Redbridge Dementia Plan 2014 -2017

‘Don’t you forget about me’
Welcome to the Redbridge Dementia Plan 2014-17 ‘Don’t you forget about me’. This is an overarching plan for the borough which includes an action plan for implementation during the life of the Plan. It has been developed in consultation with a wide range of stakeholders and is designed to help us tackle one of the most pressing challenges we face as a community.

The Redbridge Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy highlighted the need to prioritise dementia in view of the impact of the increasing numbers of people living with dementia and the need to deliver a more integrated approach to the way in which people with dementia and their carers are supported, with a view to improving their health and wellbeing, enabling people to live well with the condition for as long as possible.

We are confident that we can improve the lives of people with dementia and their carers by working together to achieve our Vision and met the ambitious outcomes set out in the Action Plan.

We would like to thank all members of the Redbridge Dementia Partnership, who have worked with a wide range of stakeholders including service users and carers to produce this document and who continue to ensure that Redbridge becomes a truly ‘dementia friendly community’ which enables people living with dementia to remain as independent as possible and continue to contribute to society for as long as they are able.

Councillor Wes Streeting
Cabinet Member for Health and Wellbeing
Chair Redbridge Health and Wellbeing Board

Dr Anil Mehta
Chair of Redbridge Clinical Commissioning Group
Vice Chair Redbridge Health and Wellbeing Board

Simon Froud
Chief Officer Adult Social Services
Chair of the Redbridge Dementia Partnership
‘Don’t you forget about me’

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Executive Summary

Dementia has been described as one of the biggest global health and social care challenges of the present day. The Government issued the Prime Minister’s Challenge on Dementia (2012) which set out targets for delivering major improvements in health and care and creating dementia friendly communities in England, while working at an international level with the G8 Countries, researchers, pharmaceutical companies and Charities to stimulate greater investment in research, improve prevention and treatment of dementia and improve the quality of life for people living with dementia and their carers. In addition NHS England has established a London Dementia Strategic Clinical Leadership Group, which involves NHS, Public Health and social care partners to inform developments at a local level across London.

The Redbridge Health and Well Being Board identified dementia as a strategic priority and work on the development of a Redbridge Dementia Plan began during the summer of 2013.

In response to the above drivers, the Redbridge Dementia Partnership (RDP), which includes Council, NHS, service providers in the voluntary and community sector working with service users and carers, produced the Redbridge Dementia Plan (2014-17) ‘Don’t you forget about me’. The Plan includes a series of actions that will be monitored through the multi-agency RDP, and which aim to achieve the Redbridge Vision for people living with dementia, which is:-

‘To cultivate a community in Redbridge in which people with dementia and those who care for them are treated with dignity and respect and are provided with the help and support they need to achieve a good quality of life’

The Plan has been informed by national strategies and guidance and the local strategic context and provides an overview of current and future levels of need and details of how through 4 Work streams, we intend to:-

- promote activities which may reduce or delay the effects of dementia including timely diagnosis, treatment, advice, information & support through to end of life care;
- support people with dementia to live well, safely and with dignity, regardless of whether they live in the community, in a hospital or residential setting; and
- Improve the co-ordination and quality of personalised care through integrated care pathways and an informed and skilled workforce.

Dementia does not discriminate and potentially can affect everyone in society irrespective of gender, ethnicity and class and it can affect people of working age, as well as older people. People with a learning disability are at higher risk of developing dementia. Despite this, a high proportion of people feel that there is stigma attached to those with dementia.

The RDP intends to work with families, carers and communities, health and social care commissioners and service providers, to help people living with dementia and their carers lead happier more fulfilled lives for as long as they can.
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What do you think of our Plan?

We are very keen to hear what you think of our plan, even though the formal consultation period has ended. By talking with family, friends and colleagues and sharing your thoughts and ideas about how to make Redbridge a dementia friendly community and what further actions you think will help us get there, you will help us to continue to improve and achieve our vision.

We produced an Easy Read version of the Plan, to help us tell as many people as possible about our plans. If you would like to comment, make a suggestion or would just like more information or details on the current plan, then you can do so in the following ways:

1. Email your thoughts to myview@redbridge.gov.uk

2. Ask for a discussion by emailing:
   - Mary Byrne, Principal Officer Provision & Change Management
     mary.byrne@redbridge.gov.uk
   - Alison Gordon, Service Manager
     alison.gordon@redbridge.gov.uk
   - Julie Fanning, Executive Policy Adviser
     julie.fanning@redbridge.gov.uk

3. In writing to:
   Adult Social Services,
   C/O Elderberries Day Service,
   Broadmead Road,
   Woodford Green,
   Essex IG8 0AD

1. Our Vision

Our vision for Redbridge is:

   To cultivate a community in Redbridge in which people with dementia and those who care for them are treated with dignity and respect and are provided with the help and support they need to achieve a good quality of life

This will be achieved through:

- The development of dementia friendly communities and by engaging people with dementia and their carers
- Provision of timely and accurate advice, information and advocacy
- High quality personalised care and support, from early intervention and diagnosis through to end of life care, in community, care home, hospital and specialist care settings; and
- Development of an informed and skilled workforce.
2. **Definition of Dementia**

Dementia may be caused by a number of illnesses that affect the brain. Dementia typically leads to memory loss, inability to do everyday things, difficulty in communication, confusion, frustration, as well as personality and behaviour changes. People with dementia may also develop behavioural and psychological symptoms such as depression, aggression and wandering.

There is no single test that can identify dementia, although a range of blood tests and sophisticated brain scans can help and are important in ruling out reversible causes. Diagnosis is made by an assessment of symptoms and the use of brief questionnaires that test ability to remember facts, or draw simple diagrams.

Most types of dementia progress slowly. People may live with the condition for ten years or more, requiring increasing levels of support as they become less independent. By carefully planning the person's environment and giving structure to their day, with supportive activities it may be possible to reduce the impact of the symptoms.

For the purposes of this Plan, we define Dementia as follows:-

*Dementia is an umbrella term. It describes the symptoms that occur when the brain is affected by certain diseases or conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding.*

*There are many different types of dementia although some are far more common than others. They are often named according to the condition that has caused the dementia. Some of the more common types are outlined below:*  
(Source Alzheimer’s Society)

- Alzheimer’s Disease
- Vascular Dementia
- Dementia with Lewy Bodies
- Fronto-temporal Dementia
- Creutzfeldt-Jakob Disease
- Korsakoffs Syndrome
- HIV related Cognitive Impairment
- Mild Cognitive Impairment

Dementia does not discriminate and potentially can affect everyone in society irrespective of gender, ethnicity and class and despite this, a high proportion of people feel that there is stigma attached to those with dementia.

Dementia will have a significant impact on those affected, their families and friends. It can affect people of working age, as well as older people. People with a learning disability are at higher risk of developing dementia.

The Department of Health estimates that only 45% of people with dementia receive a diagnosis and when it does take place it often happens when a crisis occurs or the condition has progressed to the extent that opportunities for the maximisation of quality of life and prevention of harm have passed.
Through the Prime Ministers Dementia Challenge, NHS England has quantified the national ambition to improve the dementia diagnosis rate. The aim is that by 2015 two thirds of people with dementia should have a diagnosis with appropriate post-diagnosis support. However, figures show wide variations in practice across London and England for a number of different reasons. These issues will need to be worked through in an integrated way by local partners.

3. National Strategy and Policy Context

Living well with dementia (DH 2009) was the first national strategy for dementia in England and this was followed by implementation plans to promote its delivery. Subsequently ‘The Prime Minister’s Challenge on Dementia’ (DH 2012) set out targets for delivering major improvements in dementia care and research by 2015. The key commitments were to drive improvements in health and care; creating dementia friendly communities that understand how to help and create better research. A diagram describing how this will be implemented locally is attached as Appendix A.

At the heart of the vision for dementia services is the commitment to putting patients and the public first; improving health and social care outcomes; ensuring autonomy, accountability and improving efficiency.

The Alzheimer’s Society produced a study called ‘Counting the Cost in 2009’ which provided evidence from over 2000 carers and nurses on the quality of dementia care provided on general wards in hospitals across England, Wales and Northern Ireland. The study highlighted that at that time people with dementia over 65 years of age were using up to 25% of hospital beds at any one time, it found an unacceptable variation in the quality of dementia care provided on general wards and that people with dementia stay far longer in hospital than other people who are admitted for the same procedure. The longer they stay the worse the effect was on the symptoms of dementia and the individuals physical health, discharge to a care home becomes more likely and antipsychotic drugs were more likely to be used. This creates a high personal cost to the individuals and their families and places a financial pressure on the NHS.

The Alzheimers Society has since produced Dementia 2012, a national challenge and Dementia 2013: The hidden voice of loneliness, which looks at the quality of life for people with dementia in England, Wales and Northern Ireland. Both reports provide a snapshot of how well people are living with dementia, what support they are receiving, and what barriers they face to living well.

Dementia 2013 focuses on the impact of loneliness and social isolation on people living with the condition, particularly for those living alone. Nearly two-thirds (63%) of people with dementia surveyed said they felt anxious or depressed. A third of people with dementia said they had lost friends, and 5% said they have not told their friends about their diagnosis. Of those living alone, nearly two-thirds (62%) of people with dementia reported feeling lonely.
The Government is committed to ensuring there is a greater focus on accelerating the pace of improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them. They have not been prescriptive about what services should be planned and commissioned. As highlighted in the National Dementia Strategy, the pace of implementation will vary depending on local circumstances and the level and development of services within each NHS and Local Authority area. It describes what the Department of Health considers as its priorities for improving outcomes for people with dementia and their carers.

A key element of this outcome-focused approach is to ensure greater transparency and provision of information to individuals. This enables people to have a good understanding of their local services, how these compare to other services, and the level of quality that they can expect.

There were four priority areas for the Department of Health’s policy development work during 2010/11 to support local delivery of the Strategy. The four priority areas are:

• **Good quality early diagnosis and intervention for all** - Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia; only a third of GPs feel they have adequate training in diagnosis of dementia.

• **Improved quality of care in general hospitals** - 40% of people in hospital have dementia; the excess cost is estimated to be £6m per annum in the average General Hospital; co-morbidity with general medical conditions is high and people with dementia stay longer in hospital.

• **Living well with dementia, including in care homes** - Two thirds of people in care homes have dementia; dependency is increasing; over half are poorly occupied; behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.

• **Optimising medicines use, including reduced use of antipsychotic medication** - There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription.

