Oxleas Dementia Strategy

2013 - 2016

Improving lives

oxleas.nhs.uk

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Introduction

Improving care and support for people with dementia is a major priority for the NHS. The **National Dementia Strategy** has set a vision for transforming dementia care with the aim of achieving better awareness of dementia, early diagnosis and high quality treatment at whatever stage of the illness and in whatever setting. Building on the strategy and with the aim to boost the progress already achieved in dementia care, in March 2012, the Prime Minister launched **"The Dementia Challenge"**.

In Oxleas, over the years we have continually strived to improve our dementia care. Our mental health, learning disability, community health services and forensic services are all looking after people with dementia at different stages of their illness, from early symptoms to the end of life. In 2010, a new multidisciplinary dementia service was commissioned in Bexley and, in 2012, one in Bromley. We believe that people in all stages of dementia and all settings should have timely access to specialist dementia services when needed.

Oxleas' Four Key Priorities for 2013-2016: quality, innovation, productivity and supporting the Trust Special Administrator plans relating to South London Healthcare NHS Trust all apply to our service users with dementia too.

The **Oxleas Dementia Strategy** sets out how we will meet the specific needs of people affected by dementia in our area.

To develop our strategy, we convened a group of experienced, multi-agency and multi professional staff to map out the current situation, best practices, national guidance and our own priorities. We organised two focus groups with service users with dementia and carers. Drafts were discussed within local partnership groups, involving commissioners and local authority staff.

The group considered how we at Oxleas can best work with partners to improve outcomes for people with dementia and adapt our own priorities, structure and services to meet the dementia challenge.

This document reflects the joint work which relied, among other documents, on: the National Dementia Strategy and its 18 Objectives (appendix 1), the Dementia Commissioning Guidance and its six phases (appendix 2) the Dementia Quality Outcomes (appendix 3) and the National Institute for Clinical Excellence (NICE) Dementia Pathways (http://pathways.nice.org.uk/).

The group identified the direction of service development towards a position where:

- *We provide excellent care and support at all times and in all settings to our service users with dementia and their carers*
- *Our services are dementia friendly and all our staff and our partners in care are dementia literate*
- *We promote early diagnosis of dementia*
- *Our specialist dementia services are of the highest quality*
- *Through co-operation and joint working, we implement a dementia integrated care pathway both at service user level and organisational level*

We recognise that improving quality in dementia care and achieving the aspirational outcomes is only possible through joint effort and partnership between our services, commissioners, local authorities and third sector organisations and are committed to enable this.

Our challenges

1. The number of people with dementia is increasing along with longevity and the number of years people live in good health. We praise the role older people play in our society and, for the ones affected by dementia, it is our responsibility to work, alongside other sectors, to ensure their needs are properly addressed now and in the years to come (Fig. 1).

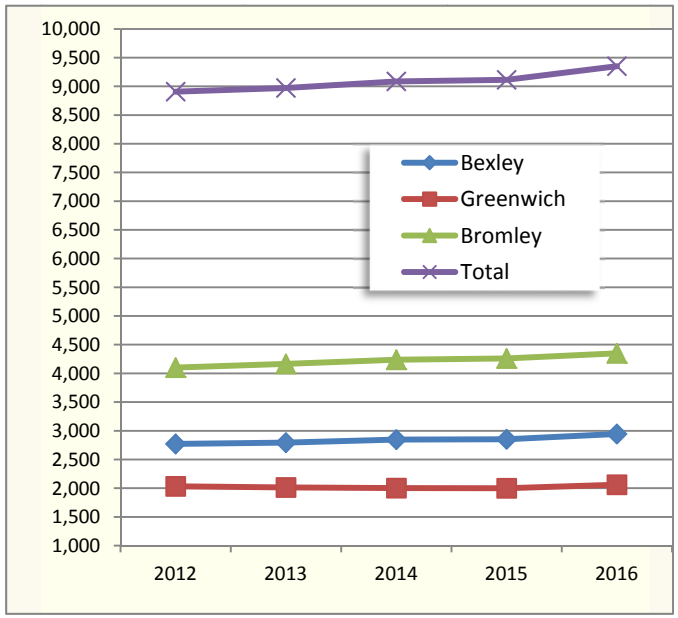

Fig. 1 Dementia prevalence in the next four years by borough (source: POPPI).

