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NHS Bedfordshire Dementia Service Mapping for Central Bedfordshire Council

3 key steps;

1 Ensure **better knowledge** about dementia and remove **stigma**
2 Ensure **early diagnosis**, support and treatment fro people with dementia and their family and carers
3 **Develop services** to meeting changing needs better

No	Objectives	Outcomes	Current Services	Gaps In Service	Gold Standard	Rag	Comments
1	Raise awareness of dementia and encourage people to seek help	The public and professionals will be more aware of dementia and will understand dementia better. This will; • Help remove the **stigma** of dementia • Help people **understand the benefits** of early **diagnosis** and care • Encourage the prevention of dementia • **Reduce other people's fear and**	• Alzheimer's Society provide Leaflets/Info • Public Champions have raised awareness e.g. Terry Prachett • POPPS in Luton raised awareness with public & GP's • Internet • Day Care in Luton provide info • Carer Support Groups via Alzheimer's Soc e.g. Music for Memory at Queens Park, Allotment Group at Queens Park - in peer groups • Alzheimer's Society Havens (South Beds) & Carers Rest • (Henlow & Bedford) • National Strategy 2009 • Awareness week – Memory Walks • Dignity Champions • Carer's Café	• Awareness within Schools & Further Education • Links needed between publicity of physical & mental wellbeing (regular awareness raising programme) • Training (refreshers for professionals – local workforce plan) • Professionals sharing info/referrals e.g. acute to specialist MH • Articles within	• National campaign e.g. Stroke, Swine Flu • National Champions • Dementia Training (Academic Unit – Competencies Standards) • Champions with CMHT and wider team (Personalisation)	Red/Amber	

		misunderstanding of people with dementia.		publications 'Stepping Out' & 'News Central' Bedford Borough & Central Bedfordshire literature • Lack of training or awareness of training around Dementia for the public, spotting early signs			

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2	Good quality **early diagnosis**, support and treatment for people with dementia and their carers, explained in a sensitive way.	All people with dementia will have access to care that gives them; • An early high-quality **specialist assessment** • An **accurate diagnosis** which is explained in a sensitive way to the person with dementia and their carers • **Treatment**, care and support as needed after the **diagnosis**. Local services must be able to see all new cases of people who may have dementia in their area promptly.	• GPs/Neurologists/Community Matrons/Social Workers/Voluntary Services can refer to CMHTs. • Memory Clinic provides Assessment & Diagnosis, Cognitive Enhancers, Cognitive Stimulation Therapy, Specialist Day Care • Voluntary Services – Alzheimer's Society, Age Concern, Carers in Bedfordshire, Rethink, Beds Advocacy Service • Training & support Exists around Mental Capacity Issues • IMCA Services • Specialist Speech Therapy • Occupational Therapy Exist • Support Groups for SU & Carers in Bedfordshire • Learning Disability Consultant at Twinwoods • MH First Aid Training Package being Developed • Support workers (Age Concern) provide home visits • Lots of information available • Consultant did home visits • Quick diagnosis for some (2weeks) • Carers/spouses felt listened to • Access to specialist centres – Bedford, Addenbrookes • Greeting at Memory Clinic –	• GPs reluctant to refer/identifying an appropriate diagnosis • Education within Primary Care • Multi Agency Working at the referral/diagnostic stage • Specialist MH workers in GP surgery with Dementia focus • Re-design of services to provide memory clinics rather than a fully commissioned service. • Too much info being given in one feedback session • Awareness of Service Directory • Dementia Advisors required (JD already drawn up by Alz Soc) • Sometimes family/Carer understanding	• GP Education • Communication with GPs/Specialist Services • Raising Public Awareness • Dementia Advisor (Contact & Signposting) • Directory of Services • Admiral Nurses • Information Distribution (Vol Sector Responsibility) • Coordinated Service • One stop services funded 24/7 and Open referral system • Royal College of Psychiatry Accreditation of Memory Services • Good Multidisciplinary Working • Liaison nurses in DG Hospitals • Mandatory Training of GPs	Red/Amber	Comment was made that the pathway could be RAG rated as follows. Before Diagnosis(Memory Clinic) RED During Diagnosis (Memory Clinic) GREEN After Diagnosis RED

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			described as wonderful • GP's – some provided prompt referrals and gave good information • Alzheimer's support group is very helpful • Some good experiences at Weller Wing with good information being given • Memory Clinic Carers Assessment	around the process and their involvement. Provision of accessible info leaflet. • Home care service to support enablement assessment/care planning • Meeting culturally diverse needs – especially use of expertise of 3rd sector. • \integrated Service across statutory & 3rd Sector. • Lack of Speech Therapy Input in Memory Clinics • Lack of Ongoing Follow Ups from Memory Clinic • Lack of clear pathway for Assessment & Diagnosis for younger people with Dementia • Lack of one point	• Home Assessments • Sensitive and appropriate forms of Assessment • Continued Follow – up support after assessment • Central Assessment Bureau – one assessment can be updated and accessed by different agencies • Self-Referral • GP provided appropriate training and understanding of Dementia to enable quick referral.		