These areas provide a real focus on activities that are likely to have the greatest impact on improving quality outcomes for people with dementia and their carers. It is important to emphasise however that the priorities are enablers for local delivery of the Strategy in full, across all 17 objectives, as well as the work to implement the
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recommendations of the report on the over-prescribing of antipsychotic medicines to people with dementia.

These outcomes reflect the key issues raised during the local consultation process and sit alongside the wider outcomes proposed in the Local Authority, NHS and Public Health national outcome frameworks. These have been updated more recently but to give a flavour of the direction of travel and the linkages, see the table at Appendix B. In particular, these refer to reducing health inequalities, promoting personalisation, health and wellbeing, enhancing quality of life for people with care and support needs and ensuring a positive experience of care and support services.

In addition to Dementia specific guidance, the impact of other wider strategic issues needs to be considered such as national strategies to meet the needs of Carers, Adults with Autism and the End of Life Strategy. There are also good practice guidelines such as Compassion in Practice and the National Institute for Health and Care Excellence (NICE) guidelines for dementia care.

Following a government spending review in June 2013, the Better Care Fund was established for NHS and Social Care services to support an increase in the scale and pace of integration and promote joint planning for the sustainability of local health and care economy, acting as a catalyst to improve services and value for money. The Fund is made up of a number of existing funding streams available to Clinical Commissioning groups and Local Authorities. Access to the fund was dependent on agreement via the Redbridge Health and Wellbeing Board by March 2014 of a local Better Care Plan for 2014-16.

A proportion of the resources will be paid subject to performance against a series of nationally and locally agreed indicators. This process presents both opportunities and challenges locally; however local provision of dementia services and support is one of the areas where improved integrated working could have a high impact on the outcome areas identified for the fund, which includes emergency admissions to hospital, delayed transfers of care, admission to residential and nursing home care and patient and user experience.

More generally, the improvement of community based personal support services is integral to, and underpins each of the four priorities as it supports early intervention; prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay. These priorities do not deflect from work that is underway and continuing in parallel on key aspects of the Strategy such as workforce development, support for carers and provision of information following diagnosis.

In September 2012, NHS London launched the London Dementia Clinical Network Programme in response to the National Strategy and the Prime Minister’s Challenge on Dementia which has successfully delivered dementia specific training and created peer support networks for GPs and NHS community and hospital based staff to help meet the strategic priorities. Following the development of Adult Social Care, NHS and Public Health outcomes frameworks this network has now become the Dementia Strategic Clinical Network (London) involving social care and public health partners. Redbridge Adult Social Services are now members of this Network at Chief Officer level.

In addition to the four priorities described above, the Dementia Strategic Clinical Network London has agreed to include a further 2 priorities which are to deliver:-

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- **Strategic commitment to improve care for people with dementia and integrating innovation**, to deliver improved assessment and care pathways, innovation, integration and best practice; and

- **Improved end of life care for people with dementia**, by making links with the London Social Care Partnership End of Life Network and the End of Life Clinical and social Care Alliance.

Initial work has included the development of a table mapping quality standards and good practice guidelines available around dementia (Appendix B) and the links across the NHS, Public Health and Social Care Outcome Frameworks (Appendix C).

4. **Local Policy context**

The focus of health and care systems has shifted towards improving outcomes for people rather than focussing on measures of process. This will have a greater impact on individuals and promote the development of a ‘whole system and integrated approach to care and support. At present there are 3 sets of outcome frameworks from the Department of Health (DH) i.e. one for Public Health, Adult Social Care and the NHS. They set out high level, complementary priority areas for improvement with supporting indicators to track performance and progress.

In 2010 Adult Social Services and Housing Scrutiny Committee undertook a review of the local dementia services and found that there were many areas of best practice in Redbridge, with good services being provided. A series of recommendations were made which included increasing awareness among the public, especially among ethnic minority groups, and among professionals, including GPs. Early discussions have taken place involving the Redbridge Dementia Partnership (RDP) and the Carers Strategy Steering Group to ensure that the recommendations arising from the above and other more recent Scrutiny reviews are addressing the cross cutting issues in a co-ordinated way.

Discussions are underway to ensure that the multi-agency RDP Group is appropriately linked in to the decision making processes through the current Health and Wellbeing Framework, which oversees the implementation of a number of local Plans.

Dementia has been identified by the Health and Wellbeing Board as a priority area for the Joint Health & Wellbeing Strategy and the Board had the opportunity to input into the development of the Redbridge Dementia Plan during the consultation period and will receive updates on progress.

No additional resources were provided to assist with the implementation of the national Strategy at local level. However, evidence highlighted in the Redbridge Joint Prevention and Early Intervention Strategy 2011-14 has shown that integrated access; shared outcomes; joint commissioning and innovation in service delivery can improve performance, quality and the service user and carer experience.

Although the statutory guidance on dementia was issued to councils and the NHS, it clearly highlights that success can only be achieved through change across all public services and with meaningful involvement of people with dementia, their carers and the wider community.
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During 2013_14, taking into account new national priorities as detailed in the Prime Ministers Challenge on Dementia ‘Delivering major improvements in dementia care and research by 2015’ this new Joint Plan was developed as a partnership with people with dementia and their carers and steered by the RDP. NHS and Social care commissioners have contributed to the Action Plan and progress will be monitored through the RDP and the Health and Wellbeing framework. The Plan links in to existing Redbridge Strategies and Plans, some of which are in the process of being reviewed, or will be superseded by more up to date plans.

The outcomes in the Action Plan reflect the current local priorities in the Joint Health and Wellbeing Strategy, the Better Care Plan and the BHR Integrated Care Coalition Strategic Plan. In addition the Plan refers to work undertaken by the Dementia Strategic Clinical network (London) including a quality standards mapping exercise to ensure we meet national strategic objectives and National Institute for Health and Care Excellence (NICE) quality outcomes.

The Barking and Dagenham, Havering and Redbridge Integrated Care Coalition (BHR ICC), which has membership across the health and social care system, has identified ‘frailty’ as a priority area for joint working and service development. The membership of the Coalition includes the three Local Authorities and Clinical Commissioning Groups across Redbridge, Havering and Barking and Dagenham, along with the Voluntary Sector, Barking Havering & Redbridge Hospitals Trust and the North East London Foundation Trust.

The frailty programme will look at services for patients over 65 with two or more complex conditions and will incorporate falls, care homes, community services, End of Life and dementia as key areas for focus as patients within these groups require a higher level and greater coordination of support. In addition work is underway to improve access to health and social care for people with even higher complex care needs across BHR.

On 14th May 2014 the Care Bill received royal assent and became The Care Act 2014. The introduction of the Act will have an impact on how people with dementia and their carers are supported in the future. The Act includes:

- a new framework of duties on local authorities in relation to the provision of social care, including assessment of care needs duties to arrange care, funding and a care cap. The provisions include:
  - new requirements to assess and meet the needs of carers
  - new provision for a single national test of eligibility for local authority involvement in arranging and funding care
  - provisions to increase transparency about costs of care and change the balance between self-funded care and local authority funded care
- a requirement to arrange for the provision of prevention services
- a duty to promote the wellbeing of individuals and promote integration between health and social care services
- powers for local authorities to delegate many of their social care functions
- duties on local authorities with respect to safeguarding of adults receiving social care
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- provisions with respect to the regulation of care providers, including:
  - a duty of candour, applying to all health and social care providers regulated by the CQC
  - a new criminal offence for some care providers of giving false or misleading information
  - changes to the CQC regulatory regime, including new powers to monitor the financial sustainability of providers
  - provision for the Human Rights Act to apply to some private sector care providers

- a statutory basis for the Better Care Fund, i.e. powers to work with Clinical Commissioning Groups to use NHS funding in projects for developing integrated health and social care services

- new arrangements in respect of discharge from hospital and after-care under section 117 of the Mental Health Act

New duties under the Care Act will also have an impact on people with dementia and their carers, particularly in relation to the provision of timely and accurate information to people with communication difficulties, which may leave them disadvantaged in the new care and support system. Integrated care and support including the provision of timely advice, information and advocacy is key to ensuring people with dementia and those with a learning disability are able to communicate their needs.

The Care Act duty on local authorities to include a personal budget with care and support plans and to offer a direct payment to people, or for those without capacity to an authorised person, will provide an opportunity for creative and positive risk taking approach to service provision.

In addition, the requirement for new Safeguarding Adults Boards means there is a need to ensure Redbridge has the right membership to consider the needs of people with dementia, as they are among the most vulnerable people in the community.

The Redbridge Joint Strategic Needs Assessment (JSNA) includes a section on Dementia, which predicts an increase in the number of people with this condition and highlights the need to identify and support people who may benefit from preventative interventions. A Training Plan alongside some of the actions in the Plan will attempt to improve this position.

Good practice in dementia care is evident in Redbridge; however there are variations and it is clear to practitioners and commissioners that a more co-ordinated whole system approach is required across health and social care. This increasingly includes working across borough boundaries reflecting the need for 5 year strategic planning, integration of services and the ambition to achieve outcome and value improvements in the context of local financial challenges across the health and social care economy and in particular in Barking & Dagenham and Havering and Redbridge (BHR).

This good practice will incorporate early intervention and preventative work to reduce the number of hospital admissions, improve hospital discharge arrangements and develop the capacity for community based support. This includes giving people the skills to better manage their own care, support for family carers, accessible and timely information and
support through the provision of equipment, telecare, support at end of life and a range of learning and development opportunities for practitioners in all care settings.

5. National and local demographics

Prevalence of dementia in UK
Recent research: Dementia 2010: The burden of dementia and associated research funding in the United Kingdom, Alzheimer’s Society (2010), estimated the number of diagnosed and undiagnosed people with dementia in UK was 821,884 in 2006, representing 1.3% of the UK population. Of the total number of cases, 39% were men and 61% were women. 61% of cases occurred in the age group 80 and above and 8% of the cases were identified in those younger than 65 years of age, with dementia being more prevalent in this age group.

In April 2013 the Department of Health (DH) estimated to cost the economy at £23 billion a year, with the number of people affected expected to double by 2040 and the cost to treble. A quarter of hospital beds are occupied by people with dementia. The DH also highlighted that although a lot can be done to help people cope with the symptoms of dementia, in England currently only 45% of people are diagnosed.

The Department of Health called for:
- increased diagnosis rates by making sure doctors give 65-74 year olds information about memory services as part of the NHS Health Check Programme and refer them for assessment if they need it, (a toolkit is available to help GPs give better support)
- hospitals and care homes to commit to being dementias friendly and sign up to the Dementia Care and Support Compact
- access to improved information
- access to breaks for carers
- dementia friendly communities

Prevalence of dementia in people with a learning disability and autism
The Royal College of Psychiatrists and the British Psychological Society published a report on Dementia and People with Learning Disabilities in September 2009 which highlighted key factors required to help the increasing number of people with learning disabilities developing dementia.