2. The gaps in dementia diagnosis, awareness education and provision of services.

Data from 2010 showed that less than 50% of people with dementia in our boroughs were receiving the diagnosis. The figures in all three boroughs have improved in the last two years but the gap remains significant. (Fig. 2) Appropriate and early diagnosis enables proper support and treatment to be planned and put in place.

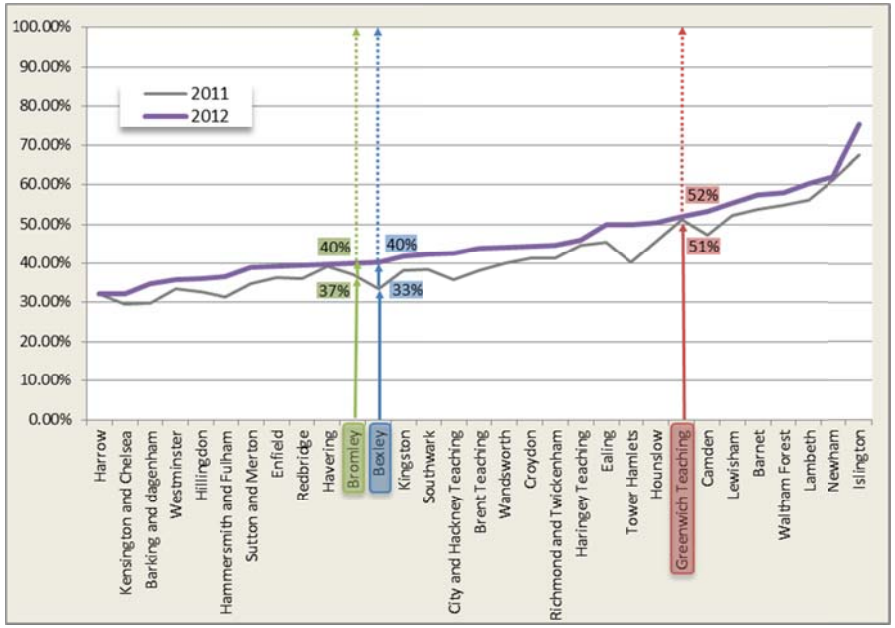

Fig. 2 Pan London and BBG diagnosis rates in 2011 vs 2012
(Source: Alzheimer's Society)

Improving dementia awareness, identification of people with early signs of cognitive problems in primary care and other health and social care services as well as within the larger society are a national and local priority.

3. The care for people with dementia in hospitals and care homes.

Thirty percent of local acute hospital beds are occupied by people with dementia who also have longer admissions than people without dementia. Service users with dementia and their carers told us how difficult it is for them to cope with the hospital environment and routines especially in the more advanced stages of the illness and how much they would like to avoid admissions whenever possible. The Francis Report has reminded us of the essential obligation we have to always provide caring and compassionate services to our service users and this is especially important for our patients with dementia who are often vulnerable.

Good care in the community and case identification in A&E and on wards was shown to reduce emergency admissions and reduce length of stay in the acute hospital.

