BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: Dementia Update

Report Author: Dr Lisa Wilkins, Consultant in Public Health Medicine, on behalf of the Oldham Dementia Partnership

Date: Dec 2014

What the issue is:

Improving the diagnosis of, and support provided to, people with dementia and their carers is a national and local priority.

Requirement from the Health and Wellbeing Board:

To note the achievements to date of the:

- Joint Dementia Commissioning Programme
- Oldham Dementia Partnership
- Newly formed Oldham Dementia Action Alliance
- Local peer and carer support groups

To note the remaining challenges and the suggested priorities for 2015/16.

Background / Current Position:

This paper provides an update of the actions taken over the last two years to address the key findings of the dementia needs assessments and uses stories of people who have accessed the new services to illustrate some of the positive outcomes from the new investments and enhanced interagency and multidisciplinary working.

Recommendations:

- To note the collective achievements to date of people with dementia, their carers, volunteers and service providers in enhancing the quality of care for people with dementia in Oldham over the last two and a half years.

- To note the ongoing challenges and support further work to address these
Mary’s always been an active member of her local community - she has been on the executive of the New Deals for Community group in Hathershaw and is very involved in her beloved rugby team.

Earlier this year, she noticed problems with her memory and was referred to the memory service. One of the new memory liaison practitioners (MLP) visited her at home to find out more about the problems Mary was having and to run some cognitive screening tests.

The MLP remembers meeting an anxious woman who had lost a lot of her confidence. She had been sent reeling with a previous diagnosis of Multiple Sclerosis and was very anxious about a possible dementia as her mother and grandmother had both had dementia.

The MLP arranged for Mary to see the memory service consultant and attended the clinic appointment with her. Mary was shocked when the diagnosis of dementia was confirmed.

At Mary’s follow up home visit with the MLP, she was invited to the 10 week structured patient education programme run by the memory service. Although initially reluctant to come, Mary and her husband, John, had a warm welcome from the psychologists and MLP running the group.

They learnt more about all sorts dementia, stress, benefits and other services. They also met others who had dementia and began to overcome the stigma of talking about it. Mary realised that it also affected her husband and they were able to talk more openly about the impact of the dementia in their life.

Mary later went to the memory management group run by a MLP and occupational therapist, whilst her husband went on the course for carers run by the Alzheimer’s Society (the CRISP programme). Whilst going to the post diagnostic group together was helpful, they also found leaning apart had benefits. They both valued the separate space and time to focus on issues that were pertinent to their situation as individuals.

When people have been part of groups they often like to carry on meeting up with people they have met. Mary and John now go to Springboard, the Oldham wide charity (set up by, with and for carers and people with a dementia). The group meets weekly in a Royton church hall – people can come and access more information, activities, support and chat over a cup of tea and go on trips.

Springboard is also part of the DEEP group – the Dementia Action Empowerment group – a national scheme which supports people with a dementia to have more of a campaigning and educational voice.

As part of Springboards work with DEEP and Oldham Gallery – the arts based team Arthur+Martha came and worked with people with dementia producing art and poetry and shared stories. This autumn the Arthur+Martha project ran a workshop at the National Dementia Congress in Brighton. Mary and her husband went down to Brighton and represented Springboard at the Congress. Mary gave a presentation at the workshop describing what it’s like having dementia and what Springboard means to her.

Of the conference Mary says “I wouldn’t have missed it for the world! I was gobsmacked … I didn’t think I could do it. I spoke from my heart not my head. It was nice of people to come up afterwards and thank me and say how well I had done. Someone said that was the best speech they’d heard at the conference. It was nice for a young person to come up and say that. I couldn’t have done it without the post diagnostic group, the memory management group and Springboard.

I didn’t realise what was happening ( out there ) … how many people are in the same position. Dementia is a closed book. People don’t want to talk about it .. they class it as stigma. It’s not a stigma. You’ve got to look forward not backwards”

Mary’s MLP says “With the previous service Mary would have been diagnosed, discharged and stayed at home with her confidence getting worse. Now Mary has turned her talents as a community activist to promote the cause of reducing the stigma of dementia in Oldham”.
1 Background
Improving the quality of care and support for people with dementia and their carers is a national priority. The 2009 National Dementia Strategy was reinforced in 2012 by the Prime Minister's Dementia Challenge.

It is estimated that there are 2,520 people with dementia in Oldham and that the number will increase by two thirds by 2030.

The Joint CCG and Council Dementia Commissioning Group was set up in March 2012 and undertook a number of dementia needs assessments in 2012 and 2013.

Over 50 key stakeholders were interviewed and a further 130 attended workshops. Age UK Oldham were commissioned to undertake in depth interviews with people with dementia. The national policy and evidence base were reviewed along with results from national and local audits.

The needs assessments focused especially on:
- Views of people with dementia
- Early diagnosis and post diagnostic support
- Communication support
- Mental health needs of care home residents
- Antipsychotics

A rapid health needs assessment of the Health & Healthcare Support Needs of Care Home Residents was also undertaken in 2013.

This paper provides an update on the key findings of the needs assessment and actions taken to address gaps. Stories of people with dementia are used to illustrate some of the benefits that the people of Oldham are receiving from the changes in services and improvements in interagency working. Pseudonyms have been used for all the case studies.
2 What were we told in the Needs Assessments?

<table>
<thead>
<tr>
<th>Key Findings of the Needs Assessments</th>
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<tbody>
<tr>
<td>• Lots of organisations involved in supporting people with dementia but <strong>little collaboration/coordination in improving services</strong></td>
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<td>• Too often takes <strong>too long to get a diagnosis</strong></td>
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<td>• <strong>Primary care not always taking initial concerns seriously</strong></td>
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<td>• <strong>Long waits</strong> for Memory Service</td>
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<td>• Once get diagnosis, <strong>little information</strong> about dementia or local services</td>
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<tr>
<td>• <strong>Little post diagnosis support</strong> until bad enough to need Community Mental Health Teams</td>
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<td>• Many professionals <strong>lack knowledge</strong></td>
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<tr>
<td>• People with dementia and their carers quickly become <strong>socially isolated</strong></td>
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<tr>
<td>• <strong>Variable quality</strong> of care in <strong>care homes</strong></td>
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<tr>
<td>• Often <strong>lack of meaningful activities</strong> for care home residents</td>
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<tr>
<td>• High levels of <strong>unmet mental health needs</strong> for care home residents</td>
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<tr>
<td>• <strong>Variable healthcare support</strong> for care homes</td>
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<tr>
<td>• <strong>High levels of antipsychotic</strong> use in care homes/own homes</td>
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<td>• <strong>Difficulty accessing specialist mental health support</strong></td>
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3 What has been done?

