A Dementia Friendly City: A strategy and action plan for dementia services within the City of London 2013-2015

Lead author:	Katherine Peddie - Interim Housing and Social Care Policy Manager Marion Willicome Lang - Interim Service Manager for Adult Social Care
Document owner:	Director of Community and Children's Services
Approved/agreed by: (name and job title or relevant group)	
Issue date:	
Version number:	DRAFT 1.0
Review due date:	

This document can only be considered valid when viewed via the City of London web pages.

Document Control Sheet

Details of development and consultation:	Developed by Interim Housing and Social Care Policy Manager. Consultation through the Interim Service Manager Adult Services. Consultees include: Adult Advisory Group, Neaman Practice, CCG, Alzheimers Society, Elders Voice, Crossroads Care, Toynbee Hall
How will the document be disseminated to all relevant staff:	All new and updated policies and procedures are notified to senior managers via email for dissemination to their staff. Notification is also sent to all adult and children's social care staff via the monthly staff newsletters (the Buzz).
How will the document be implemented:	Staff will be made aware as above
What are the training requirements:	As per the Adult Safeguarding Training Competency Framework. Skills for Care will undertake training with staff as part of the development of
Who will review the document (job title):	Dementia Implementation Group / Safeguarding Sub Group and the Assistant Director People
What CQC standards of quality and safety does this document link to:	Outcome 7 – Safeguarding people who use services from abuse.
What other documents should this be read in conjunction with:	• London Safeguarding Children Board Procedures • City of London Safeguarding Adults Board Policy and Procedure • Whistle Blowing Policy
Has an initial equality impact assessment been completed?	Yes

Revisions

Version No.	**Page/ Paragraph No.**	**Description of amendment**	**Date approved**
1		Original	

Contents

1. Executive summary

This Dementia Strategy responds locally to the Prime Minister's 'Dementia Challenge' by establishing a City-specific approach to caring for our residents whilst tapping into the rich diversity of our community.

The City of London is a small area with approximately only 9,000 residents, but has a huge daily population of workers. The City of London is bordered by the London Boroughs of Hackney, Islington, Camden, Westminster, Southwark and Tower Hamlets. For health purposes, the City is linked to Hackney through NHS City and Hackney.

Synthetic estimates predict that within the City there are up to 67[1] people living with the symptoms of dementia, some of whom have been diagnosed, but a large proportion of whom have had no formal diagnosis. Whilst this may be a relatively small number, for those with the disease, the support that they receive is vital to their quality of life and their wellbeing and we are therefore committed to providing the best possible services to this particularly vulnerable group.

The City of London Dementia Strategy establishes how the City will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 2 years (2013-2015).

The aim of this strategy is to:

Provide a responsive, high quality, personalised dementia service meeting the needs of residents of the City of London

This strategy outlines 10 key objectives that are aligned with our local need as well as the National Dementia Strategy and are complemented by a clear rationale. Additionally, the Action Plan provides operational level detail about how we will deliver on this strategy and how partners will assist us in delivering our commitments. As part of this commitment we will sign up to the Dementia Action Alliance Compact to demonstrate our commitment to making a difference locally.

We are committed to:

- Raise awareness of the disease and increase early diagnosis
- Develop and commission services including advice and support
- Improve the quality of the care experience for those with dementia and their carers
- Recognise and manage safeguarding risks appropriately
- Ensure that there is continued commitment to monitoring and delivering this strategy alongside our partners

[1] ***Prevalence Source:*** *Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007 and Census 2011.*

- Sign up to The Dementia Action Alliance Compact

The strategy emphasises our approach of early diagnosis in order to offer support at an early stage so that we can support people to maintain their independence and control over decisions which will affect them. It is underpinned by 10 strategic objectives which form the basis of our action plan:

- Improve public and professional awareness of dementia and reduce stigma
- Improve early diagnosis and treatment of dementia
- Increase access to a range of flexible day, home based and residential respite options
- Develop services that support people to maximise their independence
- Improve the skills and competencies of the workforce
- Improved access to support and advice following diagnosis for people with dementia and their carers
- Reduce avoidable hospital and care home admissions and decrease hospital length of stay
- Improve the quality of dementia care in care homes and hospitals
- Improve end of life care for people with dementia
- Ensure that services meet the needs of people from vulnerable groups

The City of London Corporation is committed to creating a 'Dementia Friendly City', where residents and local retail outlets and services have a keen understanding and awareness of the disease and offer support in a respectful and meaningful way. This builds on the longstanding tradition within the City of caring for residents and delivering individualised packages of care and support. The Joseph Rowntree Foundation has undertaken a similar project in York[2]. Skills for Care will work in partnership with the City using this model and other good practice in order to develop a safe environment for those with dementia.

The uniqueness of the City of London as the UK's centre for trade and industry allows us to be innovative in our approach, tapping into a wealth of knowledge and experience and professionals living and working within the community. The size of the authority allows us to respond quickly and directly to the needs of individuals in a way which may be prohibitive in other local authorities. This also enables us to commission services that correspond with the needs of the community as identified by service user groups.

A dementia-specific resource directory linked to the Adult Services Directory will be created to enable service users, their carer(s) and professionals to view the type of resources

[2] *http://www.jrf.org.uk/sites/files/jrf/dementia-communities-york-summary.pdf*

available locally and to make good informed choices about their care. We will ensure that this is available in other formats where residents do not have access to it online.

Incorporated into this strategy is a clear commitment to safeguarding our residents so that they are protected from abuse and to engendering a culture of quality assurance through the revision of our Adult Service Review processes.

A support group is to be commissioned that will be open to anyone in the community who has dementia and their carers. The Adult Advisory Group has assisted with the specifications for the group and it will include specific advice and support as well as activities to minimise the effects of the disease and to improve cardio vascular health. Similar schemes around the country include reminiscence work and music, art and drama which help to maintain good brain health. It is our intention to work with the vast range of cultural services available in the city, including the museums, art gallery, the Guildhall School of Music and Drama and the Barbican and encourage volunteers to support the work of the group, offering time credits for their support. Whilst some of those diagnosed will not meet the eligibility criteria for social services, this will not preclude them participating in the Dementia Group.

It is anticipated that by co-ordinating the way in which services are delivered locally and by clearly communicating the resources available locally this will encourage those who may be experiencing the early symptoms to seek a formal diagnosis, safe in the knowledge that their needs will be met.

2. Introduction

The term 'dementia' is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, mood swings and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer's disease. Dementia can affect people of any age, but is most common in older people. One in 14 people over 65 has a form of dementia and one in six people over 80 has a form of dementia.

The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 to 95+. Overall nationally, 10% of deaths in men over 65 years and 15% of deaths in women over 65 years are attributable to dementia.

The major growth in the predicted prevalence of dementia and associated increase in the cost of service provision is not the only important issue for commissioners of dementia care. The **quality of care** for people with dementia and their carers has come under considerable scrutiny over the past decade. Key issues that have been highlighted by the National Audit Commission and voluntary sector include poor diagnosis of dementia, lack of early intervention, and a paucity of support in the community. Lack of public and professional awareness and the stigma associated with dementia are also considered to be key contributors to neglect and underdiagnoses of the condition.

Traditionally, dementia has been diagnosed later as many primary care providers are frustrated by the lack of support and provision locally. This means quite frequently that the prognosis from formal diagnosis until full onset and death can be as little as 3 to 5 years. This creates further fear for those diagnosed with the disease and those caring for them and for those who may be experiencing the early onset of the disease, preventing them from seeking a diagnosis.