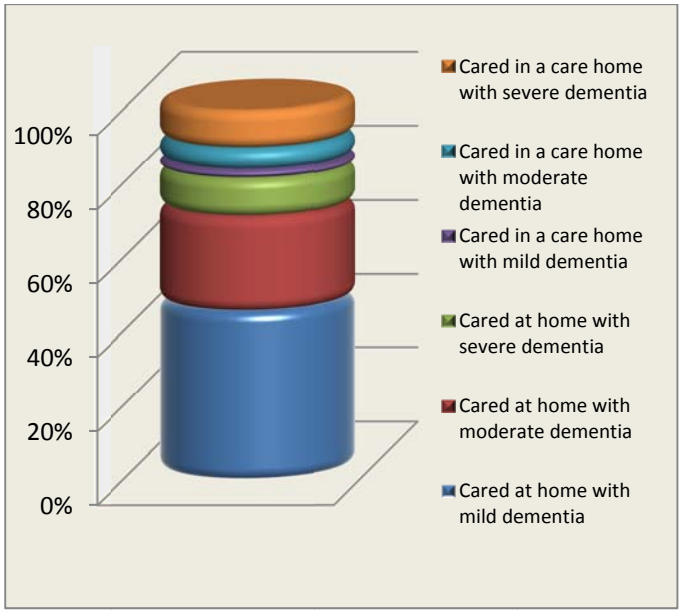

Fig. 3 BBG population with dementia by stage of illness and place of care

Having dementia carries a five fold risk of admission to a nursing home and sometimes admissions to care homes can be premature. One third of people with dementia are being looked after in a care home and quality of dementia care in some care homes needs improving.

We know that, with appropriate support in the community, people with dementia can stay in their homes safe and well for longer. This is what the daughter of one of our service users told us: "It is lovely that mom and dad are able to be together. Dad did not use to go anywhere without my mom so he is happy to sit indoors with her just holding her hand. And I enjoy every moment with her. I enjoy seeing her in her own home, nice and clean, protected and looked after as much as we can hope for."

4. The use of antipsychotics in dementia

Antipsychotics are associated with an increased risk of harm in older people with dementia. The UK parliamentary report "Always a Last Resort" drew attention to the overuse of these medicines but also introduced the concept of severe distress as a justification for their use. Regular audits of antipsychotic prescribing in dementia in our mental health services showed that their use is less than the national average and decreasing. On-going monitoring of prescribing and regular reviewing of these drugs to enable people to live well with dementia will have to continue.

5. The financial pressures

We need to continually improve our services, patient experience and outcomes while managing unprecedented efficiency financial savings year on year. We appreciate the challenges of change in NHS – both nationally and locally and the need for increase in productivity through innovation and leadership at all levels encouraging a collaborative and patient-centred culture. We understand that, in order to offer excellent care to

our service users, our staff need to feel supported and motivated in day to day work.

Our current services

At Oxleas, most of the targeted dementia care work is undertaken by the Older People's Mental Health (OPMH) Directorate. However, there are links to other areas of our work. Within Community Health Services, professionals working in physical healthcare teams e.g. long term condition and re-ablement teams come across many people who have memory problems and dementia, though this is not the reason for their intervention.

Due to a correlation between Down's Syndrome and dementia, our Adult Learning Disability services often work with people with dementia. Patients are followed up in a multidisciplinary specialised Memory Clinic.

Our Prison Mental Health services are looking after patients with dementia in the prison system.

Our Adult Mental Health Teams come across younger people with memory problems on an infrequent basis and are referring them to our OPMH services.

Services currently provided by us with our partners within the Older People's Mental Health Directorate:

Service Type	Bexley	Bromley	Greenwich
Memory Clinics	√	√	√
Therapy Groups	√	√	√
Carers support *	√	√	√
Dementia Advisors			√
Social Care support in Memory Service	√	√	√
CMHT support	√	√	√
Dedicated Crisis/ Home Treatment Team			√
Dedicated Single Sex Inpatient Beds	√	√	√
Acute Hospital Liaison		√	√
Intermediate Care Liaison		√	
Care Home Education		√	

* in partnership with voluntary organisations

Promises for dementia care

I. Early identification.

Our service users and carers have told us that sometimes the time and pathway to receiving the diagnosis of dementia was too long. With the aim to close as much as possible the 'diagnosis gap', we will continue our current dementia awareness and education work with our clinical staff, GPs, hospital and community clinicians etc. There are positive signs already as the number of referrals to our memory services has been increasing over the last year.

We aim that all our mental and physical health services will be able to recognise when one of their service users shows signs of the disease and will be able to both continue to treat them appropriately and, when necessary, refer them on to specialist services.