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<thead>
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<th>Overarching Achievement</th>
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<td><strong>Primary Care Dementia Registers</strong> have increased by over 500 between March 2012 and Nov 2014, from 1,187 to 1,721.</td>
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<td>March 2015 <strong>national dementia diagnosis rate target of 67% met</strong> by September 14.</td>
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<tr>
<td>March 2015 <strong>local Better Care Fund dementia diagnosis rate target of 68% met</strong> by November 14.</td>
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3.1 Oldham Dementia Partnership and Oldham Dementia Action Alliance (DAA)

- The cross agency Dementia Partnership was set up March 2013.
- Oldham DAA is a subgroup of the Oldham Dementia Partnership (figure one).
### Achievements

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<tr>
<th><strong>Greatly enhanced interagency communication</strong> and working</th>
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<tr>
<td>Accredited by Alzheimer’s Society as having met foundation criteria for ‘working towards dementia friendly community’ in May 2014</td>
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<td><strong>Oldham Dementia Action Alliance</strong> launched at the oversubscribed <strong>Oldham Dementia Partnership Conference</strong> in July 2014</td>
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<td>Over 2,600 dementia friends since August of 2014 – more than five times the target set on World Alzheimer’s Day (1,370 face-to-face DF sessions and 1,222 online)</td>
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<td><strong>Around 30 Dementia Friends Champions</strong> delivering Dementia Friend Sessions and peer support network set up to support them</td>
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<td>Over 30 organisations signed up to <strong>Oldham Dementia Action Alliance (DAA)</strong>, all of which are working to implement their own action plans to make their services more dementia</td>
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### Outcome

**Dementia Friendly Community and High Quality Care for People with Dementia & their Families**

### Oldham Dementia Partnership

- Collectively working to enhance quality of services for people with dementia and their carers:
  - NHS
  - Council
  - Voluntary sectors
  - Private

### Oldham Dementia Action Alliance

- **Training Needs Analysis, Competency Framework Development, Training**
- **Information Group**
  - Service guide
  - Pt/Carer information pack
  - Website
  - Bulletin
- **Public Reference Group**
  - To help identify priorities and shape implementation
- **Increasing Community Awareness of Dementia**
  - Dementia Awareness Week
  - Media
  - Libraries
  - Theatre/Performance / Art
  - Public events
- **Uppermill Dementia Friendly Communities**
  - Big Lottery / Alzheimer’s Society Pilot
- **Dementia Friends Campaign**
- **Communications Plan**

### Supporting CCG’s implementation of Dementia Primary Care Indictors (EQALS)

- Supporting the reduction of use of antipsychotics in people with dementia
- Enhancing awareness of dementia in people of BME heritage and increasing their access to dementia services

### Oldham Dementia Partnership

- Training Needs Analysis, Competency Framework Development, Training
- Information Group
  - Service guide
  - Pt/Carer information pack
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- Dementia Friends Campaign
- Communications Plan
friendly. District Partnerships supporting recruitment of local organisations and businesses to the DAA.

Developing **Oldham Dementia Action Friends** – group of people with dementia and carers who are advising the Dementia Action Alliance Steering group

**Big Lottery Funded Alzheimer’s Society Dementia Friendly Community pilot in Uppermill**

**Range of activities to increase community awareness of dementia:**

- **Oldham Theatre Workshop Christmas production.** 'Moments' - a story about the search for what matters most. Told through the eyes of young and old this cross generational piece touched on the pressing issue of dementia and explored how we learn to live with and without our memories.

- **Regular dementia coverage in Oldham Chronicle and other local newspapers**

- **Widespread distribution of promotional materials in 2103 and 2104 dementia awareness week**

- **Over 50 activities in 2104 dementia awareness week**

- **‘Worried about your memory’ poster and pop-up banner campaign 2014**

- **Dementia awareness Radio Ramadan clip played 10 x daily throughout Ramadan plus Q&A radio interview**

- **Age UK Oldham dementia awareness stall at mela**

- **Regular dementia awareness sessions run by Home Instead and Miller Care**

**Access to information for people with dementia and their carers greatly enhanced:**

- **Patient/carer information pack** is now given to all patients newly diagnosed with dementia by the memory service

- **Key Services Guide** outlining all the key services for people with dementia and their carers in Oldham. Guide available on line and from Age UK Oldham and widely distributed

- **Range of dementia related books now available in libraries** in Oldham and will be further enhanced in January 15 with the launch of the national dementia books on prescription collection

- **Range of courses accessible to carers run by Oldham Council**

- **Alzheimer’s Society** commissioned to provide **(CRISP) courses for carers**

- **Range of information sessions run during dementia awareness week May 2014**

**Training for primary care:**

- **3 half day training sessions held for primary care** – importance of timely diagnosis, management of challenging behaviour, mental capacity act and advance care planning
**Brenda and Alfred’s Story**

Brenda’s husband Alfred was diagnosed with Alzheimer’s Disease in 2014. Alfred has other long standing health issues including depression. Their son works and lives far away. Brenda is retired, and used to enjoy going away on holidays until Alfred’s health made this impossible.

Brenda was finding it difficult to communicate with Alfred and felt she had to provide growing support in an atmosphere of denial and lack of trust by Alfred. Brenda felt lost and was not sure what help she needed or where to go to get it.

Brenda met the Alzheimer’s Society staff during a market event in the locality where she lives and heard about the planned course for carers of people with dementia (the CrISP course).

After the taster session, Brenda said she had such high hopes that she invited a friend whom she knew was in the same position as herself and they have both found the information and interaction from the sessions very useful.

Brenda said the course had improved her understanding of the progression of Alzheimer’s, given her a sense of direction and that she had learnt about coping, the need to plan ahead regarding Lasting Power of Attorney (LPA) and realised the level of help she needed and where to get it.

After the session on money matters “I have opened a bank account in my name which I never had because I simply relied on the joint bank account that Alfred and I have. In addition, Alfred has accepted to do the LPA and I have registered as a carer with my GP”

Brenda was given a list of services in the local area which can provide support, details of Alzheimer’s Society staff and referred to the Alzheimer’s Society Lasting Power of Attorney Digital assistance service.

*In Brenda’s words, “The programme has given me more understanding and thereby reduced my frustration”*.