Depression, anxiety and loneliness frequently accompany dementia. "**Dementia 2013: The hidden voice of loneliness**[3]" reports that more than a third (39%) of people with dementia responding to their survey said that they felt lonely whereas only a quarter (24%) of over 55s in the general public felt lonely in the last month. Nearly two-thirds (62%) of people with dementia who live on their own said they felt lonely. Difficulties in maintaining social relationships and other features of dementia contributed to this. They also note an increase in the number of people not telling their friends about their diagnosis. A third (33%) of people with dementia said they had lost friends following a diagnosis.

Dementia care in the City of London is delivered through a range of providers, with diagnosis and medical support provided primarily by health services, and longer-term care delivered by the social care and third sector, as well as private companies providing care homes and domiciliary care.

[3] *Dementia 2013: the hidden voice of loneliness, Alzheimer's Society 2013*

It is the intention that The City of London Dementia Strategy provides a vehicle for encouraging integration and collaboration across the range of health and social care services. This strategy sets out the local direction for dementia services from 2013 to 2015, and strives to be evidence based, built on analysis of current and predicted future need and has been guided by stakeholders together with community intelligence and coproduction where ever possible.

The strategy is aligned with the National Dementia Strategy, which aims to improve dementia services across three key areas: improved awareness, early diagnosis, and a higher quality of care. It is set in the context of the transformation of the adult social care service during 2010-11, which seeks to intervene at the point in a person's life when they wish to remain healthy and independent and maximise individual choice and control.

The work underway within the Mental Health Programme Board City and Hackney CCG specifically around dementia, together with on-going work with primary health colleagues at our GP practice, and with work underway with the CCG and London Borough of Hackney and City of London around integrated care, has led the development of this strategy.

Adult Social Care is also working with Skills for Care on the training of a member of the team to become a "Dementia Champion". The Dementia Champion will go on to develop these skills in advancing the "Dementia-Friendly City" pilot scheme in conjunction with Skills For Care and the Alzheimer's Society. This work will be elaborated upon further within the action plan.

3. National Guidance and policy context

In 2009, the Department of Health published "Living Well with Dementia: A National Dementia Strategy" which aims to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.

The Prime Minister launched his challenge on dementia in March 2012 with a series of commitments to action. Creating dementia friendly communities was one of the key commitments made.

Since that time, the City of London has sought to work with key partners as a provider and commissioner of services to seek to shape future services. The City has developed a local strategy setting out how we plan to develop and deliver health and social care services to better meet the needs of people with dementia and their carers.

The City and Hackney Mental Health for Older People Strategy 2008-2018 was influenced by the larger population and needs of Hackney residents. Whilst this has served our population up until this point, the Corporation intends to put further emphasis upon Dementia and has undertaken to develop this Dementia Strategy as its main framework for action,

complementing the Mental Health for Older People strategy but being very specific about its own residents.

Dementia has been given a high profile within the current government. The Prime Minister's 'Challenge on Dementia' is being implemented across the country. Dementia is also a key priority for the Secretary for State for Care and Support.

There has been a national drive more generally towards enabling patient/customer choice and developing services that are responsive to individual needs (or 'personalised'). This agenda is outlined in the Department of Health White ***Paper Our Health, Our Care, Our Say*** (2006) which sets out a fundamental change in the way services are delivered. Of relevance to the development of dementia services are the objectives of shifting resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and individual budgets.

Following on from this, the Department of Health published ***Putting People First*** (2008), which outlines a radical reform of the way that health and social care services are delivered. The requirements set out in this document build on ***Our Health, Our Care, Our*** Say (2006) and describe a vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control. This theme continues to emerge within the initiatives surrounding dementia.

This strategy has been developed in the context of an extremely challenging financial environment. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial positions and reduce their deficits.

The Department of Health expects implementation of the National Dementia Strategy to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention. Any new investment in local dementia services will necessarily be funded through efficiency savings and/or reconfiguration of existing resources.

4. Local Strategic Context

The City of London Dementia Strategy fits with other key plans within the City. These include, but are not limited to,

- The Corporate Plan 2013-2017
- The Health and Wellbeing Strategy
- CCG Commissioning Strategy
- DCCS Business Plan
- Adult Safeguarding Policy and Procedure
- Annual report of the Adult Safeguarding Board
- City of London Cultural Strategy 2012-2017
- The City Together: Community Strategy
- The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment 2011/12
- The City and Hackney Mental Health for Older People Strategy 2008-2018
- The Carers' Strategy 2011

The Dementia Strategy has a direct link to the City of London Corporation's Corporate Plan 2013 – 2017 under the priority:

KPP4: Maximising the opportunities and benefits afforded by our role in supporting London's communities.

The core values of the Corporation have a perfect fit with the Dementia Strategy:

- **The best of the old with the best of the new**
  Securing ambitious and innovative outcomes that make a difference to our communities whilst respecting and celebrating the City's traditions and uniqueness, and maintaining high ethical standards

Within the action plan, we want to build on the talents and resources that exist locally that are unique to the City, including its historical, artistic and musical traditions. These unique resources are part of the fabric of the local area and will engender familiarity with the residents being supported through the Dementia Strategy.

- **The right services at the right place**
  Providing services in an efficient and sustainable manner that meet the needs of our varied communities, as established through dialogue and consultation.

By creating a Dementia Friendly Community, we will be harnessing the spirit of our community to support this particularly vulnerable client group. Local services will be aware of

issues related to dementia and will be able to signpost our residents appropriately to help and support locally.

- **Working in partnership**
  Building strong and effective working relationships – both by acting in a joined-up and cohesive manner, and by developing external partnerships across the public, private and voluntary sectors – to achieve our shared objectives

The Adult Advisory Group has been consulted on this Strategy. The members of this group are representative of our community and integral to its development and delivery. Furthermore, a Dementia Strategy Implementation Group reporting to the Health and Wellbeing Board which comprises other partners will oversee monitoring the delivery of the Dementia Friendly Community. The concept of co-production is integral to delivering good or outstanding services and we propose having a continual dialogue with our community groups in delivering this strategy:

The City of London Community Strategy theme of **The City Together: the heart of a World Class City** which supports our communities states as a goal that the City aspires:
"To protect and improve the health and wellbeing of our communities, by encouraging healthy lifestyles and taking a preventative approach through accessible health promotion and early intervention, whilst giving our communities greater choice and influence in the use of health and care services".

This strategy is influences by that aspiration and encourages healthy lifestyle as a preventative approach.