The report showed there have been significant improvements in the life-expectancy of people with learning disabilities from as little as an estimated 18.5 years in the 1930s to 59 years in 1970s to 66 years in the 1990s (Braddock, 1999). The life-expectancy of those with a more severe level of disability, however, remains reduced compared to the general population, as does the life-expectancy of people with Down’s syndrome, which has been estimated at 55 years (Holland et al., 2000). The life-expectancy of those with mild learning disabilities now approaches that in the general population of a similar socioeconomic status.

Given these improvements, it has been predicted that the proportion of people with learning disabilities over 65 years of age will have doubled by 2020 (Janicki & Dalton, 2000) and that over a third of all people with learning disabilities will be over 50 years of age by that time (McConkey et al., 2006). It is because of these factors that consideration needs to be given to those age-related illnesses that most commonly occur in later life, such as dementia. Down’s syndrome is the most frequent known cause of mild and severe
intellectual disability (Minns, 1997) and may account for 15–20 per cent of the learning disabilities population (Pulsifier, 1996).

Estimating prevalence rates of dementia can be problematic because of a number of methodological issues that are broadly concerned with, first, the diagnosis of illnesses such as dementia in a population which has pre-existing cognitive and functional impairments and, second, the problems with respect to establishing a true population sample of people with learning disabilities. However, there is evidence from several studies that people with learning disabilities have an increased risk of developing dementia with increasing age compared to that observed in the general population.

The National Autistic Society recently published a handbook which covers a number of issues that aging people with autism may face, including dementia. It highlighted that adults now in their 50s and 60s were amongst the first to be formally diagnosed with an autistic spectrum disorder and that little is known about how ageing affects people with autism. However it is known that the dramatic biological, psychological and social changes that happen with ageing may not be understood by people with autism and so carers may find their role more complex and challenging as changes or symptoms of ill health take effect.

An example of the difficulties that may arise in relation to dementia, are that some people with autism have higher thresholds for pain and will not report accidents or injuries. Others may feel pain but may not be able to communicate it.

Meeting the needs of Black Asian Minority Ethnic (BAME) Communities
A recent House of Commons All-Party Parliamentary Committee produced a report ‘Dementia does not discriminate’ (July 2013) highlighting the support needs of the ageing Black, Asian and Minority ethnic communities

The report suggested the numbers of people with dementia from Black, Asian and minority ethnic (BAME) groups are expected to rise significantly as the BAME population ages. The Centre for Policy on Ageing and the Runnymede Trust applied well established dementia prevalence rates to census data, giving a current estimate of nearly 25,000 people with dementia from BAME communities in England and Wales. This number is expected to grow to nearly 50,000 by 2026 and over 172,000 people by 2051. This is nearly a seven-fold increase in 40 years. It compares to just over a two-fold increase in the numbers of people with dementia across the whole UK population in the same time period.

This estimate includes all non-white groups and also the white Irish population. The white Irish community is one of the largest groups in the UK and has a significant proportion of older people. It may be possible and appropriate to include other communities from the ‘White other’ group in future estimates, as the number of older people in these groups’ increases.

It suggested that society is not geared up to deal with this increase. Currently, people from BAME communities are under-represented in services and they are often diagnosed at a later stage of the illness, or not at all. Taking action now to get appropriate services and support in place will help to ensure people can access the support they need. Families will be better able to cope and individuals with dementia will be able to experience a better quality of life.
It is important to avoid assumptions that families from BAME communities do not require any outside help. Carers of people with dementia experience greater strain and distress than carers of other older people. Stereotyping is a failure by services to reach out to BAME communities and ensure services are in place to support the wellbeing of carers and individuals with dementia.

The report highlighted that it is likely that dementia is more common among Asian and Black Caribbean communities. This is because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common among Asian and Black Caribbean communities. These are modifiable risk factors and preventative work is vital to reduce significantly the burden of dementia among BAME communities.

It is known that improved awareness leads to improved access to services. Government led public awareness campaigns to date have had limited impact on the BAME community. Evidence shows that knowledge and understanding about dementia in these communities is very low. There are myths and taboos attached to the condition. Although stigma is attached to dementia in all communities, it is likely that levels of stigma are higher in BAME communities.

The stigma and low levels of awareness surrounding dementia make it more difficult for people to get the support they need. Social isolation and delays in diagnosis are significant risks. Diagnosis can be a gateway to support, and enables people to plan for the future. It is unacceptable that people from BAME communities have poorer access to diagnosis and support.

Across the country service provision for people with dementia from BAME communities is patchy. Pockets of good practice exist, but in many areas there is lack of support that meets the needs of people from BAME communities. Families may not seek support because of a desire to care for the person within the family, but also community pressure to do so even when the burden of caring is considerable. There is also a lack of awareness of services, how they might help or how to access them. Previous experience of hostility and racism among some communities may also deter people from seeking help.

The All Party Parliamentary Committee also suggested there is a lack of culturally sensitive dementia services. Families are reluctant to use services that do not meet cultural or religious needs and try to carry on alone. There is a large ethnic minority voluntary sector providing culturally appropriate support to older people, but its members may not be skilled in providing dementia care. Shared learning between these services and specialist dementia services would improve the support each could offer people with dementia from BAME communities.

Given that there is a projected significant increase in the number of people with dementia from BAME communities and the indications are that there are low levels of awareness of dementia, late diagnosis and lack of access to culturally sensitive services, we need actions which promote integrated and co-ordinated approaches across a range of statutory, voluntary and community agencies to ensure every individual with dementia and their families can access the high-quality, person-centred support they need.

**Carer’s issues**

A carer is someone who gives a substantial amount of unpaid care and support regularly to a relative, partner, or friend. There are around 6 million carers in the UK, with 1.4 million
people providing more than 50 hours per week (NHS Survey of Carers 2009/10; Census 2011, ONS). Unpaid carers are therefore a major part of the system of support for people with dementia.

There are estimated to be over 670,000 people in the UK acting as the primary carers for people with dementia (Alzheimer’s Society Dementia 2012). They highlight that caring for a loved one with dementia can be an overwhelming experience bringing irreversible changes to lives and relationships. The report recommended that Carers should have comprehensive support, including emotional support, assistance with day to day caring and access to respite and short breaks.

The report also commented that although carers of people with dementia save the UK public purse £8 billion every year, the cost to the carer is significant, because transport bills, utility costs and care charges can all rise significantly when someone has dementia. As most of the care for people with dementia is classed as social care and as such is means tested, many carers face financial hardship, often forced to give up work, and pay care bills from limited incomes or savings.

While many carers report personal satisfaction from their caring role, it can have a considerable impact on carers’ health and wellbeing. Depression, emotional and physical exhaustion and general poor health are common.

The majority of unpaid carers of family members in the UK are women (Census 2011 ONS). This places many women in a particularly vulnerable financial situation as they will be less able to contribute to a personal pension scheme. In addition, women tend to live longer and as a result are more likely to require long term care.

The Princess Royal Trust for Carers (2011) found that:

- two thirds of older carers have long term health problems or a disability themselves;
- one third of older carers reported having cancelled treatment or an operation they needed due to their caring responsibilities;
- half of all older carers reported that their physical health had got worse in the last year; and
- more than 4 out of 10 older carers said their mental health had deteriorated over the last year.

A report from the Carers Trust ‘A road less rocky’ – supporting people with dementia’ found that carers of people with dementia are not getting the support and advice they often desperately need. The research highlighted that only 51% of carers questioned said that they were given an opportunity to talk separately about their needs and how much care they felt able to provide.

56% of carers questioned said that they had not received information about managing the medication of those they cared for. More than half (52%) of carers said that they had been given no information on how to cope with incontinence.

Other key findings included:

- Over half (52%) of carers in the survey reported difficulties in obtaining a diagnosis for dementia for the person they cared for
More than half of carers (55%) questioned said that they had not been given information on legal issues and managing money. Many had learned about Lasting Power of Attorney too late.

Many carers, particularly those caring for someone in the later stages of the illness, felt ill equipped to deal with more agitated behaviours that might develop. More than two-thirds 68% surveyed said they had not received training or advice on this issue.

82% of carers questioned said that caring had adversely affected their ability to work.

The report found that there were a number of information gaps at critical points along a carer’s journey where they would most value information and support. These critical points include:

- When dementia is diagnosed.
- When the capacity of the person with dementia declines.
- When the carer needs emotional support and/or a break from caring.
- When the person with dementia loses their mobility.
- When the carer has to cope with behaviour problems.
- When the carer’s own circumstances change.
- When the person with dementia becomes incontinent.

The report found that many carers are not being given information and advice on these issues when they need it. Often advice, if it is given, is too late.

Carers should be seen as an important resource. They know the person with dementia better than anyone else. Where a person with dementia has lost capacity to communicate, carers offer a valuable insight into what the person with dementia may be experiencing or communicating. Despite this, many carers speak of being left out of the care decisions and not included or valued as part of the care planning process, often to the detriment of the person with dementia. Carers are an integral part of the care planning process and health and social care professionals should work with them in all aspects of care and support.

The Care Act 2014 creates new duties on local authorities to assess and meet the needs of adult carers, which will mean that for the first time carers will have the same rights as the person they are caring for. There are also new duties for local authorities to provide information and advice to ensure that carers know what care and support is on offer, help them plan for the future and where to go for help when they need it.

There is also a duty to promote wellbeing to prevent care needs from developing and reduce the need for crisis intervention. The Act also mentions portability of care services so that carers can move between different local authority areas without the fear of their care services being disrupted.
Dementia Prevention

There is no certain way that all kinds of dementia can be prevented. However, a healthy lifestyle can lower the risk of developing dementia as people get older. It also lowers the risk of developing cardiovascular diseases such as heart disease and stroke.

Recommendations to lower the risk of developing dementia include:

- Eating a healthy diet - Diet that is low in fat, high in fibre, whole grains and plenty of fruits and vegetables (5 a day) is recommended to lower the risk of developing dementia and other conditions as mentioned above. It is recommended that salt consumption is restricted to 6 grams of salt per day as consuming more than six grams can lead to raised blood pressure which in turn increases the risk of dementia. A diet that is high in saturated fats, will lead to increased cholesterol which will again lead to an increased risk.