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**Dementia Awareness and Dementia Friendly Community Continuing Challenges and Priorities**

Priorities include:

- Making Oldham a Dementia Friendly Community
- Increasing the input of people with dementia and their families to the Dementia Action Alliance, eg via the developing Friends of Oldham Action Alliance group
- Procuring a service to support the DAA
- Increasing dementia awareness in all sectors of the community, including in particular communities of South Asian heritage
- Increasing awareness of sources of information about dementia and the local services available
- Continuation of the dementia friends programme
- Increasing membership of the DAA and supporting members to make their services/organisation more dementia friendly
- Having a range of events/activities for dementia awareness week in May
- Developing the role of volunteers to support dementia friendly communities
- Development of intergenerational projects

### 3.2 Peer and Carer Support Groups and Community Activities

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<thead>
<tr>
<th>Achievements</th>
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<tbody>
<tr>
<td>• More people with dementia and their carers are benefiting from peer support and community and voluntary sector led activities.</td>
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<tr>
<td>• There are a number of peer and carer support groups which have been set up by and are run by people with dementia and their families. These are all self-funding and include:</td>
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<tr>
<td>• The long standing Saddleworth Carers Group – number of people regularly attending the meetings has increased from 15 to 40 per week, frequency of meetings increased, opportunity to get support, take part in quizzes, games, activities, outings, listen to talks, or have party celebrations.</td>
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<tr>
<td>• Chadderton Café Club - Meets Wednesdays in the Chadderton Wellbeing Centre Café. It is run by volunteers from the Firwood and District Residents’ Association, led by a Dementia Champion and supported by pupils from Blessed John Henry Newman RC College as part of their Duke of Edinburgh Award Scheme. This free facility supports lonely people and individuals with dementia and enables carers to have a break knowing that their loved one is safe. There is opportunity to chat, play cards and get involved in computer activity e.g. researching your family history.</td>
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<tr>
<td>• Friday Lunch Club at Mills Hill Primary School - Meets each Friday in term time for lunch. This is another inter-generational activity run by volunteers from the Firwood and District Residents’ Association. Lunch is prepared in school and after lunch there are activities, including armchair exercises, aromatherapy and sessions run by the lifelong learning team.</td>
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<tr>
<td>• Springboard – peer and carer support group that meets weekly in Royton. See story below.</td>
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<tr>
<td>• A range of community led projects are helping people with dementia to stay active and prevent isolation. For example, in Chadderton, Walk and Talk activities in Chadderton Hall Park; Afternoon Tea 'Get Togethers' organised each week at the Hunt Lane Tavern; reminiscence project work being run within the S. Chadderton Youth Centre's Heritage Lottery Project; and weekly activities at the Chadderton Wellbeing Centre</td>
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<tr>
<td>• Age UK Oldham run a range of activities including men in sheds, a choir, storytelling, craft clubs, luncheon clubs, lifestory.</td>
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<tr>
<td>• Alzheimer's Society have a weekly 'singing for the brain' session</td>
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<td>• Oldham Community Leisure have a wide range of physical activities for older</td>
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people and have won national awards for their innovation supporting people with dementia

- **Gallery Oldham** Arthur and Martha arts/reminisce project and future work developing dementia friendly trail around gallery, reminisce boxes and local history photo albums

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**Springboard’s Story**

Group of people with dementia and their carers attended a pilot of the memory service’s structured patient education programme in 2012. Following this they got together and, with the support of Pennine Care’s consultant clinical psychologist, Springboard was formed. Springboard was successful in obtaining a small Strategic Health Authority innovation grant in 2012 but otherwise is self-funded. They became a charity in 2014.

Springboard were nominated for a Pride in Oldham award in 2014.

Springboard now has over 150 members with more than 60 attending their meetings each week. They promote themselves as ‘A social meeting place with a range of positive activities for people living with dementia, their carers, family and friends. It’s a welcoming and safe environment, where people are not judged. Our motto is “We’re here and we care”.’

Recent activities members have taken part in include:

- Age UK story telling project
- Life Story work
- Silver Stars Talent Contest at Oldham Coliseum. 2 members of the group (1 cared for) sang in the Autumn Leaves choir on the stage
- Committee members visited Educate in Stockport and we have also had guest speakers from Educate Stockport come to our group to share their experiences and coach and encourage our members to speak.
- Visits by professionals from other organisations to offer their help and support
- Talk from the Fire Service on home safety
- Fun day at pub in Shaw
- Days out
- Craft activities

Members are becoming Dementia Friends

Springboard’s committee and members are a powerful advocate in supporting wider improvements in care and support for people with dementia. For example:

- Springboard is part of the DEEP group – the Dementia Action Empowerment group which supports people with a dementia to have more of a campaigning and educational voice. This is funded by the Joseph Rowntree and the Mental Health Foundation and co-ordinated and supported by Innovations in Dementia
- Have representatives on the Oldham Dementia Partnership, Oldham Dementia Action Alliance Steering Group, Oldham Dignity Partnership and Oldham Life Story Steering Group.
- One of their members was on the Question and Answer panel at the Oldham Dementia Partnership Conference in July 2014 and spoke to an audience of more than 150 people about his personal experience. This received regional press coverage. The conference was attended by one of Oldham MPs and Prof Alistair Burns, National Clinical Director for
Dementia.

- Have attended and spoken at the National Dementia Conference
- Ran a workshop at the training for primary care on the importance of early diagnosis form the carers and person’s with dementia viewpoint
- Have provided the council with feedback on care home standards and been involved in workshops to support the development of new local care home quality standards
- Provided feedback on an NHS Dementia platform which was being developed by Pennine Care NHS Foundation Trust
- Influenced Oldham Healthwatch to ensure all their staff became Dementia Friends.

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Mr and Mrs Wilson's Story

Mr and Mrs Wilson contacted the Alzheimer’s Society Support Service. At their home visit they explained that Mr Wilson had not liked going out since he had been diagnosed with dementia because he doesn’t know enough about his diagnosis and feels embarrassed and alone in his situation.

Mrs Wilson feels socially isolated and reports feeling lonely because she says that she can no longer leave Mr Wilson at home alone. Mrs Wilson misses going out and the social network of support that brings with it. She feels that she is becoming depressed and wants to prevent this from happening.

The dementia support worker spent time talking to them about what dementia is and suggested coping strategies for specific situations individual to them. She provided information about several social groups and services that are available in Oldham, including the Singing for the Brain service.

Mr Wilson was unsure about attending any groups but the dementia support worker spent time explaining what happens and who will be there. Mr Wilson decided he would give the singing for the brain activity a try.

Mr and Mrs Wilson attended the Singing for the Brain group, both reported thoroughly enjoying it. They are now regular attendees, and both now regularly seek peer support, information and signposting from the group.

Mr Wilson has said he has made a number of friends within the group. Both Mr and Mrs Wilson have expressed on numerous occasions that they no longer feel isolated, alone and depressed with their situation.

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Peer and Carer Support Continuing Challenges and Priorities

- More meetings are really needed to support all the people with dementia and their carers now wishing to attend the support groups
- Logistics of setting up meetings, inviting speakers and organising activities is very time consuming for people who have large caring responsibilities
- Fund raising is needed to keep the groups going

Priorities for 2015/16:

- Link carer/peer support groups with Making Space (see memory service) who can provide logistical support in setting up and organising activities for more groups under the leadership of the existing groups
- Maximise fund raising opportunities in Dementia Awareness week to support the groups
Support an increase in volunteer support for the groups

Via the Voluntary Action Oldham, the Dementia Action Alliance and District Partnerships support the development of more community-based activities for people with dementia and their carers

## 3.3 Extra care housing

### Achievements

Commencement of **Extra Care in 4 housing schemes during the** summer of 2014:

- Aster House, Coldhurst (33 flats)
- Trinity House, Coldhurst (54 flats)
- Tandle View Court, Royton (60 flats)
- Charles Morris House, Failsworth (30 flats)

This is commissioned by Oldham Council and delivered by Housing and Care 21 and Domus Care.