The strategy aligns to each of the five key priorities of the Departmental Business Plan 2013/14:

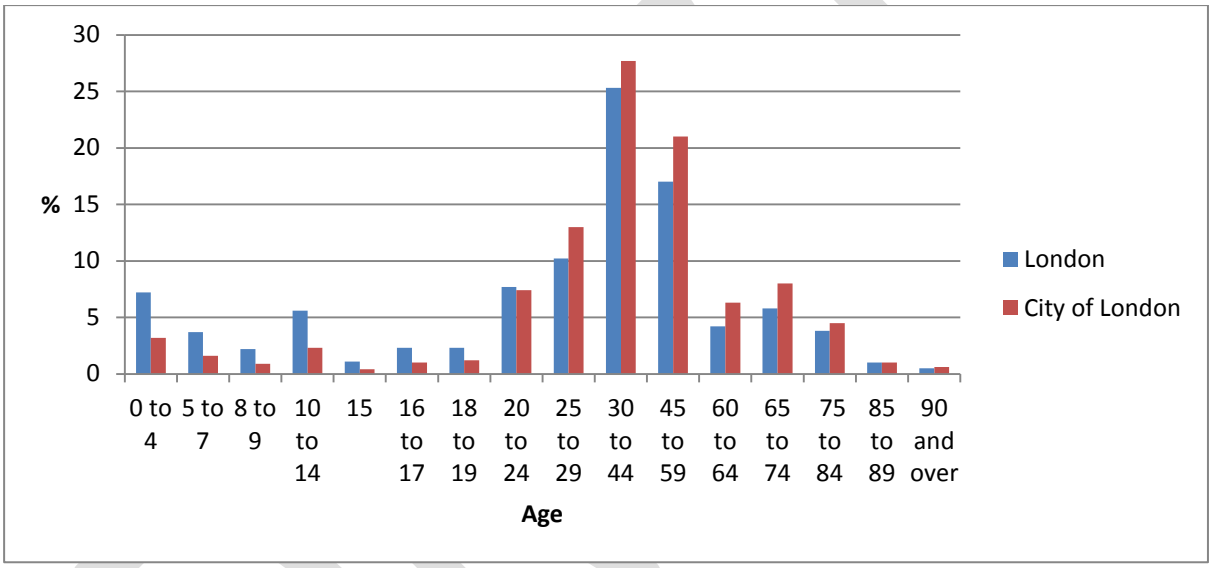
1. Improving the health and wellbeing of communities and individuals
2. Protecting and safeguarding vulnerable people through better prevention and early intervention
3. Promoting independence and choice for service users
4. Supporting and empowering our communities and enabling people to make a positive contribution
5. Making the best use of our resources and improving the way we work.

5. The City - Demographics

The information below is extracted from The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment 2011/12 (JSNA) and from the 2011 Census data from the Office of National Statistics (ONS).

The official resident population estimate for the City is 7,375 people4 (ONS). However the City of London Corporation uses the GLA's estimates for planning purposes as these take account of the constraints of housing supply. The GLA's 2011 estimate was 8,863.

The resident population of the City is predominantly working age: just over three quarters (76%) are aged between 20 and 64 years (ONS estimates). Ten per cent (1,200 people) of residents are aged under 20 years and the remaining 15% are aged 65 years or more. The City's population is 55.5% male and 44.5% female.



Source: 2011 Census: Age structure, local authorities in England and Wales (ONS)

The GLA projects a 13% increase in the City's population between 2011 and 2021. The largest growth in absolute numbers will be in the working age population but the largest proportionate growth will be in the older, pensionable age population. Since the last Census in 2001, the population over the age of 65 has increased by approximately 5% (this appears to have come from the working age cohort as the 0-20 year olds has remained relatively stable).

In 2001 the main ethnic group in the City was White (85%), with Asian (10%), Black (3%), and Other (2%) making up the up the population. In 2011, the largest ethnic group in the City continues to be White (79%), followed by Asian (14%), and then Black (4%) and Other (2%). The marginal trend of a smaller White percentage and larger Asian percentage are then projected through to 2031 where the White ethnic group is projected to decrease to 74%, the

[4] *2011 Census: Usual resident population, local authorities in England and Wales (ONS)*

Asian increase to 17%, and Other to 5%5. There is some variation across age groups with more ethnic diversity in younger age groups.

In terms of the health of the population of the City of London, there is just one GP practice within the City (the Neaman Practice). Many people are registered with GPs outside of the City area in Hackney or in Tower Hamlets or in any of the other surrounding boroughs. Therefore figures tend to be crude estimates based on the data from the Neaman practice or from the Census 2001. Furthermore, the Health Authority for the City works across the whole of City and Hackney and therefore data generally tends to reflect the whole cohort of this area rather than being disaggregated into data for City and data for Hackney.

The Neaman practice in the City had 8,751 registered patients in November 2011. Within the City, GP services are also provided by NHS Tower Hamlets at the Portsoken Health and Community Centre. It must also be noted that of the registered patients at the Neaman practice, a proportion of these will not live within the City but outside the City boundaries.

Data from primary care suggests that 436 people in Hackney and the City have dementia, giving a prevalence of 0.2%. This is lower than the POPPI estimate and may reflect the fact that dementia is not always diagnosed.

Our key residential communities are based in the Barbican, Mansell Street, Middlesex Street and Golden Lane Estate.

A recent survey of residents living on the Golden Lane and Middlesex Street estates found that people living on these estates have a slightly different age profile to the general profile for the City, with greater numbers of older people, as well as high disability rates in the oldest groups.

The Portsoken ward contains two social housing estates at Mansell Street and Middlesex Street. Some of this residential accommodation was originally in Tower Hamlets, but was transferred to the City under The City and London Borough Boundaries Order 1993. This relatively recent addition to the City means that the Portsoken area's links to Tower Hamlets are still strong, and the area is not co-terminus with some services. The catchment area of the City's only GP practice does not cover the Mansell Street and Middlesex Street estates. This means that residents of these tow estates must register with GPS from Tower Hamlets. A Tower Hamlets GP practice currently provides services to Portsoken residents from the Green Box Community Centre, located on the Mansell Street Estate.

In 2010/11, the City of London Corporation provided social care services to 296 people with a wide range of needs, both at home and in care homes. Approximately 79% of clients received services in the community. The majority of clients (62%) were older people, aged 65+ years.

[5] Source: 2012 Round of Demographic Projections - SHLAA © Greater London Authority, 2012

In this older age group, there were more women than men (52% vs. 48%). In the younger age group, under 65 years, there were fewer women than men (31% vs 69%).

These clients were 91% white, 3% black, and 3 % of mixed or other ethnicities. Compared to the GLA ethnic profile for the City, white clients are over-represented and Asian clients under-represented in this social care client group, though the numbers are relatively small so variations do not necessarily reflect inequalities in access.

Life expectancy in the City is still the highest in the country (82.2 years for men and 89.2 years for women). There is, however, a lack of data around key medical conditions that may affect the City's resident population.

Data from City and Hackney Clinical Commissioning Group gives an estimated figure of dementia cases across City and Hackney as 971 living in the community (233 living in residential care). The Practice dementia registers know of 607 people.

There are estimated to be over 67 people in the City of London with dementia and this number is set to increase by more than 40% in the next 20 years6. Adult Social Care (ASC) and the GP practice have confirmed that they currently know of 15 people referred and living in the community and 5 people in nursing care but acknowledge that there may be many more people who are not formally diagnosed via primary health or who have not accessed statutory social care.

This is recognised as quite a large discrepancy and therefore the Neaman Practice is reviewing its diagnoses of patients who may have signs and symptoms of dementia as a co-morbid factor to their primary diagnosis and referring to the Memory Clinic for a further assessment where necessary.

In 2007, the Alzheimer Society found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). Applying these figures to the City of London accounting for inflation takes this figure to £29,932[7]. This would mean that the current cost of late-onset dementia in the city could be estimated to over £2M per year (based on the estimated figure of 67 people). By 2030 the annual cost of dementia in the City of London could increase to over £ 4.8M (if inflation continues at the same rate and the synthetic estimates are correct).

[6] *This data is derived from a synthetic estimate based on national prevalence rates and our census data.*

[7] *Estimated using a web-based tool: http://www.thisismoney.co.uk/money/bills/article-1633409/Historic-inflation-calculator-value-money-changed-1900.html*

Carers

In addition to people suffering with dementia, this strategy aims to support their carers and is aligned with the principles set out in the Carers' Strategy 2011.