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				of contact & ongoing support for carers • Lack of equality in accessing/funding of drugs • Lack of expertise in meeting the needs of Dementia & Complex Physical problems • More Support Groups Needed • Quantity of specialist Services e.g. Speech & Language, OT. • Dementia Register – GP's • 4-5 Visits to GPs before referral • Wrong Diagnosis - Told it was just 'Ageing process' • Awareness of different types of Dementia • Not told immediately about Alzheimer's			

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				society • Poor communication between Agencies and • Services • Lack of Specialist In-patient service for early on-set Dementia • GP confirmed Dementia with no test • Not aware of CPN's role • Don't see the same psychiatrist • Poor English used by some clinical staff – hard to understand them • Social workers unable to refer to Memory Clinic • GPs not referring to memory clinic until crisis happens • Kept waiting for 2Hours for a 10minute appointment • Follow up			

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				• appointments with the same psychiatrist • Would prefer Memory Clinic in the community or Bedford Health Village • No clear pathway • Lack of link between Memory Clinic and Acute Wards • Written diagnosis not provided to patient or carer			
3	Good-quality **information** for people with dementia and their carers	People with dementia and their carers will be given good-quality **information** about dementia and services • At **diagnosis** • During their care	• Alzheimer's Society currently produce great literature, leaflets • Self - help books	• Get the balance right between written information & 1:1/group verbal information in relation to people with diverse cultures • Information not always clear on direct payments and Vouchers	• Internet Support	Red/Amber	
4	**Easy access** to care, support and advice after **diagnosis**	People with dementia and their carers will be able to see a **dementia adviser** who will help them	• Emergency Respite for Carers • Carer's Support Bureau through (BRCC) • Link (Alz Society) – Telephone	• Rural Issues geographic isolation/transport to access groups/peer	Generic Helpline Number (0800), • Mobile Memory Clinic	Red/Amber	

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		throughout their care to find the right; • Information • Care • Support • Advice	Service • Alzheimer's society helps direct you to different agencies and services • Age concern helped with information and form filling • Inconsistent service at Memory Clinic when providing information on Dementia and Support Groups	support • Support to make self-directed support work, presently very process driven. • Self – funding people on their – no support to find Carers/ care homes/Respite • Once diagnosed, no obvious links on where to go next • Would like information about Dementia, benefits and support groups as early as possible	• Self directed support, direct payments • To ensure Service Users and Carers are made aware of support available after diagnosis • Advice and support around power of attorney • More activity groups e.g. Gardening, Fitness, Golf • Simple overview of services • To ensure services are set-up by Health and Social Care to enable Service Users and Carers to Commission their own services		
5	Develop structured **peer support** and learning networks	People with dementia and their carers will be able to; • Get **support** from local people with	• Using Existing resources e.g. Day centres for partnership working between stautory/3rd sector	• Clarification over the remit of 'peer support' • 3 haven groups in S.Beds become more	• Increase numbers of Cafes & Drop In Centres	Red(South of County) Green (North of County)	

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		experience of dementia • Take an **active role** in developing local services		social in focus rather than peer support			
6	Improve community **personal support services** for people living at home	There will be a range of **flexible services** to support people with dementia living at home and their carers. Services will consider the **needs and wishes** of people with dementia and their carers.	• Voluntary sector support groups • Assessment and treatment team • Specialist Learning Disabilities assessment • Commissioned personal care at home • Alzheimer's society provide home care not personal care • Carers rest run by Alzheimer's society/Henlow/Barton/Dunstable/LB • Carers Café run by NHS • Drop-in Café in Biggleswade & Houghton Regis • "Dega Project" in Aspley Guise run by age concern, Transport included • Social Services, Dementia Units providing respite for carers in Biggleswade and LB 5days a week • Home support specifically for LD Patients with dementia • Communication assessment with carer – speech and language, eating and drinking	• No specialist team to assess for personal care • Crisis teams over 65 • Counselling • GP Knowledge • Training for carers and family • Lack of carers rests and cafes in Ampthill and Flitwick • Transport is Limited in Rural Areas • Day care- very restrictive depending on where you live, mid-beds very restrictive • Social care is means tested • Self-funding issues • Only one speech and language	• Respite needed • Flexible to individual needs • Specialist Dementia workers across all settings • GPs working alongside specialist services • One system pathway, measurable quality outcomes in all settings • Specialist training and development • Community Hub • Person Centred planning is a good model • Comprehensive list of services available or flowchart of pathway	**Red**	

