assess current review systems for people with dementia. Support people with dementia and their carers to develop their own person centred plans which will support them to continue or start to engage in a range of chosen activities. Ensure that people with dementia and their carers are supported to access services at the right time for them.	Dec 2010	Within budget	Service Manager, Older People's Service, Dundee Social Work. Team Manager, Social Work.
7.5 We will adopt the Long Term Conditions approach to case management.	Identify and evaluate how the Long Term Conditions case management approach can be effectively used when working with people with dementia and their carers. Involve people with dementia in the evaluation of the case management model.	Dec 2010	Within budget	Service Manager, Older People's Service, Dundee Social Work. Team Manager, Social Work.

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