- Exercising regularly - Regular physical activity lowers risk by maintaining blood pressure and cholesterol within a healthy range. It also makes the heart and circulatory system more efficient.

- Maintaining a healthy weight - Being overweight and obese increases the risk of getting dementia as it increases blood pressure.

- Stopping smoking (if smoker) – Smoking causes the arteries to narrow which will lead to raised blood pressure. It also increases the risk of developing cardiovascular diseases, cancer and dementia.

- Not drinking too much alcohol – Excessive alcohol consumption leads to an increased blood pressure which will lead to an increased risk of developing dementia.

- Maintaining blood pressure within the healthy range.

- If already diagnosed with diabetes, follow the dietary advice recommended by their care team and take any prescribed medication to lower their risk.

The NHS Health Checks Programme can ascertain a person’s risk of developing cardiovascular diseases and dementia and support them with personalised advice and support to reduce the risk. If someone is aged between 40 and 74, they can contact their GP to obtain a health check. Recently, raising awareness of dementia for patients aged over 65 and signposting them to services has been included as part of the health checks. All practices in Redbridge have signed up to deliver NHS Health Checks and the Public Health team are working closely with the Redbridge Clinical Commissioning Group and practices to improve the number of health checks offered to eligible Redbridge residents.
‘Don’t you forget about me’
Currently background work is being carried out to widen access of NHS health checks to residents by following a community outreach model. This model will enable residents that do not access primary care to have health checks with a view to reducing health inequalities. It will also aid in offering health checks opportunistically in a range of settings such as supermarkets and places of worship.

As part of the contract changes, from April 2014 practices are also required to ensure that each patient on their practice list aged 75 or over is assigned a named, accountable GP. The GP will take lead responsibility for ensuring that all appropriate services required under the contract with the practice are delivered to the patient including health checks, if requested by the patient. In addition, the GP will ensure that the physical and psychological needs of the patient are recognised and responded to by the relevant clinicians in the practice. Where appropriate, the GP will work with relevant associated health and social care professionals to deliver a multidisciplinary care package that meets the needs of the patient.

Prevalence of dementia in London
In London around 64,600 people have dementia, including 1,560 people with early onset. This makes 1.3% of total London population aged 30 years and over. In general outer London boroughs have a higher prevalence than those are in inner London and Redbridge is in outer north east London.

Prevalence of dementia in Redbridge
Good information about the numbers of people living with dementia is required in order to effectively plan dementia services in Redbridge, and by acquiring a greater understanding the current population over the age of 65 years in Redbridge; we are than able to determine likely prevalence rates of dementia. The Redbridge Joint Strategic Needs Assessment (JSNA) provides detailed information and includes the following detail:

The proportion of over 65’s resident in each ward in Redbridge varies. Monkhams ward has the highest proportion (21%); Loxford ward has the lowest (7%). (GLA 2010 population projections).

Using the prevalence estimates as described by Dementia UK (2007) it is estimated that 3008 people aged 65+ would have dementia in Redbridge, this equates to 9% of the total population of over 65’s. Table1. breaks this figure down by ward.

Table 1: Estimated number of people aged 65+ with dementia in Redbridge by ward 2011

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Resident population aged 65+</th>
<th>Estimated Nos. (9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goodmayes</td>
<td>1,050</td>
<td>95</td>
</tr>
<tr>
<td>Clementswood</td>
<td>1,090</td>
<td>98</td>
</tr>
<tr>
<td>Valentines</td>
<td>1,231</td>
<td>111</td>
</tr>
<tr>
<td>Roding</td>
<td>1,243</td>
<td>112</td>
</tr>
<tr>
<td>Loxford</td>
<td>1,246</td>
<td>112</td>
</tr>
<tr>
<td>Church End</td>
<td>1,369</td>
<td>123</td>
</tr>
</tbody>
</table>

The ward with the greatest number of cases is Monkhams (194) and the ward with the lowest number of cases is Goodmayes (95).

**Dementia Diagnosis rates per clinical commissioning group**

As part of the Quality and Outcomes Framework (QOF), GP practices maintain a register of patients with a diagnosis of dementia. Comparing the number of people with dementia against the expected prevalence allows the calculation of a diagnosis rate. NHS England has set the first ever national goal to improve dementia diagnosis rates. The goal is that by March 2015, two thirds of the estimated number of people with dementia should have a formal diagnosis, with appropriate support.

In Redbridge we currently have a rate of 43.1% (across the country the rate varies from 32.8% to 75%). The Redbridge Clinical Commissioning Group are providing training to GP practices on how they can improve these rates and will continue to work with them through 2014/15 to aim for the national target achievement of 66%.

**Dementia Commissioning for Quality and Innovation (CQUIN)**

The Dementia CQUIN data collected by NHS England reports on the number and proportion of patients aged 75 and over, who were admitted to hospital as an emergency, for more than 72 hours, who have been identified as potentially having dementia, who are assessed and, where appropriate, referred to specialist services.

For Redbridge registered patients, the rate of identification in hospital is 87.7% and the range across the country is 24% to 99.5%. The rate for assessment in hospital is currently 62.54% and the range across the country is 19% to 99.75%.

Redbridge Clinical Commissioning Group (RCCG) is using the CQUINs again in 2014/15 to incentivise improvements in these rates with acute hospital and mental health service providers.
‘Don’t you forget about me’
They also set Key Performance Indicators (KPIs) within their contracts with providers and intend to include an indicator for reviewing anti-psychotic prescriptions for people with dementia.

The Redbridge CCG are intending to include development of existing memory clinics in the contract negotiations and this will form part of the Service Delivery Improvement Plan with the North East London Foundation Trust (NELFT) who provide mental health services for the registered population.

Table 2: Recorded vs. expected prevalence of dementia by GP practices in Redbridge

<table>
<thead>
<tr>
<th>Borough</th>
<th>%</th>
<th>Lower Confidence Interval</th>
<th>Upper Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>86.0</td>
<td>82.7</td>
<td>88.7</td>
</tr>
<tr>
<td>Havering</td>
<td>83.4</td>
<td>81.2</td>
<td>85.4</td>
</tr>
<tr>
<td>Redbridge</td>
<td>80.4</td>
<td>77.7</td>
<td>82.8</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>80.2</td>
<td>77.5</td>
<td>82.6</td>
</tr>
<tr>
<td>London</td>
<td>80.7</td>
<td>80.2</td>
<td>81.1</td>
</tr>
<tr>
<td>England</td>
<td>79.3</td>
<td>79.2</td>
<td>79.5</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre

The following tables illustrate this increase within the Redbridge population.

Table 3: People aged 65 and over predicted to have dementia, by age (2012-2020)

<table>
<thead>
<tr>
<th>Age group</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69yrs</td>
<td>125</td>
<td>132</td>
<td>138</td>
<td>133</td>
<td>134</td>
</tr>
<tr>
<td>70-74yrs</td>
<td>208</td>
<td>216</td>
<td>227</td>
<td>252</td>
<td>265</td>
</tr>
<tr>
<td>75-79yrs</td>
<td>375</td>
<td>387</td>
<td>392</td>
<td>399</td>
<td>410</td>
</tr>
<tr>
<td>80-84yrs</td>
<td>627</td>
<td>623</td>
<td>620</td>
<td>634</td>
<td>654</td>
</tr>
<tr>
<td>85-89yrs</td>
<td>667</td>
<td>667</td>
<td>683</td>
<td>700</td>
<td>717</td>
</tr>
<tr>
<td>90+yrs</td>
<td>539</td>
<td>597</td>
<td>597</td>
<td>656</td>
<td>656</td>
</tr>
<tr>
<td>65+yrs</td>
<td>2,540</td>
<td>2,621</td>
<td>2,657</td>
<td>2,772</td>
<td>2,836</td>
</tr>
</tbody>
</table>

Source: Projecting Older People Population Information

Table 4: Dementia projections all ages In Redbridge, by sex 2012-2020

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>922</td>
<td>973</td>
<td>1,016</td>
<td>1,075</td>
<td>1,127</td>
</tr>
<tr>
<td>Females</td>
<td>1,680</td>
<td>1,712</td>
<td>1,707</td>
<td>1,766</td>
<td>1,781</td>
</tr>
<tr>
<td>Persons</td>
<td>2,602</td>
<td>2,685</td>
<td>2,723</td>
<td>2,841</td>
<td>2,908</td>
</tr>
</tbody>
</table>
‘Don’t you forget about me’

Source: projecting adult needs and services information and projecting older people population information

Table 5: Dementia projections in people aged 30 years and over in Redbridge, 2012

<table>
<thead>
<tr>
<th>Borough</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>1557</td>
</tr>
<tr>
<td>Havering</td>
<td>3335</td>
</tr>
<tr>
<td>Redbridge</td>
<td>2602</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>1895</td>
</tr>
</tbody>
</table>

Social Deprivation and Dementia
Similarly to all people, people with dementia are affected by their socio economic position. Residential status is of particular importance to dementia. We need to consider the number of pensioners who live alone and those who are receiving care.

The living arrangements of people with dementia vary accordingly to age, severity of the condition and personal and family circumstances. Living alone is recognised as being an indicator of isolation and lack of access to informal support. It is predicted that there was 8378 adults aged over 75 predicted to live alone in 2012; this figure is likely to rise to 9091 by 2020.

Carers of people with dementia
Almost two thirds of people who identified themselves as carers were females. The range of ages of carers was split 50% under 65 and the remainder over 65 into their late 80s-90s. The ethnicity of carers was not always clearly available; however interpretation of the information provided suggested that two thirds of carers classed themselves as White British origin and one third from Black Minority Ethnic groups. Obtaining an accurate number of carers of people diagnosed with dementia can be difficult for a variety of reasons; for example many people do not formally regard themselves as a carer or have not accessed services that support carers.

A recent qualitative study found that compared to a minority of white-British participants, half of the African-Caribbean participants held a ‘traditional ideology’ of caring. This meant that they ‘conceptualized care giving as natural, expected and virtuous’ and were less likely to seek help from statutory services (Lawrence et al., 2008). Other factors contributing to patients and family members not seeking help include: the belief that nothing can be done; lack of awareness of available services; lack of awareness of access procedures for available services; the belief that available services are inadequate, inaccessible and culturally insensitive; previous poor experience of services (Shah and Adelman, 2009)
6. Consultation and Involvement

The Redbridge Dementia Plan 2014-17 is a joint response from the HWB by local health and social care agencies, other statutory partners and people with dementia and their carers to show how we are planning and developing services and support to meet the needs of people with dementia in Redbridge. The document was developed by the multi-agency Redbridge Dementia Partnership (RDP), to take forward the priority areas and practical actions identified during the consultation process.