Good practice example:

In the last year, essential dementia training by our Nurse Consultant was offered to all non-mental health staff in the trust with the aims of: improving their ability to recognise the signs of dementia, help adjust their clinical practice according to service users' needs and facilitate further referrals for diagnosis where appropriate.

Good practice example:

Our Older People's Mental Health Directorate has organised two GP master classes on dementia topics: management of distress in dementia, antipsychotic medication initiation and review, management of advanced dementia at home, and mental capacity issues. These have been very well attended and received.

Policy Context:

National Dementia Strategy Objectives: 1 2 13

Commissioning guide phase: 1

Dementia Quality Outcomes: "I WAS DIAGNOSED EARLY"; "I FEEL PART OF A COMMUNITY AND I AM INSPIRED TO GIVE SOMETHING BACK"

Action Plans:

1. We will work towards understanding the referral pattern from local GPs and explore routes into specialist services through development of GP 'Choose and Book' access and internal referral systems.
2. We will discuss about establishing pilot Memory Clinics in some GP surgeries.

3. Together with our partners we will continue our work to raise awareness of dementia through training health and social care professionals both internally and externally (e.g GPs)
4. We will explore screening tools and early identification aids to be used by GPs and physical health teams.
5. We will explore open access clinics in the community and self-referral to the Memory Service.
6. Through partnership with other agencies, we will help build dementia friendly communities.

II. Specialist diagnostic assessment

"A diagnosis of dementia opens doors. It gives a person access to treatment and often support services" (All Party Parliamentary group on Dementia: Unlocking the diagnosis – the key to improving lives of people with dementia)

We will continue to improve our specialist multidisciplinary assessment and diagnosis services for people with memory problems in our boroughs in line with the commissioning arrangements. Our new cross-boroughs Memory Service will offer assessments close to, or in our service users' homes. It will meet Memory Services National Accreditation Programme registration requirements and ensure fidelity to National Commissioning Guidance and NICE Guidance, offering a consistent approach to assessment and diagnosis as well as post diagnosis support and treatment.

We recognise the role and needs of families and carers of people with dementia and, in partnership with voluntary services, will continue our carers' education and support work.

Good practice example:
A multi-professional programme for development of advanced skills in dementia care was organised internally for Bexley Memory Service staff. This was well received and further training sessions by different members of the team are planned.

Policy Context:

National Dementia Strategy Objectives: 2 3 4 5 7

Commissioning guide phase: 2 3

Dementia Quality Outcomes: "I UNDERSTAND SO I MAKE GOOD DECISIONS AND PROVIDE FOR FUTURE DECISION MAKING"; "I GET THE TREATMENT AND SUPPORT WHICH ARE BEST FOR MY DEMENTIA AND MY LIFE"

Action Plans:

1. We will implement and review the organisation of our Memory Service and apply for National Accreditation.

2. We will explore ways to encourage GPs to make referrals to the Memory Services.
3. We will work with the commissioners and local GPs with special interest in dementia to find the best pathway to diagnosis.
4. We will continue our continuous professional development work with the memory service team.
5. We will develop and maintain links with the third sector organisations to improve experience of people with dementia and their carers.

III. A joined-up care pathway. Working with partners.

We know how difficult (and frustrating at times) it is for our service users and carers to navigate through the multitude of health and social care services. They told us how much better their experience was when there was a professional they knew they could contact when in need of advice or in a crisis, someone who was able to bridge the gap between them and different services. They also told us they appreciate and feel supported when the follow-up plans, available local support and prognosis are clearly explained to them, services stay connected with each other and response at time of crisis is quick.

Once a diagnosis has been made, follow-up will be planned based on need in collaboration with GPs, social services and partners in the voluntary sector. We will have shared care arrangements with GPs, social services and community services. People discharged from our services will be aware of the further care pathway and will continue to have access to our services at the point of need.

There will be on-going collaboration between specialist Older People's Mental Health services and Oxleas Adult Community Health Services to ensure the needs of our service users are met in a joined up way by our services and staff.