In the 2001 Census, 598(8.3%) City residents identified themselves as being carers, providing care from 1 to over 50 hours per week[8]. These carers may include those who are providing care to people who live outside the City. Of these carers, 9% were in poor health and 7 % were over 75 years old.

In 2010/11, the City of London undertook assessments or reviews of 55 carers caring for people who were in receipt of Adult Social Care Services. The Carers register lists 60 known carers of clients over 18 years old. Of these, 15 are receiving additional support from a dedicated carers' service.

Data collected within the Carers Assessment Project 2011 suggested that most carers in the city are supporting people who would otherwise be in residential or nursing home care, and do so by virtue of being 'live-in' carers, whether spouse, civil partner son / daughter or parent. Of the City carers surveyed, 85% were living with the patient and 54% of these were either husband /wife or civil partner. Women represented 59% of the carer population and 40% of the cared for and supported.

Most are sole carers with little other support. Almost everyone is wholly committed to the role and has adjusted to what this involves both physically, psychologically and in terms of limitations of life choices.

Carers looking after someone with dementia do not necessarily benefit from the traditional form of respite care where the service user is taken out of their own home to give the carer a break from their caring responsibilities. This was recognised in the Carers' Strategy 2011 and specialist support for carers of people with Alzheimers was approved in December 2011 creating a dedicated respite scheme for carers of people with dementia.

The way the City commissions from the voluntary and community sector, including from organisations based in the City, Hackney, Islington and Tower Hamlets, is guided by Best Value principles and the Local Procurement Directive. City voluntary and community organisations are important stakeholders in this, mainly through the City of London's local strategic partnership 'The City Together'.

The City's relatively small resident population and large daytime population of commuters and workers provide a unique environment from the voluntary and community sector. There are many opportunities for City workers to volunteer their time and resources to the voluntary and community sector, particularly in the City Fringe area, and several City organisations and others exist to support this.

[8] *City of London (2011) Carers' Strategy*

6. The City of London Priorities

Our Commitment is to:

- **Raise awareness of the disease and increase early diagnosis**
- **Develop and commission services including advice and support**
- **Improve the quality of the care experience for those with dementia and their carers**
- **Recognise and manage safeguarding risks appropriately**
- **Ensure that there is continued commitment to monitoring and delivering this strategy alongside our partners**
- **Sign up to The Dementia Action Alliance Compact**

The City of London is keen to develop on the theme of dementia being "everybody's business" and about making the City a dementia friendly community, which is responsive and can understand and help in the most simplest of ways.

Skills for Care is working alongside the City to train the Dementia Champion to pilot a programme to build a more accessible and dementia aware society within the City of London. This work is aimed at staff within the City of London, our provider agencies who supply the care workers who go into to people's homes, and to staff in service industries around the City as well as pharmacies, the post office and various retail outlets around the City and community Police and Fire officers. A "Champion" for dementia has been identified within Adult Social Care, and the GP practices have Dementia Advisers attached to them, but it is important that the skills and expertise are disseminated to all.

It is anticipated that this work will help people to recognise behaviours associated with dementia and to give them the skills to be able to better support these members of the community. This is a key action within our strategy.

A further key commitment is to develop a resource that service users, their carer(s) and professionals may use to give information and advice about dementia and the provision available locally. This will link with the Adult Services Directory and will contain information so that residents can make informed decisions about their care as well as being able to find locally available information, advice and support. This is already available in hard copy format and additions specific to Dementia will be developed.

Wherever possible, we aim to support our service users and their carer(s) to stay within their own home, using a range of individualised flexible support packages and Individual Budgets. People with dementia are supported to engage in meaningful activity, doing something that they enjoy or are interested in. This can be as simple as undertaking everyday tasks such as cleaning or cooking together or more formal activities – for example, participating in a choir or swimming group. Evidence suggests exercise may directly benefit brain cells by increasing

blood and oxygen flow. Even stronger evidence suggests exercise may protect brain health through its proven benefits to the cardiovascular system[9].

The City of London is in a unique position of having some very deep cultural roots with museums, libraries, art galleries, the Barbican and Guildhall School of Music and Drama. There is therefore an opportunity to tap into some of these assets to assist in reminiscence work and to develop 'time-banking' opportunities both to support the service user and for them to engage in activities that they may enjoy, improving their mental health and wellbeing as well as their physical and cardiovascular health in many cases. We want to build on the spirit of volunteering and community action within the City, tapping into a wealth of experience and knowledge within the community in supporting our residents with dementia.

Safeguarding our vulnerable clients is a further key priority, particularly in light of the Winterbourne View and the Francis reports. It is critical that our staff work alongside service users and their carer(s) to understand safeguarding in the context of dementia, including both how to recognise signs of abuse and managing risks appropriately. Working closely with clients is key to managing safeguarding risks for those with dementia and their carer(s), as is the Adult Social Care Review process, in which services and placements are reviewed with the service user, their carer(s) and family, provider and relevant agencies.

Adult Social Care recognises that one of the key concerns of service users and their carers is the quality of the support they will receive if they go into residential care or if they have to go into hospital for any reason. For this reason, a key objective is to improve the quality of the care experience, whether this is at home, supported through a range of initiatives and support services, through intermediate care provision, respite care, residential and nursing care or in hospital. Adult Social Care will improve the way in which Adult Social Care Reviews are carried out alongside users and their carers, updating its forms to include asking pertinent questions relating to cognitive deterioration, reasons for hospital admissions, co-morbidity factors and the appropriate use of anti-psychotic medications.

Service users who do go into residential care are always placed outside of the City itself as there is no residential care provision within the City. The Adult Social Care Review process is therefore integral to understanding whether or not the needs of the service user are being met and for monitoring and potentially reducing unnecessary hospital admissions. Adult Social Care gives a commitment to enhancing their review process to ensure that the client is receiving the right package of care for them as an individual and for their carer(s).

The City of London aims to sign up to the Dementia Action Alliance (DAA), and its Dementia Care & Support Compact. It sets out the commitment to supporting the delivery of the National Dementia Strategy and improving care and support for people with dementia, their carers and families. The City's goal is to challenge the perceptions surrounding social care

[9] http://www.alz.org/research/science/alzheimers_prevention_and_risk.asp

services for people with dementia. Our services will provide the right care, in the right place, at the right time.

People with dementia using our services will be able to say:

- I am respected as an individual
- I get the care and support which enables me to live well with my dementia
- Those around me and looking after me are well supported and understand how to maximise my independence
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I am inspired to participate in community life
- I am confident that my end-of-life wishes will be respected. I can expect a good death

The Dementia Action Alliance Dementia Care and Support Compact[10] commits to:

- Focus on quality of life for people with dementia, as well as quality of care. By knowing the person, their life history and their personal culture, our staff will deliver a personalised package of care and support.
- Set a benchmark for high quality, relationship-based care and support for people with dementia. We will inspire and encourage our sector to take responsibility for delivering this, building on existing good practice
- Engage and involve the wider community to improve their support for people with dementia, including GPs and healthcare professionals
- Play our part in supporting the wider community, sharing the knowledge and skills of our staff, and inviting people into our care settings
- Work with commissioners of care for people with dementia to ensure they commission quality care services appropriately
- Clearly set out how we have delivered on this Compact to make a difference for people with dementia, their carers and families. This will link into the work on quality and transparency being taken forward as part of the Care & Support Bill.

[10] *http://www.dementiaaction.org.uk/dementiacompact*

7. Strategic Objectives

Our key strategic objectives are underpinned by specific actions that will help raise awareness of the disease amongst our residents and professionals working here to enable early diagnosis, targeted support and provision for those with dementia and those caring for them.