As a way of monitoring whether the outcomes described in the plan, are being achieved, the RDP will receive regular reports on each action which will be rated as red, amber or green to reflect progress and they will be regularly reviewed at the RDP meetings and reported to the health and wellbeing framework. The action plan is an evolving document with new priorities being added as initial outcomes are achieved.

Consultation on the Plan so far has included:

- The RDP held an initial Workshop in December 2013 to identify/review local priorities. The workshop included commissioners, service providers and carer representatives.
- The draft Redbridge Dementia Plan was circulated more widely for a 12 week consultation during February - April 2014. Comments were received on the feedback forms provided and via an on-line survey from a wide range of stakeholders, including individual carers, Voices of Experience, the Alzheimers Society, AGE UK, Redbridge Council for Voluntary Service and Redbridge Racial Equality and Community Council.
- In addition the Redbridge Learning Disability Partnership Board (RLDPB) considered the Plan and set up a small focus group to look at the detail and formally respond on behalf of the Board. Their comments were received and incorporated in the Plan. The RLDPB also requested that the RDP keep them updated on progress.
- Proposals in the draft Plan were considered at a Redbridge Health & Well Being Board Strategic Planning workshop in February 2014, which provided members of the Board and the Redbridge Dementia Partnership with an opportunity to explore links with other key agencies involved in the Health and Wellbeing Board including Vision Leisure Services and Community Safety representatives.
- The Plan was considered by the Age UK Redbridge Voices of Experience Group and subsequently presented to the Redbridge Safer Communities Partnership Board in July 2014. Their members agreed to endorse the Plan and engage in awareness training and contribute to the development of a dementia friendly Redbridge.
- The final Plan will be presented to the HWB during September 2014.

The discussions at the above workshops and Board meetings showed that there is more to do in terms of identifying how many people there are in Redbridge with dementia. Data is held in adult social care teams on people with dementia who are already getting some support, however this is sometimes held on different IT systems which do not connect with each other. This highlights there is a need for information to be collected in a more consistent way using technology and to explore mechanisms for data sharing, for example by using a common reference number or the development of electronic record systems such as Health Analytics.

The HWB Workshop also highlighted that the number of people with dementia registered at practice level is considerably lower than the estimated number for this area and
‘Don’t you forget about me’
requires further investigation and possibly training. Also the pathway to diagnosis involving the Memory Clinic needs to be reviewed to ensure an integrated approach to care and support is in place. Following a recent move to a new location, in addition to the existing outreach service, the Redbridge Memory Clinic now offers sessions in more venues closer to where people live to help make them more accessible and to reach more people.

During discussions, it became clear that the Dementia Information Pack is a useful resource but it needs updating and currently only lists dementia specific services and may need to find a way to reflect that people will approach the organisations that they are familiar with, which may be their GP, Faith based groups, or other sources of support. This highlighted the need to ensure that there is a consistent and integrated approach to the provision of information, advice and advocacy.

There is also a gap in knowledge about the number of people who do not currently access services, it may be because they fall just outside of the eligibility criteria, and appear to be managing or face other barriers for example due to communication difficulties, language or cultural issues. Some may be at risk of reaching crisis point, for example they may be experiencing isolation and loneliness, falls, family breakdown, homelessness or poverty. It would be helpful to be able to offer preventative support to those at risk, which could include help to take up community, based mainstream services. The development of the Integrated Care Coalition Frailty Project and Complex Care Scheme will be able to address some of these issues as they are progressed.

We need to clarify how services work together to provide preventative support for people with dementia and other complex needs, which might include sensory impairment, a physical or learning disability or a mental health problem. This would improve the quality of the user experience, reduce hospital admissions, improve cost effectiveness and prevent people from falling through the net. The range of services might include counselling, peer support, Telecare, therapeutic interventions, employment or volunteering advice, leisure services etc.

Further investigation into the prevalence of prescribing medication for people with dual diagnosis or complex needs will be undertaken.

Additional issues fed back by individuals and partner agencies to date include the following viewpoints:-

- People with dementia who live alone can find it difficult to use transport services that do not help them through the door;
- All care providers should undertake dementia awareness training as a minimum;
- The CCG to ensure annual health checks are taking place for 40-74 year olds;
- greater understanding in hospitals and other commissioned services is needed about people’s feelings and fears. This requires specialist training to help staff understand signs of distress in people with dementia and how to help them;
- there should be more for people to do in hospital and care homes to stimulate them during their stay;
- more volunteers are needed to spend time and support people with dementia during their stay in hospital;
- intensive reablement at discharge from hospital can help people regain independence quicker and reduce re-admission
at the point of diagnosis clinicians should ask carers and patients what help is needed, including therapeutic interventions so they know what to expect and discuss what will be available to them;  
consideration should be given to support for older carers who care for younger adults with dementia although small in number their needs can be considerable;  
training should be available on the appropriate use of antipsychotic medication 
people with learning disabilities and autism struggle to access services and communicate their needs; the use of jargon during assessment should be minimised; 
some people don’t use specialist services but gain support from faith groups or self-help groups that are familiar to them, so we need to ensure they have accurate and up to date information and are aware of how to access support through the care pathway when needed; Care navigators/befrienders can help; 
safeguarding is a concern for carers and staff when people with dementia are being discharged from hospital following an acute episode. Often the option of long term care is pursued, which may not be the best outcome for the individual; and 
there is still a need to provide information, advice and support for carers when the person with dementia is admitted to residential care because finding out what support is available during the lead up to the move and when making care arrangements can be difficult. People should be referred to support services in a timely way and be informed of what is happening and not have to chase for support.

Following the formal consultation period, analysis of responses showed that overall, the feedback was positive, the Vision and priority areas were right and that the action plan would help achieve the desired outcomes. In addition respondents helpfully suggested additional areas for consideration which have been allocated to the work streams to explore in more detail.

Key messages were: concerns that no additional funding for dementia care has been allocated, people should not have to chase the support they need but instead receive a prompt and consistent referral to appropriate services and support and receive good clear and timely information provided in accessible formats. Also, where possible, to receive more services either at home or close to where people live to reduce problems associated with travelling to unfamiliar parts of the borough.

A full record of responses received is available online on Redbridge i alongside the final revised Redbridge Dementia Plan and the updated Easy Read Version.

To help us implement the Action Plan and further develop the Redbridge Plan we have established 4 Work Streams as sub groups of the Redbridge Dementia Partnership as detailed below. Their role will be to consider the actions set out in the Areas for Improvement Section 8, which will help us respond to the priorities set out in the Government Strategy, statutory guidance and feedback from local engagement activities.

**Work stream 1. Community Development and Awareness:** Raising awareness about how to access services and building stronger dementia friendly communities to ensure that people with dementia and their carers are supported when using services in their local community and have access to the appropriate services. The aim will be to reduce stigma and promote the benefits of timely diagnosis and care. This will require input from GP Practices, Memory Clinics and Black, Asian and minority ethnic communities.
‘Don’t you forget about me’

Work stream 2. Information, Advice and Advocacy: Ensure accurate and timely information is available in a format that is clear and easily understood and that a quality assurance framework is in place to measure individual outcomes and link back into the safeguarding process.

Work stream 3. Personalisation: Ensure that people with dementia and their carers remain in their homes as long as possible with the appropriate level of support and interventions. An integrated care pathway is essential to ensure equality of access across health and social care, which includes meeting the needs of people with a learning disability and autism, effective screening and memory clinic services, routine recording of diagnosis, creative personal budgets and help to consider end of life issues. This work stream will also cover improvements in community, tertiary and hospital settings.

Work stream 4. Training and Development: Develop a Training Plan, which builds on existing arrangements, to ensure that all staff working with people with dementia and their carers have a good understanding of what good looks like and are able to deliver services with dignity and respect.

It has been recognised that the above issues will often overlap with the work of other work streams, requiring them to work together on specific actions. In addition when implementing actions all work streams will take into account the following cross cutting themes and consider how to:-

- Ensure safeguarding
- Meet the needs of carers
- Meet the needs of Black, Asian and Minority Ethnic communities
- Ensure dignity and respect (Dementia Compact)
- Promote prevention and early Intervention
- Measure performance and outcomes
- Link in to commissioning intentions

7. Progress on Priority Areas
There are many examples of good practice in Redbridge and for a number of years the Redbridge Dementia Partnership has continued to explore ways of improving the support available to people with dementia and their carers in Redbridge. The list below gives a flavour of recent developments as part of this on-going work and it is not intended to be a comprehensive list.

- A mapping exercise was undertaken as part of the consultation process to develop a picture of the wider availability of care and support. Feedback has been fed into the Advice Information and Advocacy Work stream and will be used to produce information for the Redbridge i interactive map and the Dementia Resource Pack which is also under review.

- The Redbridge Memory Service which is based with the North East London Foundation Trust (NELFT) Community Older People’s Mental Health Team receives referrals from local G.Ps for an assessment of people experiencing memory problems and can provide outreach services at satellite buildings and in the home.

- Adult Social Services support people who meet the eligibility criteria, either directly or via direct payments and provide preventative support through the provision of
‘Don’t you forget about me’

day services, assistive technology, equipment, adaptations and home care. Work is underway to explore the benefits of using new technology for example Global Positioning Systems (GPS) and other applications that can help locate people and provide support to carers.

- Home Care contracts are under review and new arrangements will ensure that providers can demonstrate their ability to deliver general or specialist care to meet individual care needs including care for people with dementia and people approaching end of life.

- Developing a ‘Dementia Friendly Redbridge’. Work is underway to help bring about changes to the way in which people with dementia and their carers are supported in the community by the general public, statutory agencies and local businesses. A programme of short awareness raising sessions are being arranged to help people become ‘dementia friends’ or join a similar campaign to sign up small localities or clusters of services to the dementia awareness alliance (DAA) for which they produce an action plan to demonstrate how they are improving access and support for people with dementia using their services. A diagram is attached as Appendix A to describe how this work fits in with national and local arrangements.

- **Adult Social services Community Bridge Builders working with G.Ps** in their localities to provide support to people newly diagnosed with dementia and those with memory problems.

- **ReFRS**: The newly developed Redbridge First Response Service (ReFRS) is a multi-agency referral scheme that co-ordinates the provision of universal information, advice and preventative services for hard to reach adults, and/or adults at risk living within Redbridge. These services are provided directly to the service user through trusted and known partners from the statutory, voluntary, and independent sectors.