Our multidisciplinary liaison services in Queen Elizabeth Hospital and Princess Royal University Hospital will continue supporting colleagues in the acute general hospital with assessments, appropriate diagnosis and management of people with dementia and different physical or psychiatric comorbidities.

Within the changing environment, our plans will have to take into account potential new local providers.

Good practice example: A shared care protocol with GPs for follow-up of people on memory enhancers was developed in all three boroughs. This will be applied in individual cases when it is thought to be the optimum solution for the patient.

Good practice example: In Greenwich, Alzheimer's Society Dementia Advisors meet people before they are discharged from the memory clinic and offer an on-going point of contact and support.

Policy Context:

National Dementia Strategy Objectives: 3 4 6

Commissioning guide phase: 3 4

Dementia Quality Outcomes: "THOSE AROUND ME AND LOOKING AFTER ME ARE WELL SUPPORTED"; "I KNOW WHAT I CAN DO TO HELP MYSELF AND WHO ELSE CAN HELP ME"

Action Plans

1. We will support voluntary agencies in their plans to provide dementia advisors/navigators across our three boroughs.
2. We will continue our integration work in the three boroughs to ensure people with dementia receive high quality services.
3. We will work to improve liaison services to ensure needs of people with dementia are met in acute hospitals.
4. We will improve collaboration between mental health services and out of hospital and intermediate care services to ensure people with dementia are benefiting from these services and help avoid inappropriate admissions to acute hospitals.
5. GPs will be given contact numbers for direct communication with all our senior doctors.
6. We will develop an IT system that will allow us to know the service users and families that Older People's Mental Health and Community Health services have in common and will work towards sharing information between organisations (e.g. with local social services, Bromley Healthcare etc.)
7. From 2015, we will replace the current patient electronic records with a more integrated system to improve communication across services.

IV. Help to live well in the preferred or appropriate place of care.

We will support people with dementia to stay at home throughout their illness whenever possible and ensure their mental health needs are met. We will continue to develop in-reach services to care homes in our three boroughs and expand the psychiatric liaison services to the local acute hospitals (including A&Es, acute medical units, intermediate care and community hospitals). Working jointly with primary care, we would like

to put illness contingency planning and rapid response review in place with care homes teams as an alternative pathway to acute admission.

Technology is playing an increasing role in enabling older people to remain in their home environment, specifically assistive technology and telecare. We will promote the benefits of telecare for people in the early stages of dementia via our memory clinics, to enable systems to be in place to fully support people and reduce risk. We will continue to ensure that patients are being looked after in their preferred place of care.

Good Practice Example: 'Just Checking' is a simple web-based activity monitoring system, with small wireless movement sensors that attach temporarily within all rooms in the home. Activity is monitored, giving a detailed assessment of a person's movement patterns over a period of days or weeks. It has proven particularly useful for assessing people with dementia who live alone at home and concerns have been expressed by carers in regard to a change of routine or habits. In partnership with the three boroughs, Oxleas Occupational Therapy staff have access to the Just Checking kits and the Telecare steering group is developing a shared protocol across health and social care.

Good Practice Example: The Bromley Care Home Project has been helping care home staff to understand the reasons for and signs of distress in people in their care with moderate and more severe dementia and develop ways to manage this and avoid placement breakdown or the need for hospitalisation. The initial pilot was commissioned this year on a larger scale.

Policy Context:

National Dementia Strategy Objectives: 6 8 9 10 11

Commissioning guide phase: 4 5

Dementia Quality Outcomes: "THOSE AROUND ME AND LOOKING AFTER ME ARE WELL SUPPORTED"; "I KNOW WHAT I CAN DO TO HELP MYSELF AND WHO ELSE CAN HELP ME"

Action Plans:

1. We will lead an Assistive Technology and Telecare steering group, with membership from health and our three local authority partners. This will ensure we embrace current technological advances and prioritise integrated working for the full benefit of our service users.

2. We will appoint a within Oxleas, a Telecare lead to take forward a year long project.
3. We will continue implementing and developing Telecare and other innovative ways of working.