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			• Community Dietetic support for LD Patients with Dementia • LD services are not split for under/over 65s • Limited OT Support • Families providing respite care • Respite breaks provided by Kilorian & winged fellowship holidays	therapist across the county • Patients feel in the middle of social and Health Care • Crisis Support Team • Respite care – emergency break, plan in place now before I need it • Someone to come into our own home, could be family – if paid (Respite) • Residential care – over night in a familiar care home • Bed & Breakfast rooms purchased by the PCT for respite • Holiday Initiatives and provision for Service User and Carer • More Vouchers for Service Users & Carers – three hours a week	• Admiral Nurses Scheme – more chance of staying at home • Educated Staff, GPs, Nurses, Reception Staff etc • Good signposting by front line staff • Nurse Training covers both Physical and Mental needs • Home Carers who are highly qualified and skilled • More time per care slot • Flexibility in Care • Opportunities to socialise for person with Dementia and Carers • Keeping familiar structures for the day • Good support in a crisis • Ongoing practical advice and support		

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				instead of eight hours a month • Turn one of the Bupa homes into a resource centre where all services are under one roof • More publicity about benefits and financial help that may be available • Access to Occupational Therapist • Not aware of how to access care at home • Poor Quality Home Care, in-experienced Care staff • Carers for Individual staff, rather than alternating (seeing different Carers each time) • Task orientated and not Holistic Home Care • Regular monitoring of	• Specialist help with daily tasks • One point of call for all services – e.g. Specialist Link nurse to help co-ordinate social and Health Issues • Live – in Carers where appropriate		

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				• people without family • Confusion and fear of Accessing social services			
7	Implement the **New Deal for Carers**	Carers will: • Have an **assessment** of their needs • Get better **support** • Be able to have good-quality **short breaks** from caring.			• Carers Strategy • Personalisation • Carers Assessment • Choice	Red/Amber	
8	Improve the **quality of care** for people with dementia in **general hospitals**	This way people with dementia will get better care in hospital: • It will be clear **who is responsible** for dementia in **general hospitals** and what their responsibilities are • They will work closely with specialist	• Ambulance, A&E, Paramedic service – Excellent • Older persons team liaison	• Support for challenging behaviour • Learning Disability Liaison in general Hospitals • Lack of dignity on the ward, level of training is patchy • Focus on beds rather than patients • Lack of information stating if dementia	• Dementia Liaison in General Hospital and community-specific role, not add-on • Hospital and Clinical Environments that are easy to access • Facilities for person with Dementia in hospitals while carer sees hospital consultant	**Red**	

		older people's **mental health teams**.		assessment have been made, triggers, preferences • Nutrition issues on ward-staffing commitments to assist eating • Night Cover – Staffing issues • Mental Capacity assessment – not clear • No Liaison with memory clinic and general acute ward • No provision for relatives to stay • Poor In-patient care and Discharge information • Confusion over appointment times • Hospital Transport – Unreliable • Car-Parking difficult at hospital • Lack of basic care i.e. Food and Drink			

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				• Lack of Dementia Training & Information available for nurses on ward – Cultural shift needed • Inappropriate discharges home – without social work assessment • Poor communication of patient needs • Not in specialist ward because admitted with Physical problems • Better link between Addenbrookes and NHS Bedfordshire • General wards not picking up on symptoms when un-diagnosed patients are in hospital • Social workers sometimes have to insist on a diagnosis if client			