  ReFRS focuses on providing easy access to a range of vital services and support networks available in the community through the completion of a simple checklist by a ReFRS partner with a service user. ReFRS complements existing services and strengthens partnership work in the best interests of the service user. Referrals received to date have come from the Metropolitan Police, GPs, Redbridge Carers Support Service, Victim Support and others. Referrals were made to the Fire Brigade, Redbridge Council for Voluntary Service, Citizens Advice Bureau and others and were all dealt with within 14 days.

- Development of ‘Early stages groups’ for people recently diagnosed with dementia and younger people with dementia - Age UK Redbridge Early Intervention Service has worked in partnership with Alzheimer’s Society and the Memory Service to open this 6 week course for people newly diagnosed with dementia.

- **A Dementia Befriending Service** to provide in-reach support to identified people living in residential or nursing care homes. The Redbridge Dementia Befriending Service continues to support residential care homes by providing trained volunteers to provide one to one support to those diagnosed with dementia.
‘Don’t you forget about me’

- Development and facilitation of a programme of education and awareness sessions in community faith groups, commissioned by NHS North East London and the City. The Changing Minds/1000 Minds Project was a Community Faith and psychological awareness education programme developed by RCVS which was supported and jointly facilitated by BAME Early Intervention Workers from the Adult Social Services Living Well with Dementia Team. Over a thousand local people from ethnic minority communities now know more about dementia, thanks to this awareness project.

Using 2011 Census population statistics, RCVS was able to ascertain that the number of Asian/Asian British residents living in Redbridge was significantly higher than that for the total population of London. Alongside this, dementia diagnosis in Redbridge was found to be one of the lowest in the country.

2011 Census population statistics were essential in ensuring that the information was aimed at the right ethnic minority groups and provided in the most appropriate languages. Films and discussions were used across eighteen different locations across the Borough to give information about dementia symptoms and care pathways available.

As a result of this programme, many more Redbridge residents have the knowledge to decide when it is the right time to approach their GP if they have concerns about this condition affecting themselves or a loved one, as well as now having information about healthy lifestyles that may help to delay the onset of dementia and a greater awareness of the negative impacts of stigma and discrimination that can surround the condition.

- NELFT undertook a review of anti-psychotic prescription for service users known to them; this included those living in care homes and an audit of anti-dementia drug prescription.

- BHRUT have created an Action Plan to meet the standards for a Dementia Assurance framework covering all aspects from leadership to the details of the care pathway. BHRUT are focusing on embedding the dementia/delirium pathway and the butterfly scheme. There is also a plan to introduce a “buddy” scheme using trained volunteers to assist at mealtimes, and provide company and reassurance to patients during their stay.

- The development of a Creative Arts Plan, which builds on existing activities and creates new activities/opportunities for people with dementia and their families to access a wide range of arts, music, theatre, culture and heritage activities that promote well-being and help prevent isolation and loneliness. Work continues to create an action plan to explore ways of ensuring a sustainable way forward.

- Community Based Activities include a number of opportunities for people to take part in singing for the mind sessions including an intergenerational choir, singing and dancing at Elderberries and the Music Lounge sessions which continue to produce very positive outcomes for service users and their carers, enabling people to take part in social interaction, peer support and active participation in their locality.

- The Dementia End of Life Care Project – DELCAP was successful in its application for further funding and is now working with Redbridge partners to obtain new
measurable outcomes, a coordinator role is being appointed to support the continuation and development of the service.

- **Redbridge Carers Support Service** (RCSS) provides Information, advice and signposting from their Carers Centre in Ilford, drop in facilities, counselling and therapies to promote mental and physical health and wellbeing.

- Another example of how we support carers of people with dementia is the **Carers Alert Card**. The benefits are that by highlighting that the cardholder cares for someone who is vulnerable and if they find themselves in difficulty, the card contains details of the family support network.

- **BAME Specific Dementia Services**: Dementia UK estimated that in total, there are nearly 11,860 people with dementia in the UK, from BAME communities. This is based on the assumption that the prevalence in these groups is the same as for the general population; however this may be an under-estimate.

Elderberries is a Centre for day time support for people with dementia and complex needs and offers personal care as well as a range of activities including chair based exercise and a session for Asian women. In addition a Living Well team is based at Mildmay Community Options Centre which provides a range of activities based in locations around the borough including gardening, walk and talk and Saturday drop-in sessions. Staff from both Centre’s work closely with partner agencies from the statutory, voluntary and community sectors

Redbridge is one of the 8 London boroughs taking part in the Alzheimer’s Society Connecting Communities Project. This project offers the opportunity to focus on organisational diversity in dementia service provision and volunteering. It will also inform work to influence London wide dementia service commissioning and volunteering good practice. The Living Well Team has dedicated Early Intervention Workers that work within local communities in raising awareness and reducing stigma of dementia. Early onset dementia (a rare type affecting people under 65) is more frequent among Black and other minority people with 6% of people having it compared to 2% of the white population

**Telecare Services:**
The balance of care continues to shift towards promoting independence health and well-being through proactive community based support, increasingly focusing on preventive activity such as telecare and re-ablement. There is strong evidence that telecare can extend the period that a person with dementia can be supported safely in the community by up to two years.

Telecare is a means whereby care and support can be provided to people through the use of telecommunication and technology in their own homes. The benefits for service users and their carers are that it:

- Helps to maintain or retain their autonomy;
- Provide greater flexibility and choice in the care and support they receive
- Help people to live safely at home;
- Improves service user confidence and mobility;
- Promotes healthy lifestyles;
‘Don’t you forget about me’

- reduces the likelihood of inappropriate hospital visits and unscheduled care and also supports discharge to avoid delayed transfers of care;
- supports carers
- Improves and makes safe the living environment; and
- Enable service users to maintain their dignity and self-respect

Telecare is as much about the philosophy of dignity and independence as it is about equipment and services. Equipment is provided to support the individual in their home and tailored to meet their needs. It can be as simple as the basic community alarm service, able to respond in an emergency and provide regular contact by telephone. It can include detectors or monitors, such as motion, exit or falls, fire and gas, that trigger a warning to a response centre whenever a person falls, the temperature drops, etc. The alarm operators can then talk to the person or arrange for a rapid response.

As well as responding to an immediate need, Telecare can work in a preventative mode, using the technology to provide safety and security through bogus caller and burglar alarms. It can therefore support people to live in their own homes in community settings for longer and prevent or delay unnecessary admissions to hospital and residential care.

The benefits of using technology to maximise the potential for independence for adults with learning disabilities is also well established. The technology enables people who have defined problems of attention, security or safety to take control over their lives and to avoid the need for higher levels of support from care workers. It has been very beneficial in supported living environments in Redbridge.

Some people with dementia may have additional long-term conditions, which may prevent them from performing daily living activities or personal care tasks in case of accidents. Many of these risks can be managed through sensors that quickly detect emergencies such as falls, floods and seizures. The event will be reported to the monitoring centre so that an intervention can be arranged to prevent the need for hospitalisation.

The benefits of Telecare for individuals with dementia are well recognised in Redbridge; however, use of some equipment may raise ethical concerns particularly when considering the potential introduction of Global Positioning System (GPS) enabled equipment to the mainstream Telecare service. GPS technology is not yet used in Redbridge although it has recently been introduced in other authorities, including Havering. The new Dementia Plan provides the opportunity to consider /explore with partners including service users and carers, some of the ethical issues of Telecare and develop clear guidance and a protocol for practitioners, for example in obtaining consent. Valid consent should be: informed, competent, un-coerced and continuing and is a right which respects and protects a person’s autonomy. Work stream 3 is leading on the development of this technology.

Table 6 Numbers and types of telecare currently in use in Redbridge

<table>
<thead>
<tr>
<th>Number in use</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2100</td>
<td>pendant alarm</td>
</tr>
<tr>
<td>1900</td>
<td>pendant alarm for service users within sheltered housing schemes</td>
</tr>
<tr>
<td>64</td>
<td>Fall Detectors</td>
</tr>
<tr>
<td>54</td>
<td>Pressure Mat Sensors</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>51</td>
<td>Smoke Detectors</td>
</tr>
<tr>
<td>37</td>
<td>Gas Detectors</td>
</tr>
<tr>
<td>37</td>
<td>Medication Dispensers</td>
</tr>
<tr>
<td>29</td>
<td>Bed Occupancy Sensors</td>
</tr>
<tr>
<td>23</td>
<td>Magi Plug Sensors</td>
</tr>
<tr>
<td>18</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>16</td>
<td>property exit sensors</td>
</tr>
<tr>
<td>14</td>
<td>Temperature Extreme Sensors</td>
</tr>
<tr>
<td>11</td>
<td>Chair occupancy Sensors</td>
</tr>
<tr>
<td>11</td>
<td>socket guards</td>
</tr>
<tr>
<td>11</td>
<td>epilepsy sensors</td>
</tr>
<tr>
<td>6</td>
<td>flood detectors / Lamp Module/ Pillow Alert</td>
</tr>
</tbody>
</table>

**Housing**

In Redbridge there are a number of ways in which people with dementia can be supported to live as independently as possible for as long as they are able. In addition the Housing Service is:

- scoping the development of 60 units of accommodation that will increase access to extra care for people with a range of support needs including people with dementia;
- running a Housing Panel which meets monthly to review all referrals for supported living and matches people to suitable properties;
- promoting supported housing options for new placements and working with providers to re-model residential care homes into supported living schemes;
- developing a service improvement programme to improve the quality of contracts for supported living including developing more outcome based contracts together with an expectation that providers work pro-actively with service users to develop independent living skills;
- working with older carers to identify potential future housing needs;
- continuing to host housing fairs to raise awareness of housing options;
- actively using the London Care Funding Calculator (CFC), for supported living placements, which helps tailor support to meet individual needs and helps to manage the market;
- keeping the accessible housing information booklet updated; and
- establishing a Floating Support Service to support 20 residents in their own homes to maintain their tenancies.

In addition the Housing Service is actively taking steps to improve access to appropriate housing and is committed to extending staff awareness through training, of the needs of
people with dementia, including those that may have support needs but may not be in
the care system. The Council’s Housing Allocation Scheme and Tenancy Strategy were
reviewed during 2013.

Workforce Development

The National Strategy and local feedback clearly highlighted that training, ranging
from awareness-raising to more specialised training for professionals diagnosing and
working with people with dementia is a key issue.

In Redbridge there are a number of partnership groups and forums that work with a range
of organisations from the statutory, private and voluntary sector in terms of learning and
development opportunities on priority areas across NHS and social care, and a varied
programme of training opportunities is provided.