V. Appropriate use of antipsychotics. A focus on alleviating distress and promoting comfort.

We will keep under review the use of antipsychotic medication to alleviate distress and challenging behaviour with the intention of reducing the use of this type of medicine and increasing access to psychosocial interventions. There has been a significant reduction in the use of antipsychotics in our trust in the last two years: from 16% to 9% (compared to from 16% to 12% nationally).

Good Practice Example: Over the last years, our mental health services have participated in several local and national audits of antipsychotic use in dementia. The results of these audits have been published in national medical journals. Our care pathway for prescribing and reviewing antipsychotics was presented to local GPs in one of our masterclasses. The pathway was published as a best practice resource on the NHS London website.
The overall effort has led to a significant reduction on patients with dementia on antipsychotics.

Policy Context:

National Dementia Strategy Objectives: 11 18

Commissioning guide phase: 4

Dementia Quality Outcomes: "I GET THE TREATMENT AND SUPPORT WHICH ARE BEST FOR MY DEMENTIA AND MY LIFE"; "I CAN ENJOY LIFE"

Action Plans:

1. We will continue to strengthen the robustness of the process of prescribing and reviewing antipsychotic use in dementia.
2. We will develop business cases for care homes in-reach support across all three boroughs.

VI. Good care towards the end of life

We will aim to improve care towards the end of life for people with dementia in all our three boroughs. This will involve improved partnerships between our commissioners and our physical and mental health services as well as social care services to ensure timely and flexible access to a range of aids, adaptations and services, along with a skilled responsive team of professionals supporting families to care for their relatives at home when it is their choice to do so.

Good Practice Example: The Greenwich Advanced Dementia Service has looked after more than 100 patients with dementia at home achieving very positive outcomes in terms of patient quality of care, carer satisfaction and avoidance of care home and hospital admissions. Together with its twin service in Bexley, they were selected as 'demonstrator sites' in King's Fund research on care co-ordination.

Policy Context:

National Dementia Strategy Objectives: 12

Commissioning guide phase: 6

Dementia Quality Outcomes: "I AM CONFIDENT MY END OF LIFE WISHES WILL BE RESPECTED. I CAN EXPECT A GOOD DEATH."

Action Plans:

1. We will continue to run our successful advanced dementia care at home services in Greenwich and Bexley, strengthen our business cases and apply for funding from commissioners to support and further develop them.
2. We will organise awareness training in end of life skills in dementia.

VII. Support to carers

We will work to recognise, value and support carers of people with dementia in accordance with the **Oxleas' Carers Strategy 2012-2015** and the **Carer's Charter**.

We greatly value the important work of the carers of people who use our services. We recognise that caring can be very stressful. Often carers also talk about the reward they get from their role. Here is what a daughter of one of our patients in the advanced dementia care at home service said:

"I enjoy every moment with mum. I enjoy seeing her in her own home,

nice and clean, with dad, protected and looked after as much as we can hope for."

We will listen to carers and work with them to ensure we support them in their roles through recognition and involvement.

We will ensure carers support groups and services are available in each borough.

Good Practice Example: We have been gathering names of carers who would like to become more involved in helping us develop services and will be establishing focus groups and other opportunities for participation.

Policy Context:

National Dementia Strategy Objectives: 7

Commissioning guide phase: 3

Dementia Quality Outcomes: "THOSE AROUND ME AND LOOKING AFTER ME ARE WELL SUPPORTED."

Action Plans:

1. We will continue to identify and keep records of our carers, implement carers' assessments, strengthen the follow-up and audit them.
2. We will develop post diagnosis support for carers (as well as patients) and have carers groups in all three boroughs.
3. We will map out the local carers groups and strengthen our co-operation with Alzheimer's Society and other voluntary sector organisations.
4. We will identify the sectors which could provide a person carers could contact once the patient is discharged from the Memory Service (e.g. dementia advisors)
5. We will participate in trustwide plans to undertake Carers Experience Surveys.