The objectives were developed through consultation locally with the Adult Advisory Group, with the Clinical Commissioning Group (CCG), the Dementia Advisers based in the GP surgeries and through understanding of local needs.

The Strategic Objectives will be achieved through the Delivery Action Plan that is attached as Appendix A. This Action Plan highlights the steps that will be taken over the next 2 years at a fundamental level.

Resources are outlined in section 8.

1. Improve public and professional awareness of dementia and reduce stigma

Outcome: *The public and professionals will be more aware of dementia and will understand dementia better.*

This will:

- *help to remove the stigma of dementia by reducing other people's fear and misconceptions*
- *help people understand the benefits of early diagnosis and care*
- *encourage the prevention of dementia*

Why we are going to do this

Research undertaken by the Alzheimer's Society[11] indicates that:

- People currently wait up to three years before reporting symptoms of dementia to their doctor;
- 70% of carers report being unaware of the symptoms of dementia before diagnosis;
- 64% of carers report being in denial about their relative having the illness;
- 58% of carers believe the symptoms to be just part of ageing;
- Only 31% of GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia, a decrease since the same question was asked in the Forget Me Not report;
- 50 % of the public believe that there is a stigma attached to dementia; and
- People over 65 are more worried about developing dementia (39%) than cancer (21%), heart disease (6%) or stroke (12%)

Awareness-raising is fundamental to ensure that everyone understands dementia and is working to the same definitions locally. Many cases of dementia go un-noticed because people with dementia and their carers see the signs and symptoms of the disease as merely 'old age' or because of the stigma and misapprehension associated with dementia and therefore a reluctance to seek help at an early stage.

Professional attitudes to dementia further compound the issue as it is given a low priority for the development of training and skills, leaving a false belief that little or nothing can be done to assist people with dementia and their carers.

These issues result in delayed diagnosis and delayed access to good-quality care.

[11] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=535&pageNumber=2

What we are going to do:

- We will work together with partners to develop a targeted local awareness campaign that aims to raise public and professional understanding of dementia and the stigma associated with it, linking it with existing health promotion activities and activities arising from the Government's National Strategy. The awareness campaign will focus on encouraging people to seek early diagnosis and care and increasing people's knowledge of how to reduce their risk of developing dementia through making healthy lifestyle choices.
- The City of London's Dementia Champion will be trained by Skills for Care and will engage with local employers such as retailers, pharmacies, cafés and supermarkets and staff in Housing, Community Police and Fire officers to develop staff awareness of dementia including access to local resources, on a programme of developing a 'Dementia-Friendly City'
- We will develop and implement a local dementia care pathway, spanning early diagnosis to end of life care. We will ensure that people with dementia, carers and health and social care professionals are all aware of this pathway.

How we will know that this objective has been achieved

We will undertake service user feedback exercises with service users and their carers to establish whether the awareness raising has had any impact on their confidence in asking for help and on the support they receive.

Regular mystery shopping exercises will be undertaken to test staff responses and highlight further training and development needs.

We would expect to see a rise in the number of people with diagnoses of dementia.

2. Improve early diagnosis and treatment of dementia

Outcome: *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*

Why we are going to do this

Currently there are limited services available within the City for those with dementia, so in addition to factors such as the sensitivities in diagnosing dementia and managing this sensitively with the service user, there are concerns that there may not be the right type of support available to them. It is anticipated that by increasing the range of services available to service users, GPs will be better supported to give a formal diagnosis as sensitivities relating to such a diagnosis are reduced and more resources become available in the community. This in turn may encourage people with early symptoms of dementia to seek a formal diagnosis.

What we are going to do:

- Work in collaboration with City and Hackney CCG and primary health to explore the merits of early identification and support to people with dementia and their carers, through collaboration with the GP attached Dementia Advisor in offering outreach to those newly diagnosed.
- Work with GP practices in line with NICE guidance to enable tit to have a greater role in early diagnosis and to better manage existing and future demand via enhanced primary care services
- Work in partnership with primary and secondary health settings to ensure a more timely and integrated service is offered, providing assessment and treatment as part of the service
- Ensure timely assessments of carers' needs are undertaken, and services to support carers are creatively utilised, for maximum benefits for carer and cared for. To look at respite care needs and what would suit each individual circumstance and set of needs
- Establish regular meetings and workshops between ASC, the Neaman practice and Dementia Adviser and extend to Tower Hamlets and Islington surgeries where City patients may be registered, to explore similar collaborations.
- Ensure people with dementia and their carers and family have access to sound counselling and therapeutic interventions should they wish it via Improving Access to Psychological Therapies (IAPT)
- In line with NICE guidance, City of London will work with GP practices to enable it to have a greater role in early diagnosis and to better manage existing and future demand via enhanced primary care services

- Establish partnership processes to ensure that GP practices are notified when one of their patients is admitted to hospital with a diagnosis of dementia (working across differing Accident and Emergency departments)

How we will know that this objective has been achieved

It is anticipated that there would be an increase in the number of early diagnoses of dementia within the City although this number may be quite small. An increased number of users and carers will be signposted to access the resources available.

3. Increase access to a range of flexible day, home based and residential respite options

Outcome: *Support for carers will play a significant role in reducing admissions to residential care and enabling people with dementia to live in the community for as long as possible, but where residential care is the best option, there will be a range of options to choose from.*

Why we are going to do this

In order to better support people to live at home longer there needs to be a focus on the delivery of services at an early stage to support both the person with the diagnosis and their carer(s). A range of different support options will be necessary to meet individual needs.

What we are going to do:

- Review and promote local initiatives through effective partnership working to make more effective use of existing resources provided by commissioned and dedicated carers organisations to provide increasingly flexible and emergency respite and support responses to people's expressed needs.
- Forge links with specialist dementia organisations to build a network of support for groups and individuals, which will feed into the resource directory as a specialist resource to people living in the community with dementia despite their age or stage
- Focus within ASC on personalisation outcomes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers through the use of creative Individual Budgets.
- Ensure that the need for respite is an integral part of people's assessment and care planning and that the rights of carers to an assessment of needs are upheld.
- Ensure all local initiatives are collated and gathered as part of community intelligence for the compilation of dementia specific resource pack.
- Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.
- Work alongside colleagues in Local Authority Commissioning and with the Clinical Commissioning Group to ensure that services are of a high quality, achieving good value for service users and their carers and for the City.

How we will know that this objective has been achieved

The Adult Social Care Review processes will identify whether or not service users and their carers are happy with the arrangements and whether needs are actually being met. Themes arising from these reviews will be monitored by the Dementia Implementation Group.

4. Develop services that support people to maximise their independence

Outcome: *Good-quality, flexible home care services will contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.*

Why we are going to do this

Where possible we want to aim to support people to live at home as long as possible to retain links with familiar surroundings and networks should they need additional support. In maintaining independence, people can maintain the activities they enjoy which in turn contribute to maintaining their vascular health.

Developing a range of different options will give service users, their carers and families confidence to make choices and maintain control over decisions that can affect them. Studies carried out by the CSCI and others point to the importance of continuity, reliability and flexibility of home care services, in ensuring that people with dementia and their carers have choice and control over the services they receive.