Existing forums such as the Redbridge Learning Collaborative and the Outer North
East London Learning & Development Partnership are a good source of information and
good practice examples and they routinely advertise training sessions to local providers.

Work is also underway to improve the end of life experience of people with dementia and
their carers through a range of learning and development opportunities ranging from End
of Life Gold Standard Framework (GSF) training for G.Ps, Care Homes and Domiciliary Care
providers, to specialist, one off sessions on specific issues such as having difficult
conversations with service users and carers about advanced care plans.

The growth in pan London strategic health and social care networks, particularly around
end of life and dementia, also provide the opportunity to benchmark against other areas
and for professionals and clinicians to develop and share training and audit tools to
improve local practice, across GP practices, day care, home care, residential, specialist and
acute hospital settings.

An example of this is the Health Education North Central & East London  with UCL Partners
who are working together to lead a cultural change in dementia care across London, by
aiming to ensure 12,000 clinical and non-clinical health care staff receive introductory
awareness training by March 2014. The programme is being rolled out to a wide variety of
staff including those working in hospitals, general practice and community settings.

A session took place at a protected learning event for Redbridge CCG GPs and BHRUT have
won an award for exceeding the target of 15% of their workforce by training more than 786

Areas for Improvement

Prior to the development of the Plan, the Redbridge Dementia Partnership undertook a
review of its role and terms of reference to reflect the new local landscape in terms of
health and social care commissioning and service delivery. They also developed an Action
Plan, see table below, which reflects national and local priorities and will include the
actions described in the consultation section above derived from feedback from service
users, carers and their representatives, to ensure continuous improvement. In addition the
RDP has strengthened its position within the health and well-being framework for
reporting progress and making sure that creating dementia friendly communities
becomes everybody’s business.
Areas for improvement – Redbridge Dementia Action Plan

Nb. The actions included here form part of the consultation process and may therefore be subject to change. Lead work streams 1-4 have been identified, however they will be expected to work together on many of the actions allocated to them to ensure a co-ordinated and integrated approach to all developments.

| Outcome 1: *I was diagnosed early*  
| National Dementia Strategy Objective 1 & 2 | Lead for implementation  
| **Actions:**  
Contribute to the redesign of the dementia care pathway from a community perspective to enable service users, carers and professionals alike to have clarity where and how to seek support and access to services.  
Promote lifestyle activities that may contribute towards the prevention of dementia by developing an awareness-raising plan that reduces the stigma associated with dementia and promotes the benefit of timely diagnosis and care.  
Develop a programme of public awareness and information sessions within GP practices. | Workshop activity December 2013  
then to work stream 1  
Work stream 1 to develop a plan for implementation across work streams 2, 3 & 4  
Work stream 1 |

| Outcome 2: *I know what I can do to help myself and who else help me*  
| National Dementia Strategy Objective 3, 4, 5, 6, 13 | Lead for implementation  
| **Actions:**  
Increase awareness and access to Early Intervention Services for Black, Asian and Minority Ethnic communities.  
To consider how to ensure Memory Clinics are accessible to all and services work together in a co-ordinated way across health and social care.  
Through learning and development opportunities support the development of a dementia friendly Council | Work stream 1  
Work stream 1  
Work stream 4 |
### Outcome 3: Those around me and looking after me are well supported
National Dementia Strategy Objective 1, 4, 5 & 6

<table>
<thead>
<tr>
<th>Actions:</th>
<th>Lead for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Living Well Resource Centre as a community hub</td>
<td>Work stream 1</td>
</tr>
<tr>
<td>Develop Community Bridge Builders</td>
<td>Work stream 1</td>
</tr>
<tr>
<td>Promote health &amp; wellbeing events with other long term conditions teams to develop awareness of conditions</td>
<td>Work stream 1</td>
</tr>
<tr>
<td>Raise awareness and promote opportunities for carers and people living with dementia to make Advance Care plans and discuss end of life needs in a suitable and responsive way through a series of events</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>To ensure that in re-design of a dementia care pathway that the needs of carers are taken fully into account, including access to carer’s assessment, access to supportive therapies including psychological therapies and access to carers’ peer support group</td>
<td>Work stream 1</td>
</tr>
</tbody>
</table>

### Outcome 4: I feel included as part of a society
National Dementia Strategy Objective 1, 5 & 16

<table>
<thead>
<tr>
<th>Actions:</th>
<th>Lead for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop User Involvement/ Engagement Group</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>Develop opportunities to access creative arts, sports &amp; leisure activities and volunteering when considering the care pathway</td>
<td>Work stream 3</td>
</tr>
<tr>
<td>Explore sustainability of community based creative arts projects</td>
<td>Work streams 3 &amp; 4</td>
</tr>
<tr>
<td>Development of Dementia Friendly Communities Pilots</td>
<td>Work stream 1 &amp; 4</td>
</tr>
<tr>
<td>Consider the impact of limited availability of transport escorts and look for solutions.</td>
<td>Work stream 1</td>
</tr>
</tbody>
</table>
**Outcome 5: I understand, so I can make good decisions**  
National Dementia Strategy Objectives 3, 4 & 5

<table>
<thead>
<tr>
<th>Actions:</th>
<th>Lead for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review, in terms of quality and accessibility and if required improve current information, advice and advocacy which is available for people with dementia and their carers to ensure that it meets a range of communications needs</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>Review the dementia resource pack and target GPs</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>Review information sharing protocols</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>Promote increased partnership working with Learning Disability Community Teams and develop care pathway, education and awareness for people with a learning disability and adults on the autistic spectrum</td>
<td>Work stream 4</td>
</tr>
<tr>
<td>Review current training &amp; development offered to LBR, RCCG, BHRUT, NELFT and voluntary and community sector agencies to ensure all staff working with people with dementia and their families have access to good quality training</td>
<td>Work stream 4</td>
</tr>
</tbody>
</table>
### Outcome 6: *I get the and support which are best for my dementia and my life*

**National Dementia Strategy Objective 2, 6, 8, 9, 10, 11, 13 & 18**

<table>
<thead>
<tr>
<th>Actions:</th>
<th>Lead for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that processes for personalised services are fully accessible to people with dementia and their carers.</td>
<td>Work stream 3</td>
</tr>
<tr>
<td>Develop a guide to creative personal budgets specifically tailored to people with dementia and their carers and develop awareness sessions for key stakeholders</td>
<td>Work stream 3</td>
</tr>
<tr>
<td>Raise awareness and provide alternative solutions to long term care, through the use of assistive technology and supported housing options</td>
<td>Work stream 3</td>
</tr>
<tr>
<td>Improve quality of care for people with dementia in our local general hospitals including the care pathway, care environment and leadership for dementia care.</td>
<td>Work stream 3</td>
</tr>
<tr>
<td>Explore commissioning of specialist liaison through older people’s mental health teams in the general hospital.</td>
<td>Work stream 3</td>
</tr>
</tbody>
</table>

### Outcome 7: *I am treated with dignity and respect*

**National Dementia Strategy Objective 1 & 13**

<table>
<thead>
<tr>
<th>Actions:</th>
<th>Lead for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure dementia features into workforce development strategies across all sectors.</td>
<td>Work stream 4</td>
</tr>
<tr>
<td>Develop a Dementia Training Plan across agencies and BHR covering who/how/cost/formal/Informal</td>
<td>Work stream 4</td>
</tr>
<tr>
<td>To develop quality assurance framework that incorporates dementia and measures outcomes feeding into safe guarding quality assurance framework.</td>
<td>Work stream 2</td>
</tr>
<tr>
<td>To develop dementia activists within a range of care settings</td>
<td>Work stream 4</td>
</tr>
<tr>
<td>To explore issues relating to use of telecare technology such as GPS detectors particularly with regards to mental capacity.</td>
<td>Work stream 3</td>
</tr>
</tbody>
</table>
| **Outcome 8:** *I know how to participate in research*  
National Dementia Strategy Objective | Lead for implementation | Work stream 4 |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Actions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase opportunities for people with dementia and their carers to participate in research projects such as SHEILD</td>
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</tr>
</tbody>
</table>

| **Outcome 9:** *I am confident my end of life wishes will be respected and I can expect a good death.*  
National Dementia Strategy Objectives 1 & 13 | Lead for implementation | Work stream 4  
Workstream2  
Work stream 2 |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Actions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with End of Life (EoL) specialist facilitators to develop accessible training for staff who work with people with dementia to increase awareness of advance directives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raise awareness and promote opportunities for carers and people living with dementia to make advance care plans and discuss their end of life needs in a suitable and responsive way through a series of events.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the local End of Life procedures consider options for people living with dementia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Don’t you forget about me

APPENDIX A

Prime Minister launches Dementia Challenge

By 2015, the plan is for there to be a million people with the know-how to help people with dementia feel understood and included in their community.

REDBRIDGE DEMENTIA PARTNERSHIP

DEVELOPING A DEMENTIA FRIENDLY REDBRIDGE

Aims to improve the lives of local people with dementia

DEMENTIA FRIENDS CHAMPIONS ETC

Members of the Dementia Action Alliance (DAA) form part of a local network of organisations signed up to implement the 7 outcomes in the National Dementia Declaration

A DEMENTIA FRIEND etc.