VIII. Excellent community mental health services and dedicated inpatient services

Some people with dementia develop complications which mean that they need to be assessed by and cared for by mental health specialists. This might be if the person with dementia has become very distressed and because they cannot communicate, have developed behaviours which are very difficult and stressful for them and others to deal with. In these

circumstances Older People's Mental Health Services can be asked to help and could provide specialist interventions at home, in day treatment or in specialist inpatient settings.

We will continue to improve the quality and efficiency of our services while supporting staff to provide best care. We know that quality of care is closely linked with the whole team effort, staff well-being and satisfaction with team work and leadership at all levels. We acknowledge the significant failures in the care of people with dementia revealed in the The Ombudsman's 'Care and Compassion' report and the Francis Report and will ensure dignity, compassion, appropriate nutrition, listening to carers and learning from mistakes are at the core of our day to day practice.

We will aim to improve:

- physical healthcare skills of inpatient and community mental health staff
- the way we respond in a crisis environment
- activities on the ward
- the discharge process.

We will work towards increasing access to out of hospital services e.g. by asking commissioners to invest more in home treatment type services as opposed to hospital services.

Good Practice Example: Dementia care mapping is a process that helps professionals observe life through the eyes of a person with dementia. We use this method to promote person centred dementia care. Maps are conducted every six months. The information collected is used to develop our care practice, plan training and quality assurance projects.

Good Practice Example: In October 2011, we reorganised out inpatient services and patients with dementia are now admitted to two dedicated single sex inpatients units. We have designed the ward environment to be 'dementia friendly' for example using colour, reminiscence resources and specially designed furniture.

To reduce the risks of falls in inpatient settings, we have introduced 'Telecare' solutions and all our bedrooms in the dementia wards are installed with bed and chair occupancy sensors.

Policy Context:

National Dementia Strategy Objectives: 6 11

Commissioning guide phase: 5

Dementia Quality Outcomes: "THOSE AROUND ME AND LOOKING AFTER ME ARE WELL SUPPORTED." "I AM TREATED WITH DIGNITY AND RESPECT."

Action Plans:

1. Implementing dignity in care and nutrition audits
2. Implementing harm-free care initiatives
3. Working towards developing a community crisis team so that more people with complicated dementias can be supported in community.
4. We will work towards developing Older People's Health Hubs which will include services for people with dementia in Bexley and Greenwich.

IX. Supporting research in dementia

We have been a site for two randomised controlled trials looking at treatments for people with dementia (MAGD and MAIN-AD). We have also supported research looking at psychological and occupational therapy interventions. At the moment, we are a site for the multicentre VALID trial which is looking at community occupational therapy interventions for patients with dementia. We see research as a way of enhancing care and wellbeing for people with dementia and their carers. The Older People's Mental Health Research and Development group meets regularly and has participation from a carer.

Policy Context:

National Dementia Strategy Objectives: 

Action Plans:

1. We will continue to host good quality dementia research and engage with other organisations in order to achieve this.
2. We will continue our work on distress in dementia research.

What happens next?

We have an action plan in place for each of these priorities and the Dementia Strategy Group will continue to meet quarterly to keep progress against the actions under review. This group will report to the Older People's Mental Health Director and Oxleas Quality Board as well as to local partnership groups in each borough. The Dementia Strategy Group will also closely monitor any developments in practice or policy which may affect the plan and ensure improvements are incorporated into action plans as required.

We will work closely with health and social care commissioners around service developments to assist the delivery of this strategy.

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Appendix 1: National Dementia Strategy Objectives

- **Objective 1:** Improving public and professional awareness and understanding of dementia.

- **Objective 2:** Good-quality early diagnosis and intervention for all. All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

- **Objective 3**: Good-quality information for those with diagnosed dementia and their carers. Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

- **Objective 4:** Enabling easy access to care, support and advice following diagnosis. A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

- **Objective 5:** Development of structured peer support and learning networks. The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

- **Objective 6:** Improved community personal support services. Provide an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority arranged services.

- **Objective 7:** Implementing the Carers' Strategy. Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia.

- **Objective 8:** Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

- **Objective 9:** Improved intermediate care for people with dementia. Intermediate care which is accessible to people with dementia and which meets their needs.

