

# LIVING WELL WITH DEMENTIA

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*Our local strategy 2013-16*



# Executive summary

## 1. **More people with dementia will be diagnosed, at earlier stages of the condition, and this will lead to better support and quality of life.**

- Increase memory service capacity, to reduce waiting time for assessment and diagnosis.
- Review the “shared care” for diagnosis, prescribing and post-diagnosis support. This will free up memory services capacity to work with people and carers according to need; improve consistency of care; and improve the experience for people and families.
- A local public awareness campaign, and local initiatives to identify and assess people who may have dementia, to complement national schemes.
- Develop and implement a Leeds standard of post-diagnosis care and treatment, for people with dementia and families / carers. This will include opportunities for information, education, social and therapeutic activities, and peer support. It will ensure that diagnosis is a genuine gateway to help, and encourage people with memory problems to seek a diagnosis.
- Continue to improve access to services and activities provided by voluntary and community groups and social enterprises (“third sector”).
- Support and pilot innovative approaches to eg. overcome barriers to diagnosis; support people with difficult decisions; and cope with the impact of dementia on relationships.

### **Results and Measures:**

- Diagnosis rate: This measures the number of people with a diagnosis as a % of the estimated number of people with dementia in the population. All 3 Leeds CCGs have set a minimum target for annual improvement of 2.5%. This means that, each year, the number of people on Leeds GP dementia registers will increase by at least 220.
- Reduced waiting time for memory assessment.
- There will be a new national indicator for NHS and adult social care, specifically for dementia, which will measure the effectiveness of post-diagnosis care in sustaining independence and improving quality of life. (expected 2014).

## 2. **Leeds will become more ‘dementia-friendly’, linked to our aspiration for Leeds to be the “best city”, and similar initiatives to be eg. ‘age-friendly’ and ‘child-friendly’. This will mean that people with dementia can participate more in everyday life, and maintain confidence and independence for as long as possible.**

- Leeds dementia strategy, action plan and its projects will be influenced by the involvement and experiences of people with dementia and carers.
- The Leeds Dementia Action Alliance will involve local communities, business and providers of services beyond health and social care, to develop initiatives that together will make Leeds dementia-friendly.

### **Results and Measures:**

- Local organisations and businesses signed up to Leeds Dementia Action Alliance and committed to actions.
- Leeds will be among the first local authority areas to be accredited with “dementia-friendly” status.

## 3. **People living with dementia alongside other health conditions and disabilities, will have integrated support to maintain emotional, psychological and physical well-being.**

- Community-based health, social care and third sector services will have improved access to dementia expertise, through co-working with mental health specialists and training initiatives.
- Social care providers and NHS services will work together better, so that people with dementia, frailty and complex needs are supported by a multi-disciplinary approach. This includes a new specification for the care homes liaison service, with capacity to provide educational and preventive approaches.

- Increase the opportunities for people to sustain daily routines, and participate in physical, creative and therapeutic activities, to promote dignity and self-esteem, and reduce boredom and frustration.

#### **Results and Measures:**

- Further reduction of inappropriate prescribing of anti-psychotic medication.
- Measures to be developed, including individual studies, of interventions which prevent admissions to hospitals and care homes.
- Consider a dementia 'sub-set' for joint health and well-being indicators which measure hospital and care home admissions.
- National indicator expected in Public Health Outcomes Framework – dementia and its impacts.

#### **4. People with dementia and carers are supported to plan and design care packages, and to make decisions about treatment, care and daily living. This will make it easier for people with dementia to accept services, sustain social and community life, and plan for the later stages of dementia.**

- Improve access to advocacy at key points in the “dementia journey”.
- Promote the benefits from, and share good examples of, self-directed support.

#### **Results and Measures:**

- More people with dementia with self-directed support.
- More people with advance care plans, especially in care homes.

#### **5. Develop a confident and capable workforce which provides person-centred care for people with dementia, including people with other health conditions and frailty.**

- Ensure NHS providers report on workforce eg. through quality accounts.
- Develop effective incentives and support for health and social care providers to train staff to the required level; eg. agreeing and achieving annual training plans.
- Make good use of the expertise within specialist services to provide training, and share skills.
- Offer training for voluntary and community organisations, and organisations outside health and social care, to improve dementia awareness, and promote inclusion in services.

#### **Results and Measures:**

- If feasible, to measure compliance with workforce statement from NICE quality standard: People with dementia who receive health and social care services, are supported by appropriately trained staff.

#### **6. People with dementia and carers have support to plan and prepare for the end stages of dementia; decisions about treatment and care are informed by a shared understanding of prognosis; and ensure services at end of life offer good care for people with dementia.**

- Promote awareness amongst clinicians and care providers of the signs and symptoms that dementia is reaching its end stages;
- Produce and disseminate clinical guidance for recognising and managing symptoms for people with dementia at end-of-life.

#### **Results and Measures:**

- People with a dementia diagnosis who have plans and decisions recorded on electronic palliative care co-ordination system (to be developed).
- If feasible, to use local data from the national survey on: Bereaved carers views of quality of care in the last 3 months of life. The survey reports data for when dementia is recorded on death certificates.



The artwork in this document is from The Living Story project, led by Artlink West Yorkshire, working with people with dementia who were inpatients at Asket Croft and The Mount in Leeds, and staff from those units. The project was funded by the Evan Cornish Foundation. Further information and a book from the project are available from Artlink West Yorkshire <http://www.artlinkwestyorks.org/projects.php>

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