**Extra care housing (ECH):**

- Seen as “Step up” from sheltered housing & “Step down” from residential care
- Offers affordable rented self-contained apartments
- Predominately (not exclusively) for over 60s with care and/or support, and housing needs, where ECH is a part of enabling them to remain independent
- Designed with services and amenities to enable residents to maintain choice and control over their daily lives.
- Working towards a more integrated model where users health and social care needs are met and responded to as they change.

**Residents benefit from:**

- **24/7 service:** mix of care, security or support: at least 1 member of staff on site at all times, so offering more instant access to care/support, consistent care team on site.
- **Night Concierge:** Housing and Care 21 staff from 11 pm – 7 am every day
- **Care Provider:** 7 am – 11 pm every day
- **Court Manager:** HC21 from 9 am-5 pm Monday – Friday
- **Helpline & Response:** for emergencies & response at nights and during the day, as necessary if the Care Team are not able to respond first
- **Wellbeing service from Domus Care** includes:-
  - Programme of Daily activities (including Weekends)
  - Morning well-being (call each day by care team)
  - Support access to activities/amenities
  - Access to short term Step up/down care for FACs eligible tenants (<two weeks)
• **Immediate response to care call** from care team/concierge on site
• **Meals on site** with support to get there

Care staff report positive increase in people participating in social activities and that tenants are feeling part of a community again and say that they don’t feel isolated and lonely anymore.

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### Alan’s Story
Alan lives in Charles Morris House where he would stay in his bed most days, only ate cereal and was assisted to eat by carers most days.

Alan is now getting up having breakfast in the restaurant and isn’t requiring support from staff now to do this having increased his confidence. He is participating in a cards & dominos group in the evening and has now built confidence to talk with other tenants where he lives.

Alan has been dancing with carers on a social evening event that was arranged within the extra care setting, which has identified how far he has come in the short time the on site care has been in situ.

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### Bernard’s Story
Bernard is a gentleman that lives within an extra care setting.

He was discharged home from hospital back to his flat which he had been away from for a number of weeks. With the care support now working on site Bernard was greeted on his arrival home and supported from the staff on site to unpack, reoriented to his flat and settled with a drink.

Bernard was waiting for his son to arrive and was getting anxious as he was late. The staff supported Bernard to go down into the reception area to wait for his son. This calmed him down and also gave him a chance to talk with other individuals that live within the building.

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### Andrew’s Story
Andrew lives in Charles Morris House where he didn’t take part in any social activities or access the restaurant for his meals. Andrew was very isolated even though he lived in a setting where activities & groups were available.

With support from staff & carers Andrew has now gained confidence where most days he will access the restaurant for his daily hot meal. He is now able to go without support and has started to access the male card group in the evenings where he is forming friendships.

Andrew is now less socially isolated and his health and wellbeing has increased significantly.

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### Extra Care Continuing Challenges and Priorities

**Extension of Extra Housing to additional schemes:**
- About to consult with tenants in a further two schemes – Old Mill House, Hopwood Court with a view to a new offer in the Summer in these schemes

**Planned improvements:**
- Better CCTV with monitoring linked to First Response service
• Better progressive security, signage, perimeter fencing and door security
• New Dementia Gardens
• Consistent staff teams leads to less anxiety, better condition management
• Develop close links with Community Health Services. Shared approaches with DNs, Physios, Medics, Pharmacists locally, to develop relations with care providers, care management to provide more joined up inputs and planning given new service in ECH
• Need for staff and tenants to be more dementia aware

**Care and Repair / Home Agency Service**

• A business case is being prepared for the Integrated Commissioning Partnership for a home care and repair/home improvement agency to help support people to maintain and stay in their own homes for longer.

### 3.4 Oldham Memory Service

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<tr>
<td><strong>New enhanced multiagency memory service commissioned</strong> with:</td>
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<tr>
<td>• An increase in diagnostic assessment service capacity</td>
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<tr>
<td>• Greatly improved post diagnostic support for patients with dementia via an enhanced multi-disciplinary team</td>
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<tr>
<td>• Greater collaborative working between partners</td>
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<tr>
<td>• Greater support for primary care and other community health and social care services</td>
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This is facilitating the early diagnosis of dementia and provision of early interventions to support people with dementia and their carers, with the aim of helping to reduce / delay the need for more intensive services and crises that precipitate admission to hospital and care homes.

The Service is commissioned by Oldham Clinical Commissioning Group and Oldham Council, and being delivered via a partnership approach, including a mental health provider and voluntary sector partners working closely with, and supporting, primary care.

The Service also looks to build on the current role of volunteers and peer support.

**Pennine Care NHS Foundation Trust Memory Service: Supporting diagnosis and post diagnostic support**

• Enhanced **multi-disciplinary team** including 8 mental health nurses (Memory Liaison Practitioners), psychologists, occupational therapist and speech and language therapists.
• Nearly **1,400 referrals to memory service** during the calendar year of 2014 - more than doubled compared to the 623 referrals in 2011/12
• All new patients offered **initial home assessment by memory liaison practitioner within 3 weeks of referral**
• **Most consultant memory clinics moved to community settings**
• All new patients whose diagnosis of dementia is confirmed are given a named **Memory Liaison Practitioner** who provides follow up home visits post diagnosis to
give further information and support development of a care plan, provide on-going advice and annual reviews

- **Over 900 calls for advice to MLPs each month**
- Two well attended **drop in sessions** per week
- Structured **patient/carer education programme**
- **Memory management group**
- Support to **peer support groups**
- **Training and awareness sessions provided to primary care**

**Age UK Oldham Dementia Information Service**

- **340 contacts per quarter** to provide face to face, home visits or telephone **advice to people with dementia, their families, public and professionals** eg welfare advice, shopping/domestic services, choosing the right care (domiciliary and care homes), planning ahead, lasting power of attorney, information about and support to access local services and community activities and leisure opportunities
- **Range of dementia resources**
- Responsible for update and distribution of **key service guide and patient/carer information pack**
- Developing **dementia webpages** for Oldham Council Website
- Supported or led **wide range of awareness raising activities**

**Making Space: Supporting community participation and social activities**

- New service commenced Nov 14
- Service will support people with dementia to **maintain independence, social participation, confidence and motivation** via befriending, volunteer support to access activities, range of group activities for people with dementia, develop and support peer and carer support groups
- The Service will also advise other organisations to make their activities more dementia friendly

**All three partners are very active members of the Dementia Partnership and Action Alliance**

The **Alzheimer’s Society** has a part time support worker who provides their **Oldham Dementia Support Service** which commenced in 2013. This post is funded by the Alzheimer’s Society and works closely with the Memory Service. The support worker provides:

- One to one advice to people with dementia and their carers
- Runs the ‘Singing for the brain group’
- Has attended 21 events leading to dementia awareness raising and information provided to over 500 people.
- Has provided the CrISP courses for carers
Joyce and Clare’s Story

Joyce’s daughter, Clare contacted Age UK Oldham’s Dementia Information Service as she was concerned about her mum displaying signs of dementia and wanted guidance on what steps to take.