- **Objective 10:** Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

- **Objective 11**: Living well with dementia in care homes. Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

- **Objective 12**: Improved end of life care for people with dementia. People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

- **Objective 13**: An informed and effective workforce for people with dementia. Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

- **Objective 14:** A joint commissioning strategy for dementia. Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class.

- **Objective 15**: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers. Inspection regimes for care homes and other services that better assure the quality of dementia care provided.

- **Objective 16:** A clear picture of research evidence and needs. Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.

- **Objective 17:** Effective national and regional support for implementation of the Strategy. Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

- **Objective 18.** The use of antipsychotic medication for people with dementia. Reduction in the prescribing of antipsychotic medication for people living with dementia.

Appendix 2: Dementia Commissioning Phases

Phase 1 When memory problems have prompted me, and/or my carer/family to approach my GP with concerns.

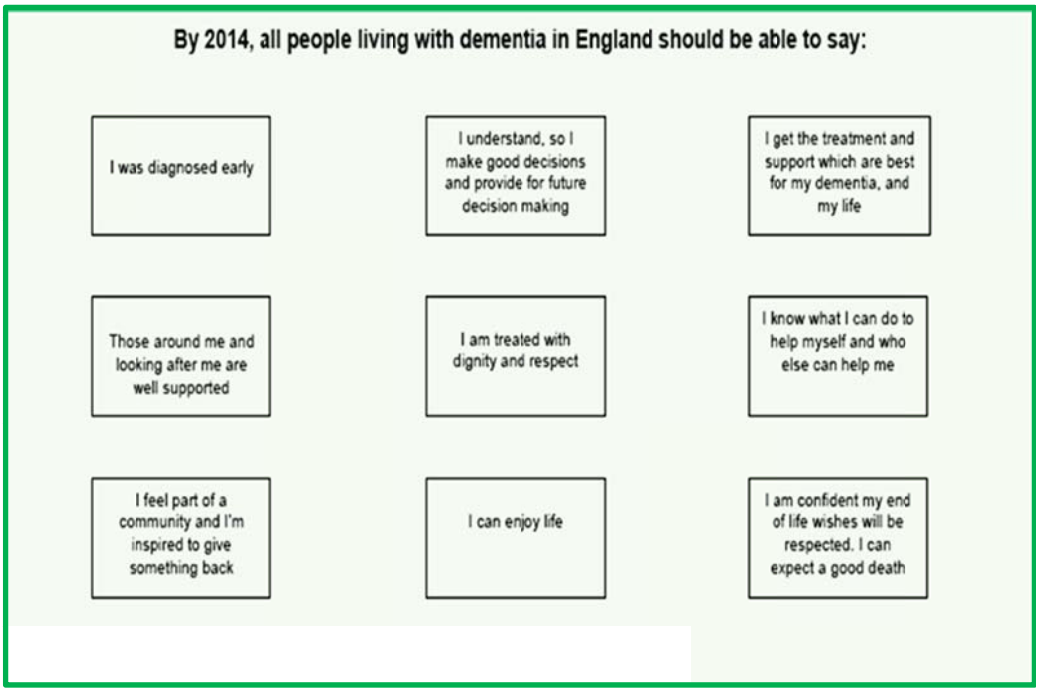
Phase 2 Learning that the condition is dementia.

Phase 3 Learning more about the disease, options for treatment and care, self-management and support for me and my carer/family.

Phase 4 Getting the right help at the right time to live well with dementia, prevent crises, and manage together.

Phase 5 Getting help if it is not possible to stay at home, or if hospital care is needed.

Phase 6 Receiving care, compassion and support at the end of life.


By 2014, all people living with dementia in England should be able to say:
I was diagnosed early
I understand, so I make good decisions and provide for future decision making
I get the treatment and support which are best for my dementia, and my life
Those around me and looking after me are well supported
I am treated with dignity and respect
I know what I can do to help myself and who else can help me
I feel part of a community and I'm inspired to give something back
I can enjoy life
I am confident my end of life wishes will be respected. I can expect a good death