A DAA Signatory agrees to develop an action plan to deliver the National Dementia Declaration and be part of micro dementia friendly communities e.g. by ward or catchment area

Our towns, our shops, our communities.
## APPENDIX B

### Quality standards mapping exercise *(Produced by London Dementia Strategic Clinical Network)*

<table>
<thead>
<tr>
<th>Strategy statements</th>
<th>Quality statements in the NICE Pathway on dementia</th>
<th>Outcomes</th>
<th>Commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Dementia</td>
<td>Areas in the NICE Pathway³</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality statement in the 2010 quality standard on</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>dementia⁴</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality statement in the 2013 quality standard on</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>supporting people to live well with dementia⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting commitment to improve care for people with dementia at every level of the NHS in London</td>
<td>8 Planning and evaluating services</td>
<td>I feel part of a community and I’m inspired to give something back</td>
<td>Local authority and CCG</td>
</tr>
<tr>
<td></td>
<td>Local authority and CCG</td>
<td></td>
<td>Local authority and CCG</td>
</tr>
<tr>
<td></td>
<td>ESS</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>

### Notes

² Department of Health, National Dementia Strategy
³ NICE, Dementia Pathway
⁴ NICE, Dementia quality standard, 2010
⁵ NICE, Quality standard for supporting people to live well with dementia, 2013
⁶ Department of Health, Quality outcomes for people with dementia: building on the work of the National Dementia Strategy, 2010
<table>
<thead>
<tr>
<th>Objective</th>
<th>Workforce and Care</th>
<th>Assurance and Evaluation</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Improving public and professional awareness and understanding of dementia</td>
<td>Staff training</td>
<td>1 Appropriately trained staff</td>
<td>I was diagnosed early</td>
</tr>
<tr>
<td>Objective 2: Good-quality early diagnosis and intervention for all</td>
<td>Specialist assessment services</td>
<td>2 Memory assessment services</td>
<td>I am treated with dignity and respect</td>
</tr>
<tr>
<td>Objective 4: Enabling easy access to care, support and advice following diagnosis</td>
<td>Investigation of suspected dementia</td>
<td>1 Discussing concerns about possible dementia</td>
<td>I understand, so I make good decisions and provide for future decision making</td>
</tr>
<tr>
<td>Objective 3: Good-quality information for those with diagnosed dementia and their carers</td>
<td>Promoting choice</td>
<td>5 Decision making</td>
<td>2 Choice and control in decisions</td>
</tr>
<tr>
<td>Needs arising from diagnosis</td>
<td>4 Leisure activities of interest and choice</td>
<td>9 Independent advocacy</td>
<td>I get the treatment and support which are best for my dementia, and my life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I am treated with dignity and respect</td>
</tr>
<tr>
<td>Improved quality of care in general hospitals/NHS care</td>
<td>Needs arising from diagnosis</td>
<td>3 Written and verbal information</td>
<td>Those around me and looking after me are well supported</td>
</tr>
<tr>
<td>Objective 5: Development of structured peer support and learning networks</td>
<td>Staff training</td>
<td>1 Appropriately trained staff</td>
<td>I understand, so I make good decisions and provide for future decision making</td>
</tr>
</tbody>
</table>
### Objective 8: Improved quality of care for people with dementia in general hospitals

<table>
<thead>
<tr>
<th>Inpatient care and care in an acute hospital</th>
<th>8 Liaison services</th>
<th>I get the treatment and support which are best for my dementia, and my life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated and coordinated care and service provision</td>
<td>1 Appropriately trained staff</td>
<td>I am treated with dignity and respect</td>
</tr>
<tr>
<td>4 Assessment and personalised care plan</td>
<td>8 Planning and evaluating services</td>
<td>I know what I can do to help myself and who else can help me</td>
</tr>
</tbody>
</table>

**CCG**

**CQUIN**

### Objective 9: Improved intermediate care for people with dementia

<table>
<thead>
<tr>
<th>Promoting independence and maintaining function</th>
<th>4 Assessment and personalised care plan</th>
<th>Those around me and looking after me are well supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing support</td>
<td>5 Maintaining and developing relationships</td>
<td>I can enjoy life</td>
</tr>
<tr>
<td>4 Assessment and personalised care plan</td>
<td>10 Involvement and contribution to the community</td>
<td>I feel part of a community and I’m inspired to give something back</td>
</tr>
<tr>
<td></td>
<td>3 Reviewing needs and preferences</td>
<td>Local authority and CCG</td>
</tr>
<tr>
<td></td>
<td>6 Physical and mental health and wellbeing</td>
<td>QOF (review)</td>
</tr>
<tr>
<td></td>
<td>9 Independent advocacy</td>
<td></td>
</tr>
</tbody>
</table>

**CCG**

### Objective 6: Improved community personal support services

<table>
<thead>
<tr>
<th>Providing support</th>
<th>4 Assessment and personalised care plan</th>
<th>I feel part of a community and I’m inspired to give something back</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 Maintaining and developing relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 Involvement and contribution to the community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Reviewing needs and preferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 Physical and mental health and wellbeing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 Independent advocacy</td>
<td></td>
</tr>
</tbody>
</table>

**Local authority and CCG**

### Living well with dementia in care homes

<table>
<thead>
<tr>
<th>Living arrangements and care home placements</th>
<th>7 Design and adaptation of housing</th>
<th>Those around me and looking after me are well supported</th>
</tr>
</thead>
</table>

**Local authority and CCG**

### Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.

<table>
<thead>
<tr>
<th>Living arrangements and care home placements</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Design and adaptation of housing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Those around me and looking after me are well supported</th>
</tr>
</thead>
</table>

**Local authority and CCG**

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"Don’t you forget about me"
<table>
<thead>
<tr>
<th>Objective 11: Living well with dementia in care homes.</th>
<th>Support for carers</th>
<th>6 Emotional, psychological and social needs of carers</th>
<th>Local authority and NHS England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced use of antipsychotic medication</td>
<td>Interventions for non-cognitive symptoms and behaviour that challenges</td>
<td>7 Non-cognitive symptoms and behaviour that challenges</td>
<td>I get the treatment and support which are best for my dementia, and my life</td>
</tr>
<tr>
<td>Improved end of life care</td>
<td>Objective 12: Improved end of life care for people with dementia</td>
<td>Palliative and end-of-life care</td>
<td>5 Decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I am treated with dignity and respect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I am confident my end of life wishes will be respected. I can expect a good death</td>
</tr>
<tr>
<td>Objective 7: Implementing the Carers’ Strategy for people with dementia</td>
<td>Support for carers</td>
<td>6 Emotional, psychological and social needs of carers</td>
<td>Those around me and looking after me are well supported</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 Respite services for carers</td>
<td>Local authority and CCG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appendix: C</td>
</tr>
</tbody>
</table>
Outcomes, overarching indicators and improvement areas for Adult Social Care, Public Health and NHS

**Adult Social Care Outcomes Framework 2013-14**

<table>
<thead>
<tr>
<th>Domain 1: Enhancing quality of life for people with care and support needs</th>
<th>Overarching measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Social care related quality of life</td>
<td>People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>1B. Proportion of people who use services who have control over their daily life</td>
</tr>
<tr>
<td></td>
<td>Carers can balance their caring roles and maintain their desired quality of life.</td>
</tr>
<tr>
<td></td>
<td>1D. Carer-reported quality of life</td>
</tr>
<tr>
<td></td>
<td>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.</td>
</tr>
<tr>
<td></td>
<td>1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3: Ensuring people have a positive experience of care and support</th>
<th>Overarching measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3A. Overall satisfaction of people who use services with their care and support</td>
<td>People who use social care and their carers are satisfied with their experience of care and support services.</td>
</tr>
<tr>
<td>3B. Overall satisfaction of carers with social services</td>
<td>3E: Improving people's experience of integrated care</td>
</tr>
<tr>
<td>3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for</td>
<td>Outcome measures</td>
</tr>
<tr>
<td></td>
<td>Carers feel that they are respected as equal partners throughout the care process.</td>
</tr>
<tr>
<td></td>
<td>3D. The proportion of people who use services and carers who find it easy to find information about support</td>
</tr>
<tr>
<td></td>
<td>People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.</td>
</tr>
<tr>
<td></td>
<td>This information can be taken from the Adult Social Care Survey and used for analysis at the local level.</td>
</tr>
</tbody>
</table>

**NHS Outcomes Framework 2013-14**

‘Don’t you forget about me’
| Domain 2: Enhancing quality of life for people with long term conditions | Overarching indicator  
2 Health-related quality of life for people with long-term conditions  
Improvement area  
Ensuring people feel supported to manage their condition  
2.1 Proportion of people feeling supported to manage their condition  
Enhancing quality of life for carers  
2.4 Health-related quality for carers  
Enhancing quality of life for people with dementia  
2.6i Estimated diagnosis rate for people with dementia  
2.6ii A measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life |
|---|
| Domain 4: Ensuring that people have a positive experience of care | Improvement area  
Improving people’s experience of integrated care  
4.9 Indicator in development |
| **Public Health Outcomes Framework 2013-16** |
| Domain 4: Healthcare public health and preventing premature mortality | Objective  
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.  
Estimated diagnosis rate for people with dementia |
Redbridge Dementia Plan 2014-2017
Continuing Engagement Feedback Form

1. Your Name: ………………………………………………………………………….

Organisation (if relevant)…………………………………………………………………….

Address:
…………………………………………………………………………………………………….

Tel:……………………………………………………………………………………………….

E-mail address:……………………………………………………………………………….

2. Do you agree that we have got the right priorities in the plan?

YES   NO

If No, please explain why and what you would have liked us to include

3. Do you agree that the tasks listed in the Action Plan will help achieve the desired outcomes?

YES   NO

If no, please say what else we could do

4. Are there any additional services to include in our service mapping?


Can you suggest ways of improving the overall Plan?

If you would like to be involved in Dementia Friendly Communities Work or help to achieve other outcomes? Please say how:-

If you have dementia or care for someone who has dementia and you would like to be asked about your views on some of the Projects listed in the Action Plan, please let me know

YES  NO

Thank you for completing this form. We welcome comments on our plan at any time. Please send your comments with the Equalities Monitoring Form to;

Julie Fanning
Adult Social Services,

Please send by e-mail to:

Myview.asc@redbridge.gov.uk or to,

julie.fanning@redbridge.gov.uk
Redbridge Council is committed to equality in all its activities and responsibilities. This means taking action to ensure that all our services are accessible and that all service users are treated fairly.

It will be very helpful if you can complete this form and return it to Julie Fanning at the above address. Your name and address or any other identifiers are not recorded and data will be treated confidentially. The information you provide will be used for monitoring purposes only.

**Gender:**
- **Tick**
  - Male
  - Female
  - Transgender

**Disability:**

- i.e. long-term illness, health problem or disability which limits daily activities or work (including problems due to old age).

**Ethnic Group:**
- **White**
- British
- Irish
- Polish
- Lithuanian
- Romanian
- Any other White background
- **Mixed**
  - White and Black Caribbean
  - White and Black African
  - White and Asian
  - Any other Mixed background
- **Asian or Asian British**
  - Bangladeshi
  - Indian
  - Pakistani
  - Any other Asian background
- **Black or Black British**
  - African
  - Caribbean
  - Any other Black background
- **Chinese**
- **Irish Traveller**
- **Roma**
- Any other Ethnic group

**Age:**
- 0-17
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

**Do you have an autistic spectrum condition?**

**Religion and Beliefs:**
- None
- Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Any other religion

**Sexual Orientation**
- Heterosexual/straight
- Bisexual
- Gay Man
- Gay woman/Lesbian
- I prefer not to say
Monday - Friday
9.00am - 5.00pm

London Borough of
Redbridge

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對於免費翻譯電話
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020 8554 5000

'Don't you forget about me'