What we are going to do:

Reviewing Best Practice

- Review models of similar nature carried out elsewhere, particularly in neighbouring boroughs, for good practice examples and explore whether it can have a "City fit"
- Develop partnership working with City and Hackney CCG to plan clear care pathways, that offer appropriate intermediate care to all COL residents.
- Explore a shared care model between CCG, primary and secondary care adult social care and dementia advisor and users of dementia services to ensure co-production is explored, in order to provide a seamless service with a continuum of care and support.
- ASC to work with commissioning on a review of contracts and to revisit the option of commissioning a dementia specialist community home care "service" rather than commission a number of hours.
- Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their wellbeing. These services will be appropriate for people at different stages of the disease.

Housing and assistive technologies

- The Supported living review to incorporate the specialist needs of people with dementia into its on-going dialogue and planning and review process.
- Increase investment in assistive technology to support people to remain in their own homes and ensure that appropriate housing related support is available to

people with dementia and family members to be supported to look after them safely.

- Develop a dialogue within the City between ASC and Housing regarding a range of housing options that better meet the specialist needs of people with dementia, in relation to extra care settings in the community, that meets the additional needs of people with learning difficulties, mental health, and alcohol related dementia (Korsakoffs) as well as the needs of the elderly with dementia.

Consultation and Participation

- People with dementia will be supported to engage in meaningful activity, doing something that they enjoy or are interested in. This can be as simple as undertaking everyday tasks such as cleaning or cooking together or more formal activities – for example, participating in a choir or swimming group
- Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.
- Skills For Care to undertake 'Dementia Friends' training and 'Dementia Friendly City' initiative
- Highlight ways that people with dementia and their families and carers can be involved in decisions about their care or in their community
- Undertake joint work as part of the partnership board in relation to dementia, seeking the views of service users at all times
- The commissioning of a Dementia Group will give support to those with dementia and their carers. This resource will also be a hub for consultation and participation to ensure that we are delivering the right mix of services.

How we will know that this objective has been achieved

An increased number of people will seek early diagnosis with the understanding that they will be supported to live at home and that their wishes and feelings will be supported.

There will be an increase in the number of people attending the Dementia Group and they will report feeling more prepared and confident to deal with dementia, that they have a network of support and less isolation and loneliness.

5. Improve the skills and competencies of the workforce

Outcome: *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 learning more about dementia*

Improved skills and competencies of the workforce will improve the early diagnosis of the disease and improve the quality of life of those suffering with the disease and those who care for them.

Why we are going to do this

Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer. Improving the understanding will enable service users and their carers to have the confidence to make choices and maintain control of their own care.

Frequently, dementia affects a person's ability to understand and use language accurately and appropriately and this can lead to confusion and frustration. By having a workforce that understands these difficulties and who adapt their communication skills to meet the needs of the person, these frustrations can be reduced.

What we are going to do:

- Skills for Care to hold a City of London providers' forum, where dementia will be a key developmental topic for their staff groups. Workforce development and full skills audits will be undertaken at that forum, and Skills for Care will work with each agency to ensure that they are all National Minimum Data Set (NMDS) compliant and can then take part in subsidised training modules run by Skills for Care, to enhance expertise and seek to professionalise the service offered.
- Develop the ASC workforce plan to incorporate dementia skills that links to, and complements, the identified national workforce development initiatives.
- Invest in targeted dementia training for ASC staff and use person-centred thinking tools with staff
- We will tap into and nurture skills in the wider community and unpaid 'workforce' – for example, linking with community groups such as 'time-banks' and supporting families and carers
- Ensure that ASC and other staff working with service users with dementia have the skills to recognise and appropriately manage safeguarding risks.
- Engage with the NHS Rapid Assessment Interface Discharge (RAID) liaison service with a view to expanding the role of the service to include responsibility for general hospital staff dementia training and education across City of London.

- Ensure that all services specify dementia training and core competencies that include, but are not limited to, the national minimum standards.
- Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from specialist MHCOP team.

How we will know that this objective has been achieved

The workforce will be compliant with the Common Core Principles for Supporting People with Dementia[12] and service users and their carers will report that they feel supported and that the social care workforce understands their needs.

[12] *Common Core Principles for Supporting People with Dementia: A guide to training the social care and health workforce, 2011, Skills for Care, Skills for Health and Department of Health*

6. Improve access to support and advice following diagnosis for people with dementia and their carers

Outcome: *People with dementia and their carers will have a clear understanding of the support and advice available to them*

People with dementia and their carers will be given good-quality information about dementia and services:

- *At diagnosis*
- *During their care*

People with dementia and their carers will be able to see a dementia adviser who will help them throughout their care to find the right:

- *Information*
- *Care*
- *Support*
- *Advice*

Why we are going to do this

The National Dementia Strategy states that:

"One of the most clear and consistent messages emerging from discussions with people with dementia and their carers has been the desire for there to be someone who they can approach for help and advice at any stage of the illness. This is almost always perceived negatively by people with dementia and their carers, who, faced with a serious illness where there is inevitable long-term decline and increase in dependency, want to feel that there is continuing support available to them when they need it.

"In the course of consultation it has become clear that this support needs to be provided without removing health and social care professionals from front-line care, and needs to be complementary to the other elements of the care pathway described here"

Within Adult Social Care there is a Dementia Champion and within the local GP practices there are already 'Dementia Advisers' whose role it is to support, signpost and facilitate engagement with the specialist services that can best provide the person with dementia and their carers with the help, care and support they need simply and quickly. We will promote this role within our community.

The need for improved access to support and advice has been identified as a priority by local stakeholders and is a key objective of the National Dementia Strategy.

What we are going to do:

Information

- The Dementia Champion, Carers' Lead and Service Manager ASC to build a dementia specific directory / resource pack for people ensuring that literature is co-produced and ratified by users and carers of dementia services to be used by staff, service users and their carers
- We will ensure that good quality dementia information materials and resources are accessible and available for all people with dementia and their carers
- Ensure that information about community activities, leisure and transport is available and accessible in a range of formats, and not just relying on a website

Care

- Ensure that service users and their carers are able to access good quality accessible information and advice about care options
- Ensure that agencies we use have specialist skills in dementia care
- Explore the options of Admiral Nurse specialists in the community.

Support

- Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia is available to help maintain their wellbeing. These services will be appropriate for people at different stages of the disease
- Ensure high quality support planning and advocacy is available from diagnosis
- Develop partnership working with primary care to provide an integrated hub for support in the form of a 'Dementia Café'

Advice

- There is a strategic approach to providing information as part of creating a dementia-friendly community. This involves making all information that people need to live and independent life accessible.
- City of London has commissioned a new carers service – Elders Voice which provides information, advice and support to people with dementia and their carers. If a review of the outcomes indicates that it is achieving the desired outcomes then COL will continue to commission the service.

How we will know that this objective has been achieved

The resource pack will be printed and used by service users and carers. Increased numbers of people may seek a diagnosis knowing that they will receive support. An increased number of people will contact the Dementia Champion or the Dementia Advisers for support and advice.

7. Reduce avoidable hospital and care home admissions and decrease hospital length of stay

Outcome: *Improved outcomes in terms of length of stay, mortality and institutionalisation by reducing avoidable hospital and care home admissions*

Why we are going to do this

This objective links very closely with the quality objective, in that reviewing the reasons that people are admitted to hospital and having good planned discharges may help to prevent future admissions or to reduce the length of stay. This will help people to maintain their independence following a hospital episode and to receive the right support when they are discharged thereby reducing the risk of re-admission.