Joyce lives alone. Clare had noticed recently that Joyce was struggling to complete some tasks that she would normally enjoy doing and was forgetting many things. Joyce used to be a cook, so food and preparing meals was one of her favourite pastimes but now she would only attempt to make a meal if her daughter assisted her. Joyce’s appetite seemed to be decreasing and she had become very forgetful, repetitive and on occasions anxious.

Clare’s main concern was to keep her mum at home and as independent as possible. She wanted to get the right help at the earliest stage possible and to find out how she can move forward. Joyce’s daughter worked for the NHS and had some experience of people with the later stages of dementia and was distressed when thinking about her mother’s future. She needed reassurance and a structured plan to move forward.

Age UK advised the family to make an appointment with the GP to get a check on Joyce’s general health and discuss the symptoms she was displaying. They explained about the tests which may be carried out and what may happen next. Details about the Memory Clinic were given.

Age UK provided Clare with some general information books which deal with the early symptoms and provide practical advice and support for carers including relevant questions to ask when visiting the GP. She was also given details about local support groups which can offer help to both the person with dementia and carers.

Clare was keen to find out about how she could adapt her mum’s house to support her changing physical needs and she was advised to contact the Community Occupational Health Department regarding aid and adaptations and given details of other suppliers of small aids which could assist.

Other services which could be beneficial were also discussed e.g. lunch clubs. Her mum was still very sociable but during the day was becoming increasingly isolated. The lunch club could offer some structure and some company whilst family are working as well as a hot meal.

They looked at what financial benefits may be applicable and made an appointment with Age UK benefit advisor to complete an Attendance Allowance claim form. This could provide extra weekly income and help with costs associated with low level care.

With the support and information they received from Age UK Oldham’s services, mum and daughter planned to make an appointment with the GP, go and view a Lunch Club together and possibly try the Springboard Support Group.

They contacted the Occupational Health Department about drafting plans to adapt Joyce’s house and looked at other small aids which could be useful.

Clare who is the main carer has approached her work about possibly altering her work patterns in the future if her mum’s needs necessitate it. However, at the moment she feels positive that they can move forward.

Clare said: “The advice and support I got at a time when we were both very anxious about the future really helped me to put things into perspective. Knowing there is somewhere that I can go and seek help and who will look at things not only from my mum’s point of view but will advise and support me is very reassuring”.
David’s Story

David is 83 and he lives alone with his dog Pru. In the past he had come into Age UK Oldham each year to insure his car. On this occasion he came to the office worried and tearful with quite an extensive pile of mail. He complained that he could not remember a thing and this was really frustrating him. He had come along to Age UK as he had a vague idea they had something to do with his car and that is what he thought he was in trouble with.

At his invitation the Dementia Information Service staff went through his mail with him and reassured him that they would help him to sort out any outstanding issues and find the right help for those they couldn’t assist with.

Amongst the letters was a note to ring Oldham Police Station regarding damage to his property. David was upset because he said he didn’t remember having any dealings with the Police. With David’s permission Age UK staff contacted Oldham Police Station who explained that the note was a follow up to an incident reported to them where they had to gain entry to David’s property and there had been some damage to his front door. This incident had been instigated by a worried neighbour. Until reminded David had no recollection of the incident. At this stage David felt slightly relieved as he was concerned that there had been an incident whilst driving his car. Age UK staff were not so relieved as it was becoming apparent that David was very confused and still driving. Amongst the mail there were many parking and speeding tickets.

There was also an unopened appointment for the Memory Clinic for two weeks earlier. Age UK staff contacted the Memory Clinic and arranged another appointment for him and for their Dementia Co-ordinator to accompany David to ensure his attendance.

David seemed reassured and happier that someone was now involved and was able to try and put things in some sort of order with him. His network of support had fallen down with neighbours who he had relied on in the past having their own problems and no longer able to help him.

The Age UK support worker later visited David at home to discuss his situation in more detail. David wants to remain in his own home and care for his dog. David admitted to getting mixed up with his medication, not eating properly and driving his car and on occasions not knowing where he has parked it or even if he had gone out in it.

David gave Age UK permission to contact his GP and make a follow up appointment with him. The GP had already forwarded a concern to the Adult Contact Team. David was not able to say if he had received any follow up from this referral and Age UK staff were concerned that he may have been able to answer the questions quite well on a telephone screening and could have appeared non eligible for support.

The GP agreed to visit again to ensure David was safe and managed to persuade David not to use his car until he had seen the doctor at the memory clinic.

Age UK staff visited David a few days later and found him unwell. He said he hadn’t eaten for two days and was mixed up with his medication again. A lot of the food in his fridge was now out of date. Age UK went out for essential items and put together a meal for David.

David explained how low he was feeling and how he now knew he needed help to remain in his home and to look after his dog. All the options were explained to David who then agreed for Age UK to contact the Adult Contact Team to reinforce the concerns for him. David was allocated a social worker who did a joint visit with Age UK and put in place some domiciliary care.

Arrangements were made with the GP and pharmacy to provide blister packs to aid taking his medication correctly. During the assessment and liaison with the GP it was clear that David has a range of complex physical conditions which without correct medication would have adverse effects on his judgement. As a result of that visit David has now been allocated a worker from Community
Mental Health Services to address his day to day safety, put an enablement care package in place to ensure he has regular meals, takes medication and longer term possibility of rehousing along with his dog Pru.

This has improved the overall general situation. David now feels that he is able to manage his day to day life on his good days. The allocated worker from CMHT is liaising regularly with his GP and the Age UK Dementia Co-ordinator is continuing to support David.

David said he felt better and reassured that things were moving forward to getting the right help to keep him in his home with his dog. “Taking regular medication and not getting so mixed up, having regular food has improved my situation and helped me to be less frustrated and confused. I will be keeping the appointment at the Memory Clinic and I have someone to take me which will help a lot.”

Jean and Paul's Stories

Jean’s husband had recently been diagnosed with dementia and she had been finding it very difficult to come to terms with his diagnosis and the changes in her husband. Jean’s own mental health had deteriorated to the extent that she was expressing suicidal ideation.

Paul was struggling to care for his wife who has dementia and felt he had no option but to consider full time care for his wife.