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				in Hospital showing signs of Memory loss			
9	Improve **intermediate care** for people with dementia	There will be more **care** for people with dementia who need help to stay at home.	• Learning Disabilities pathway • Intermediate beds and care homes	• Specialist Training for all front line staff, with further updates • Rehab • Register of Support Workers	• Intermediate care service tailored to Individual needs • County-wide definition of what good quality Dementia Care is • One statutory organisation providing dementia support • One point of access	**Red**	
10	Consider how housing support, **housing-related services, technology and telecare** can help support people with dementia and their carers	Services will: • **Consider the needs** of people with dementia and their carers when planning housing and housing services • Try to help people to **live in their own homes**	• "Projects" Aarogan Housing-Clophill Shillington • Telecare care line • Smart Flat Technology	• Knowledge of SMART facilities • Availability of SMART facilities • Awareness of Telecare • Web Based Support • Making adaptations to the homes – very difficult & very costly	• Assistive technology for all – adaptations and equipment • Information about panic alarms, and assisted technology	**Red**	

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		for longer					
11	Improve the quality of care for people with dementia in **care homes**	Services will work to ensure; • **Better care** for people with dementia in care homes • **Clear responsibility** for dementia in care homes • A **clear description** of how people will be cared for • Visits from specialist **mental health teams** • **Better checking** of care homes	• Learning Disabilities homes – personalisation agenda, April 2010 • Some good care homes/day care/dom care • Some training available via Alzheimer's society • Some specialist training (AMHP- Approved Mental Health Practitioner), BIA (Best interest Assessors) • Family needed for support • New care homes for couples to stay together	• There is not enough care homes in Bedford • Some Care home rates are above the funding ceiling • Some care homes not specialist in Dementia even though they state they are • Sexual/Intimacy support • Valuing of Care Home staff • Not enough care homes for younger people in Mid-Beds • Registration Criteria can lead to inappropriate placements • GP Assessments do not happen at all homes • Funding is an issue • Lack of Activities stimulation/therapy/no music	• Care home support, networks/forums	**Red**	

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				• Unclean • Not being prompted to walk by Care Staff			
12	Improve **end of life care** for people with dementia	People with dementia and their carers will be **involved in planning** end of life care. Services will consider people with dementia when planning local end of life services.	• Bereavement services offered	• Provision for families staying at hospitals • Liaison with continuing health care • Clear discussions with family on expectation of end of life • Dignity Choices	• Admiral nurses for end of life • Palliative care	**Red**	
13	An informed and **effective workforce** for people with dementia	All health and **social care** staff who work with people with dementia will; • Have the **right skills** to give the best care • Get the right **training** • Get **support** to keep leaning more about dementia.	• Bedford college run NVQ style distance learning • Dementia Care planning in some homes and hospitals • Learning Disabilities, Multi Disciplinary Teams • EoE 1-2day training course	• No mandatory awareness training • In depth Quality Training	• Harmonise training for health/ social/independent sector • Statutory training • Continue on professional development • Clear standards of quality and assurance	**Red**	
14	A **joint commissioning**	Health and **social care** services will	• Move away from Silo working has improved]	• Duplication of work	• World Class Commissioning		

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	strategy for dementia	work together to develop systems to: • **Identify the needs** of people with dementia and their carers • Best meet these needs There is guidance in the **Strategy** to help services to do this.	• The work on joint strategy should lead to joint working • NHS Bedfordshire taking the lead on the strategy	• Criteria of the social services and NHS • Access to direct payments & personalised budgets • Lack of presence of world class commissioning • Framework for implementation – action plan to continue to drive forward • Ring fenced funding for dementia			
15	Improve **assessment and regulation** of health and care services and of how systems are working	There will be **better checks** on care homes and other services to make sure people with dementia get the best possible care.	• Safeguarding Adult procedures			**Red**	
16	Provide a clear picture of **research** about the causes and possible future treatments of dementia	People will be able to get information from r**esearch about dementia**. We will do lots of things to indentify gaps in the research information and do	• Information from Alzheimer's society • Cognitive stimulation therapy • Dendron – Research network, Luton registering and creating database	• Dementia Champions at Clinical/Consultant Level • Sharing of research outcomes	• Research outcomes disseminated • Reduce anti-psychotic meds and focus on behavioural	**Red**	

		more research to full the gaps.					
17	Effective national and regional support for local services to help them develop and carry out the **Strategy**	The Government will give advice and support to local services to help them carry out the **Strategy**. There will be more good-quality information to help develop better services for people with dementia.	• Consultation/ Forums to capture all sectors demographically e.g. Young Persons, LD etc • Darzi review looking at uniform memory clinic model and education unit for service providers	• Uncertainty of take-up for service users – adapting existing services • Regional lead for dementia	• Local Implementation Network (LIN Group) • Memory Clinic accreditation (Aspire to obtain excellent status within two years)	**Red**	