What we are going to do:

- Identify dementia care leads in hospital settings wherever possible and to liaise regarding the care pathway and aftercare needs on discharge
- Establish partnership processes to ensure that GP practices are notified when one of their patients is admitted to hospital with a diagnosis of dementia
- Commissioning organisations have been tasked with the key outcome to work with the main hospitals used by CoI residents and seek to raise awareness of dementia, especially when the person is known to community services and has been admitted for a non-overtly dementia relation condition.
- Use the revised ASC Review form to audit admissions to hospital for people with dementia.

How we will know that this objective has been achieved

The Adult Social Care Review forms will be used consistently for all clients known to Adult Social Care. ASC will monitor trends in relation to individual clients and to the client group as a whole and determine whether further specific training or intervention or safeguarding measures are needed.

8. Improve the quality of dementia care in care homes and hospitals

Outcome: *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*

People with dementia who are living in care homes will be offered appropriate treatment that will improve their quality of life and delay deterioration of their condition

Why we are going to do this

Nationally, there has been a high level of inappropriate prescribing of anti-psychotic drugs for people with dementia who are living in care homes. We will ensure that our staff have an understanding of the medications that clients require and are equipped to appropriately challenge the use of anti-psychotics that are used in residential care.

Stays in acute general hospitals affect people with dementia badly – increasing their confusion and speeding up deterioration.

What we are going to do:

- Adult Social Care (ASC) to amend their review forms to include a specific focus on dementia and to ensure that staff have asked pertinent questions in relation to cognitive deterioration and in relation to medications used, in order to monitor quality and to ensure that anti-psychotic medications are used appropriately
- Staff to be trained in understanding the appropriate use of anti-psychotic medication in order to monitor and document within the ASC Review.
- Ensure that ASC staff is scrupulous in their review of care homes with a sound understanding of good practice and care standards for people with dementia, particularly in relation to safeguarding and to the use of medications.
- As part of the statutory review of service users placed in care homes, the ASC team will ensure that the needs of those with dementia are well catered for, that they are placed in a suitably registered home, and that they will document this clearly as part of the review process. They will ensure they have checked with the Care Quality Commission (CQC) on any recent inspections and to request updated information at the time of the review.
- We will improve liaison with commissioners in local authorities where residents of the City are in residential care to monitor the quality of care provision within the homes in their area. We will liaise especially closely with commissioners in the City's neighbouring local authorities where our residents may be living in residential care homes.

- Ensure that where appropriate (and where the client is capable consent obtained), family members are consulted and invited to the review meeting and that Mental Health Care for Older People team (MHCOP) are aware of the person living with dementia in their locality and invite them and the GP as appropriate.
    - To ensure all physical conditions are being followed up and person not solely treated as a person with dementia
    - To have knowledge of the medications given and to take note to ensure the over-use of anti-psychotics is not prevalent and being utilised regarding the person we may have placed
- Social workers to request input of hospital MHCOP team in assessing consent, Capacity and best interest decisions in a timely manner at ward meetings, to ensure best possible care is given.
- Establishment of quarterly meetings with the regional CQC lead, to look at the specific needs of the City and those we currently have placed.
- Ensure that all services, particularly commissioned or spot purchased services specify dementia training and core competencies that include, but are not limited to, the national minimum standards
- Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from specialist MHCOP.
- Carers' lead in ASC and commissioned carers organisations to have a specific focus on the needs of family members and main carers of people with dementia throughout the progression of the condition.
- Identify dementia care leads in hospital settings wherever possible and to liaise regarding the care pathway and aftercare needs on discharge.

How we will know that this objective has been achieved

Adult Social Care Review forms will be completed for all service users that will clearly identify the wishes and feelings of the service user. Where issues in relation to their care are raised within the forms, audit will identify that these issues have been followed up appropriately and the service user and their carer are happy with the outcome.

9. Improve end of life care for people with dementia

Outcome: *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*

Why we are going to do this

Evidence suggests that people with dementia receive poorer end of life care than those who are cognitively intact.

What we are going to do:

- Ensure that people with dementia have the same access to palliative care services as others.
- Adult social care staff to be aware of local end of life care pathways for dementia
- Raise awareness of the Mental Capacity Act amongst health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so.
- ASC to study the NICE guidance on End of Life care. To provide an integrated service as and when required to compliment and support health colleagues so that people with advanced dementia can die at home if they and their family members so wish.
- Ensure that carers are fully supported through the end of life and that they have access to advice and support as they go through it.
- Those in receipt of Adult Social Care services will be given opportunities while they have capacity to do so to discuss their wishes in relation to their end of life care.
- Whilst those receiving end of life care would potentially meet the criteria for health funding under Continuing Care, Adult Social Care would support this where necessary and be vigilant to the needs of the carer(s).
- The Carers worker will be notified of Adult Social Care users who are reaching their end of life in order to offer advice and support to their carer(s) where required.

How we will know that this objective has been achieved

Carers will report feeling supported through the process and will be comfortable in requesting advice and support from the Carers' Champion.

10. Ensure that services meet the needs of people from vulnerable groups

Outcome: *Services will meet the needs of all members of the community but will ensure that those who are most vulnerable because of their age, disability, ethnicity gender, religion or sexual orientation will receive support appropriate to their needs to enable them to live well.*

Why we are going to do this

Early-onset dementia is more common amongst black and minority ethnic groups and the number of people with late onset dementia is set to rise sharply. It is also more common amongst women and there is a genetic connection between 'Down's Syndrome' and Early onset dementia. We want to ensure that service users who might otherwise be considered 'hard to reach' receive an equitable service meeting their individual needs. People with learning disabilities who develop dementia will generally be of a younger age group and may have needs which services designed for people 30 or 40 years older find hard to meet.

People with dementia are known to be an 'at risk' group in terms of abuse, particularly (although not exclusively) through financial exploitation, fraud and theft. Reliance on others for support to manage finances can expose people with dementia to the risk of abuse. Additionally, the complex dynamics of caring relationships mean that people do not always report abuse or mistreatment. This becomes even more problematic if the individual lacks the capacity to be able to complain. (Living Well with Dementia, 2009, Department of Health)

What we are going to do:

- Work with neighbouring local authorities and health commissioners in primary and secondary care and CCGs to ensure an Equality Impact Assessment is undertaken to gain a better understanding of the needs and current gaps in service provision, and whether current service provision is meeting need.
- Ensure that health and social care staff working with younger people at risk of dementia receive training in dementia awareness, this includes staff at the Tower Project where our younger service users with Learning Difficulties receive day provision.
- Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia when required.
- Develop the skills of ASC staff and provider staff to recognise signs of abuse and neglect in a client with dementia and to be able to manage the risks appropriately whilst safeguarding the interests of the client at all times.

How we will know that this objective has been achieved

An Equality Impact Assessment will be completed and staff will have a good understanding of the needs of people from different groups, including those for whom Dementia may be a secondary condition. Service users and their carers will be confident that Adult Social Care staff are able to appropriately manage risks and safeguard the service user.

8. The Resource Envelope

Currently, the City of London Corporation spends £250K on dementia services, of which £138k is spent on residential care and £84k individualised budgets, supporting people to live at home.

Grant funding under Section 256 has been made available for Dementia Services and specific projects. A proportion of this (£5k) will be allocated to backfill the role of the Dementia Champion whilst she is undertaking training with Skills for Care to develop a Dementia Friendly City. A further £8k will be allocated to commissioning a support group for service users and their carers. £10k will be allocated to the development of information leaflets.

9. Implementation and monitoring

It is envisaged that full participation of our key stakeholders, including carers and service users group will play a full role in implementation and monitoring of this strategy.