In each case the memory service’s clinical psychologist saw the spouse for an hour a week for 8 weeks. Techniques and strategies were worked out to help them cope.

Jean and Paul both now feel able to continue to care for their respective spouses with ongoing support from their memory liaison practitioners.

Had it not been for the intervention of the clinical psychologist working with these carers, carer breakdown would have been inevitable, necessitating social care intervention.

Michael’s Story

Michael was referred to Memory Services Speech and Language Therapist by one of the consultant psychiatrists to help with diagnosis and to provide communication support.

Michael was very anxious and upset about the difficulties he was having finding words and with his memory.

The Speech and Language Therapist assessed Michael's language and cognitive abilities. He was found to have significant long term memory difficulties but relatively intact language. This information helped the consultant to make the diagnosis of Alzheimer’s disease.

Michael and his wife didn’t understand the changes that he was experiencing nor did they expect the diagnosis of Alzheimer’s disease.

Michael was very anxious about his lost memories. It was mutually decided that a Life Story Book would be the best way to relieve Michael’s anxieties about his “lost” memories. It wasn’t easy to gather the information needed for the book from Michael and his wife but they gave the speech and language therapist permission to contact a sister of Michael’s to help.

This enabled completion of the Life Story Book, thus relieving Michael’s anxieties about this lost information. It also rekindled links between him and his sister, which further decreased his stress. His sister has become an additional source of support.

Michael remains on the speech and language therapists caseload for regular reviews/support.
### Memory Service Continuing Challenges and Priorities

#### Challenges:
- The success at increasing referrals to the memory service has led to more referrals than predicted. In order to cope with the number of new referrals, the allocation of memory liaison practitioners to people on the dementia registers not previously known to the memory service has been delayed. On-going capacity pressures are likely as the case load of the service increases year on year.
- The planned social work input to the memory service has not yet been realised
- The planned specialist carer support worker has not yet been commissioned

#### Priorities for 2015/16:
- Allocation of MLP to people with dementia not previously known to the memory service
- Commissioning the specialist carer support worker and gaining Social Work input to the service
- Developing relations with adult social care, integrated community health and social care teams and primary care
- Development of dementia web site and updating of the key services guide
- Establishment of the Making Space service
- Supporting peer/carer support groups
- Supporting the Dementia Action Alliance and Dementia Partnership

### 3.5 Mental Health Care Home Liaison Service

#### Achievements

New dedicated Mental Health Care Home Liaison Service, commissioned by Oldham CCG and provided by Pennine Care NHS Foundation Trust, commenced 2014.

- **Multidisciplinary team** in place since February consisting of part time nurse manager, 3 mental health nurses, part time occupational therapist, an occupational therapy technical instructor and admin support
- All care homes have a named mental health nurse who works proactively with the home and contacts/visits the home at least once every fortnight.

- **Direct patient care:**
  - Care home staff can **directly refer residents** to the service
  - **Over 500 residents** referred for individual review
  - Previously unidentified mental health conditions such as **dementia, delirium, and depression** being identified
  - Mental health nurses work collaboratively with GP’s to **formulate treatment** /
management plans for individual residents

- Homes being supported to manage residents with behavioural and psychological symptoms of dementia – helping to prevent / reduce need for use of antipsychotic agents.
- Residents on antipsychotic agents regularly reviewed
- Liaison with the hospital RAID team regarding residents going in and out of hospital

- Care home approach to improving quality of care and quality of life for residents
  - Development of one page resident profiles for about 100 residents - one on file and one up in the residents' room - encourages person centred care and promotes well-being (example given below)
  - Life story work – working with Age UK – 18 full life story books completed
  - Dementia care mapping and action planning being undertaken with care home staff
  - Homes supported to implement the Let's Respect tool kit
- Education and training of care home staff given eg on capacity issues, DOLS, medication, hand massage workshops, posters on delirium. Looking at every interaction with staff as an opportunity to teach/educate.

Meaning full activities for residents:

- 118 referrals for Occupational Therapy support
- OT supporting and training the care home staff to provide meaningful interaction and activities with/for residents. Trying to build into daily routine plus encouraging homes to deliver specific activities eg OT staff recently delivered a 6 weeks baking programme, supported a home to develop an activity room.
- All the Care Home liaison staff take rummage bags out with them to see what interests residents so they can advise the home staff on ideas for meaningful activity.
- Looking how to use Skype and tablets for younger residents with IT skills

Limecroft, Medlock Court and Butler Green

- Also have named nurse for provision of advice and patient assessments/reviews.
William’s Story

William is a seventy one year old gentleman with alcohol induced dementia “Wernicke-Korsakoff syndrome who lives in an EMI unit in Oldham.

The care home staff asked one of the Care Home Liaison nurses to review William as his mood seemed low, he wasn’t engaging well and he had had episodes of agitation directed towards the staff and other residents.

The nurse found that William had significant extra pyramidal side effects from the antipsychotic agent that he was taking (haloperidol). This was giving him a tremor in his right leg when sitting and retardation of movement when mobilising around the unit. Use of a standardised assessment tool (Cornell Scale for Depression in Dementia) also indicated that William had symptoms of depression.

Following discussion with the psychiatrist a revised treatment plan was formulated. In liaison with his GP, William’s haloperidol medication was reduced and then stopped; a small dose of Lorazepam as required was started to treat episodes of agitation and an antidepressant was commenced.

The nurse monitored William’s response to the medication changes and within 6 weeks his tremor had reduced significantly and his mobility increased. Staff reported an improvement in mood and engagement, improved sleep and fewer episodes of agitation. He was needing the Lorazepam less frequently. William began to engage in activities with the Occupational Therapy members of Care Home Liaison our team and he has been discharged from the nurses active caseload.
### Care Home Mental Health Liaison Service Continuing Challenges and Priorities

**Challenges:**

- Capacity to meet the very high level of unmet need – high referral rate for ‘crisis’ intervention, limiting amount of proactive work that can be undertaken.
- Service has been extremely well received but still varying levels of engagement with some homes.
- Interface concerns with Acute Hospitals regarding rapid discharge of patients with delirium leading to readmissions.
- Challenges with training care home staff due to high care home staff turnover and limited time of staff for training.
- Lack of confidence / time of care home staff to continue activities after OT training completed.

**Further work to be done:**

- With GPs to build confidence in managing reduction of antipsychotic agents
- Develop relationship with district nursing and other community services
- Training for care home staff
- Dementia care mapping
- Supporting care homes to develop activity programme

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### 3.6 Supporting Primary Care

**Achievements**

- **Named** Memory Liaison Practitioner for each GP practice
- **Dementia awareness session** delivered by MLP in each practice in 2014
- Incentives given for all qualified nurses and doctors in Oldham practices to undertake dementia e-learning package and for each practice to complete self-assessment template regarding their processes of care for dementia patients
- Half day **training** sessions held on:
  - Importance of timely diagnosis
  - Managing behavioural and psychological symptoms of dementia
  - Mental capacity act and advance care planning
- **Dementia diagnosis quick reference guide**
- **Toolkit for primary care and care homes – Preventing and managing behavioural and psychological symptoms of dementia**
Challenges:
- Varying quality of care and understanding
- Many competing priorities in primary care

Further work needed to:
- Enhance primary care practitioners understanding of and ability to support people with dementia and their carers
- Increase awareness of support that is now available
- Enhance quality of annual reviews for people with dementia
- Maximise benefit of MLP support to practices

3.7 Decreasing the use of antipsychotics in people with dementia

Behavioural and Psychological Symptoms of Dementia (BPSD) are very common, with point prevalence estimates (ie the proportion having any problem at a single time point) ranging between 60% and 80%, and a cumulative risk of 90% across the course of the illness. They can occur at any stage of the illness and often cluster together, so people with dementia are commonly affected by multiple, and recurrent, behavioural problems. BPSD are distressing and problematic for carers as well as the person with dementia; they make a large and independent contribution to caregiver strain and are a common precipitating factor for institutionalisation.

Although psychosis is relatively rare in patients with dementia, the use of antipsychotic medications to deal with BPSD in a more general sense (for behaviours such as agitation, aggression, wandering, shouting, repeated questioning and sleep disturbance), has become common place.

In recent years there has been growing anxiety over this high usage of antipsychotic medication for people with dementia, with the high level of its use within care homes being of particular concern. Not only do antipsychotic drugs have minimal efficacy for the treatment of BPSD but they are also associated with a significant excess in mortality in this group of patients.

Achievements

- **25% reduction in number of people with dementia on antipsychotic agents between Nov 2013 and Nov 2014**
- **Local audit undertaken** and 22 recommendations made
- **Actions that have been taken to date to support the reduction in use of antipsychotic agents in people with dementia**
  - Commissioning of the dedicated Mental Health Care Home Liaison Service
  - Commissioning of the enhanced Memory Service
Pennine Care NHS Foundation Trust commissioned to undertake **specialist mental health reviews of patients with dementia currently on antipsychotic agents** between March and Sept 2014. Of the 116 reviewed, 54% had their antipsychotic agent stopped and 18% had their dose reduced, 7% had a pre-existing psychosis for which the treatment was prescribed, leaving 21% who still had symptoms and attempted reduction not advisable on medical grounds.

**Training for primary care and care home staff** in July

**Toolkit for the management of behavioural and psychological symptoms of dementia** disseminated to primary care practices, care homes, domiciliary care providers, social work teams, community matrons and district nurses

New PCFT **shared care protocol** for the use of antipsychotics for PBSD in patients with dementia

**Care home resident primary care reviews** and medical management plan as part of EQALs

**Report circulated in CCG cluster cascade giving practices advice on how to minimise use of antipsychotics**

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**Antipsychotic Use Continuing Challenges and Priorities**

**Challenges:**

- 200 people with dementia remain on antipsychotic agents. Some of these people may be experiencing harm but no benefit from the agent. Prescribing rates remain much higher in Oldham than the national average

- Widespread culture change needed to help to prevent people with dementia developing behavioural and psychological symptoms of dementia and if they do for non-drug interventions to be tried

- Supporting practitioners to differentiate between delirium (an acute confessional state often due to an acute illness) and changes in behaviour due to dementia

**Further work to be done:**

- While there is likely to be a cohort of people with dementia who will need to continue their antipsychotic agents and some patients who will develop new symptoms that do require the initiation of antipsychotic agents, we need to be preventing the inappropriate initiation of antipsychotic agents and ensure when needed:
  
  - they are only initiated on the advice of a mental health practitioner and a shared care protocol is put in place
  
  - the drugs they are prescribed in line with NICE clinical guidelines
  
  - they are used for the minimum amount of time needed, with the need for the drug reviewed at least 3 monthly

- All patients with dementia on antipsychotic agents or who have significant behavioural and psychological symptoms to receive support from a mental health nurse

- Ongoing support and training for care home staff from the Mental Health Liaison Service

- Support for informal carers via training, memory service and community mental health teams
• Development of range of training programmes for cross agency staff and informal carers – see training needs analyses below
• Primary care practices to be sent a proforma to complete each time a patient is newly commenced on an antipsychotic agent and return to the CCG
• Three monthly data to be given to GPs regarding number of their patients with dementia who are on antipsychotic agents and the full audit repeated in 12 months.

3.8 Acute hospital care – Psychiatric Liaison Service

Two thirds of hospital beds are occupied by over 65’s and evidence suggest prevalence of co-morbid mental disorder is high with 26% of over 65s admitted having depression, 17% delirium, 13% dementia, 30% “cognitive impairment”. Outcomes for these groups are poorer across the board: longer length of stay in hospital, higher rates of mortality, institutionalisation, physical dependence and readmissions.

Achievements

- Rapid Assessment Interface and Discharge (RAID) model of hospital psychiatric liaison service commenced at Royal Oldham Hospital October 2012. Commissioned by Oldham CCG and provided by Pennine Care NHS Foundation Trust.
- Older person assessment team of a Consultant Psychiatrist, Mental Health nurses and Mental Health support workers established.
- Comprehensive, specialist mental health assessment and support for inpatients over 65’s provided at ROH 7 days a week.
- Over a 100 people a month supported in Royal Oldham Hospital

Edward’s Story

Edward was referred to the Older People’s RAID team following his admission to hospital. Edward has a diagnosis of dementia and had been living with his son temporarily while his flat was being refurbished. He usually lived independently at home in sheltered accommodation without any support other than his family.

Unfortunately Edward had found the transition to living with his son difficult and he had needed input for the Intensive Home Treatment Service, based at Forest House who visited him at his sons home. Edward had been unsettled because of the change of environment. Edward sustained a fall which resulted in a broken hip and was admitted to hospital where he had an operation to repair his hip.

Following the operation Edward experienced an increase in his confusion as a result of delirium, a condition which presents with acute confusion as a result of a physical health problem. Delirium is very common following a fractured hip and people who have existing memory problems are also at higher risk. When Edward was seen by the RAID nurse on the ward he was very confused, restless and agitated. It had been difficult for the nurses to care for because he didn’t always understand what they were doing and he could be resistive. Edward was ex SAS and very large in stature so could present to staff as very intimidating. We were able to offer advice and support to the nursing staff about how...
best to manage this and provide Edward with the care that he needed, making sure things were explained fully to him for example. RAID were also able to explain to Edward’s family what was happening and why he had suddenly become more confused.

Edward was prescribed by one of the RAID doctors a very small but appropriate dose of medication to reduce his levels of distress as recommended by the NICE delirium guidelines. This was monitored closely by the RAID nurses. He was also seen by the RAID support worker who was able to spend one to one time with Edward re-orientating him and engaging him in some meaningful conversation and activity whilst he was in hospital, talking about his travels and such like. Over the course of a couple of weeks his confusion did lessen and he was able to recognise where he was and recall what had happened to him.

RAID were also able to give advice with discharge planning. Edward was able to move back in with his son.

7 months on his son reports that he now settling down at home with his son and grandson who gave up his flat and moved back home to help care for him. He has his things round him and is more than happy with a bacon sandwich for breakfast and regular cups of teas. Initially on his discharge from hospital he couldn’t walk and was incontinent – his son describes the first few months after discharge as very challenging but this has now improved and whilst Edward continues to have good days and bad days and remains confused, on the whole the family is managing without any help from social services or other agencies.

Their GP has been very supportive and whilst Edward does get occasional urine infections which make him more confused with delirium his son is happy with his health. He says it has been a very steep learning curve for him as a carer but he is now able to go with the flow and ‘each day is an adventure’. His son has a wonderfully positive approach to caring for his father and is great example of the many family carers the RAID team come across.

Sarah was initially seen in the Royal Oldham Hospital by the RAID team in September 2014.

In June 2014, she had been admitted with acute confusion (delirium), triggered by her diabetes. Although she had recovered from this episode, there had been concerns that her memory was worse and that she was still experiencing some cognitive impairment. She was referred to Memory clinic at this time, but admitted to Royal Oldham Hospital again before her appointment.

Initially the RAID team felt she had another delirium due to her diabetes, with a fluctuating picture of confusion and difficulty in thinking clearly due to her health issues.

Over the course of the admission with stabilisation of her medical issues the fluctuations became less marked. She settled into a more consistent pattern of having some problems with memory and knowing where she was and what she was doing there. In the absence of reversible causes and the results of her brain scan, Sarah was diagnosed with a mixed picture Dementia.

She had developed this over a shorter time period than normal but her cognitive decline may have been accelerated by an intensive care admission in June 2014 where she may have had some decrease in oxygen to her brain.

The RAID team were able to provide some information and meet with Sarah, her husband and his sister to discuss Sarah’s diagnosis. This allowed the family to start to process and come to terms with
a devastating diagnosis. The family were grateful for the specialist teams input on the ward, which could be provided in a timely manner and support Mrs S and also the staff who were caring for her.

Staff completed a “this is me” document that assisted staff to understand some of Sarah’s behaviours and the drivers for them. One example of this was a care plan which included, where possible, staff spending time with Sarah doing purposeful activity to help her manage her impulse to wander which decreased her distress and anxiety.

As Sarah lacked capacity to plan her discharge, decisions were made in her best interest using the Mental Capacity Act Framework. This involved meetings together with the family, social worker and medical team to find a suitable placement where Sarah would the best possible quality of life while having the safety of staff on site at all times. The decision was made to discharge to a residential home which the family had chosen that they liked and which was in close proximity to family so they could visit regularly. When she was discharged follow up was arranged with the care home liaison team to manage the move, as people can sometimes experiences increasing confusion and distress at these times.

The process of coming to a diagnosis of dementia can be a difficult time for families and patients. Sarah’s story illustrates how the RAID team can support integration between the acute hospital trust, primary care and mental health services to plan seamless care and avoid duplication of work and delays for patients and families.

4 Training needs analysis

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<th>Achievements</th>
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<td>- Support gained from Partners for a cross agency dementia training needs analysis, development of a competency framework and commissioning of interagency training courses</td>
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<td>- CCG funded Dementia Development Consultant appointed by Oldham Council, commenced October 2014</td>
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<tr>
<td>- Mapping of existing training being undertaken</td>
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<td>- Informal carers training needs analysis completed and training being arranged</td>
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Training Continuing Challenges and Priorities

<table>
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<th>Challenges:</th>
<th>Priorities:</th>
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<tr>
<td>• Number of stakeholders and breadth and diversity of knowledge and skills required</td>
<td>• To secure high level organisational ‘buy in’ across all partners</td>
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<tr>
<td>• Scale of gap between current knowledge and skills and desired level</td>
<td>• To develop competency framework and identify learning needs</td>
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<tr>
<td>• Staff having time to attend training</td>
<td>• To develop / commission innovate ways to deliver training</td>
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<td>• To identify all potential funding sources</td>
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5. Respite care

Achievements

| Contract for residential respite care for people with dementia re-procured |
| More flexible options around respite in day care, such as emergency respite if the carer needs medical treatment, being developed |

Continuing Challenges and Priorities

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<th>Challenge:</th>
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<td>• Meeting the increasing need for short breaks and residential respite with the increasing emphasis on supporting people to live in their own home longer</td>
<td>• Redesigning the care at home offer to provide a respite service in people's own homes.</td>
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6. Summary

Dementia is a highly complex condition that affects everyone differently but can result in high levels of health and social care needs. However, with the right support at the right time people with dementia and their carers/close family members can continue to live well for longer.

As demonstrated in the report great strides have been made in improving the support available to people with dementia and their carers over the last 2 years. This has been achieved with the benefit of significant new investment by Oldham Clinical Commissioning
Group and the Council but also through the efforts of many people with dementia, their carers, volunteers and a wide range of voluntary sector, care and housing providers and statutory organisations who are all working together.

There is still much to do. The report identifies some of the on-going challenges and priorities. These include:

- Increasing community awareness of dementia (especially in communities of BME heritage) and making Oldham a Dementia Friendly Community
- Supporting peer and carer support groups and developing volunteering roles
- Expansion of extra care housing and development of other housing options and a home care and repair / home improvement agency to support people to maintain and remain in their own homes
- Identifying people with dementia who have not yet been diagnosed and ensuring sufficient capacity in all elements of the new memory service to meet need
- Supporting care homes to enhance the quality of their offer to people with dementia and meeting the mental health and physical health needs of care home residents
- Supporting primary care to further develop the care they offer people with dementia and their carers
- Decrease the use of antipsychotic agents in people with dementia
- Secure a long term psychiatric liaison service for the Royal Oldham Hospital and improve the quality of hospital care
- Undertake the training needs analysis and develop a commissioning framework for dementia training
- Further develop the respite care offer

Other areas that have not yet been looked at but require attention include:
- Advocacy for people with dementia
- Domiciliary care provision
- Reablement and intermediate care
- Hospital care
- End of life care
- Transport.

7. Recommendations
Health and Wellbeing Board are asked to:

- To note the collective achievements to date of people with dementia, their carers, volunteers and service providers in enhancing the quality of care for people with dementia in Oldham over the last two and a half years.

- To note the ongoing challenges and support further work to address these.

- Note the need to ensure interventions are offered at sufficient scale to support the individual but also to have a population impact.
Acknowledgement: I would like to thank all of the people with dementia and their families who have agreed to share their stories and for the clinicians/service providers in providing the story summaries.