A Dementia Implementation Group will be established and chaired by the Service Manager for Adult Services. Key stakeholders on that group will include:

- Representatives from the GP practices
- City of London Corporation Adult Social Care
- A representative of the Adult Advisory Group (AAG)
- Representatives from the voluntary sector
- Representative from Healthwatch

The strategy will be reviewed regularly and progress on implementation will be monitored by the Implementation Group who will have a remit to review and make recommendations for further developments. They will report annually to the Health and Wellbeing Board.

References

Legislation

Mental Capacity Act 2002

Care and Support Bill 2010

Carers' Assessments: the background. Under the terms of the Carers (Recognition and Services) Act 1995

Carers (Equal Opportunities) Act 2004

Resources

http://www.dementiaaction.org.uk/who_are_we/national_dementia_declaration

Alzheimer's Association (USA) http://www.alz.org/research/science/alzheimers_prevention_and_risk.asp

Alzheimer's Society (2013) Dementia 2013: The hidden voice of loneliness

The City and Hackney Mental Health for Older People Strategy 2008-2018

Dementia Action Alliance (2011) National Dementia Declaration

Dementia Action Alliance (2011) National Compact

Department of Health (2009) Living well with dementia: A national dementia strategy for England

Department of Health (2010) Quality outcomes for people with Dementia: building on the work of the national dementia strategy

Department of Health (2010) Recognised, Valued and Supported: the next steps for the Carers' Strategy

Department of Health (2012) Prime Minister's challenge on dementia: delivering major improvements in dementia care and research by 2015

Department of Health (2012) Prime Minister's challenge on dementia: delivering major improvements in dementia care and research by 2015: A report on progress

Mental Health Foundation (2011) An evidence review of the impact of participatory arts on older people

Mental Health Foundation (2011) The milk's in the oven,

My aging parent.com Cost Calculator: http://www.myageingparent.com/calculate-the-cost-of-your-parents-care/

Office of National Statistics (2011) Census 2011

Office of National Statistics (2010) General lifestyle survey 2010

Skills for Health (2011) Carers Matter- Everybody's Business

Skills for Care, Skills for Health and Department of Health(2011) Common Core Principles for Supporting People with Dementia: A guide to training the social care and health workforce

Appendix A – City of London Dementia Strategy Action Plan April 2013 – April 2015

1. Improve public and professional awareness of dementia and reduce stigma

Outcome: *The public and professionals will be more aware of dementia and will understand dementia better.*

This will:

- *help to 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 misunderstanding of people with dementia*

Improved awareness should encourage behaviour change in terms of appropriate help-seeking and help provision

Ref	Action	Lead	Timescale	Update
1.1	Develop targeted local awareness campaign that aims to raise public and professional understanding of dementia and the stigma associated with it, linking with existing health promotion activities and activities arising from the Government's National Strategy	COL to work with partners to ensure that "Dementia is everyone's business", and produce publications alongside health that are balanced and informative. To raise public and professional awareness.	December 2013	TBC at introductory strategy group meeting

Ref	Action	Lead	Timescale	Update
1.2	Focus on Dementia awareness at the City of London Providers Forum	ASC, SFC LFB	July 2013	Providers meeting was held, and providers signed up to undertake training modules for staff around Adult safeguarding, Dementia, and Fire Safety for care staff
1.3	Adult Social Care have identified 3 local retailers in the start of a training programme that City of London have applied to secure funding to progress and evaluate via Skills for Care in conjunction with the Alzheimer's society , designed to raise awareness, train champions and endeavour to see the City as a pilot for a "dementia friendly community". In implementing the strategy group, key partners from housing, police and fire brigade will be invited onto the panel and there will be an expectation that Champion training will be disseminated within each respective service as part of an on-going workforce development programme.	COL Dementia Champion. A lead within retail work force to be identified. Leads within housing, police and LFB to be identified as champions to embed Dementia into everyday understanding.	November 2013	Dementia Friendly City (DFC) plan has been submitted which illustrates work plan. Outcome as to £3000 grant is awaited, but Champion training has been identified for 14/8/13 with SFC.
1.4	Develop and implement a local dementia care pathway, spanning early diagnosis to end of life care and ensure that people with dementia, carers and health and social care professionals are aware of this pathway.	TBC in conjunction with health colleagues within primary care and CCG, at strategy meeting level	December 2013	TBC

2. Improve early diagnosis and treatment of dementia

Outcome: *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*

Ref	Action	Lead	Timescale	Update
2.1	Work in collaboration with City and Hackney CCG and primary health to explore the merits of early identification and support to people with dementia and their carer's, through collaboration with the GP attached Dementia Advisor in offering outreach to those newly diagnosed.	To work in collaboration as part of the strategy implementation group	To commence at initial meeting October 2013	To ensure that knowledge of Mental Capacity Act and Court of Protection is embedded as appropriate
2.2	Work with GP practices in line with NICE guidance to enable it to have a greater role in early diagnosis and to better manage existing and future demand via enhanced primary care services.	To invite GP leads or cluster practice managers from City, Islington and Tower Hamlets where City of London residents are registered to participate in strategy group to assess levels of service to those in most need.	To progress at initial meeting October 2013	TBC

Ref	Action	Lead	Timescale	Update
2.3	Work in partnership with primary and secondary health settings to ensure a more timely and integrated service is offered providing assessment and treatment as part of the service	ASC duty team , Dementia Champion, and commissioned provider Toynbee 50+	October 2013	Work is already progressed in this sphere, but a dementia focus will be emphasised, in relation to integrations with primary and secondary health colleagues.
2.4	Ensure timely assessments of carers' needs are undertaken, and services to support carers are creatively utilised, for maximum benefits for carer and cared for. To look at respite care needs, and what would suit each individual circumstance and set of needs	ASC and Elders Voice , and Crossroads Care	October 2013	On-going, but reporting mechanism for purposes of action plan for strategy group will require regular updates
2.5	Establish regular meetings and workshops between ASC Neaman practice and Dementia Adviser and extended to Tower Hamlets and Islington surgeries where City patients may be registered to explore similar collaborations.	ASC Dementia Champion, Alzheimer's Society Dementia Advisor, and GPS. To identify leads at Islington and Tower Hamlets practices	Septembers 2013 For Neaman practice October 2013 for Islington and Tower Hamlets practices	To work on identifying key partners in neighbouring boroughs where COL residents are registered.
2.6	Ensure people with dementia and their carers and family have access to sound counselling and therapeutic interventions should they wish it via NHS Improving Access to Psychological Therapies (IAPT)	CCG leads	October 2013	To establish pathways and referral routes and thresholds

3. Increase access to a range of flexible day, home based and residential respite options

Outcome: *Support for carers will play a significant role in reducing admissions to residential care and enabling people with dementia to live in the community for as long as possible, but where residential care is the best option, there will be a range of options to choose from.*

Ref	Action	Lead	Timescale	Update
3.1	Review and promote local initiatives through effective partnership working to make more effective use of existing resources provided by commissioned and dedicated carers organisations to provide increasingly flexible and emergency respite and support responses to people's expressed needs.	Elders Voice and Crossroads Care	October 2013	Elders Voice and Crossroads care are existing commissioned providers for support information, advice and respite care to carers. Awareness has already been raised by dementia champion at contract review around the need to target carers of people with dementia
3.2	Forge links with specialist dementia organisations to build a network of support both group and individual, as a specialist resource to people living in the community with dementia despite their age or stage and their carers	Commissioning officer, Dementia champion and team manger ASC	November 2013	Draft specification has been co-produced drawn up and consulted upon at Adult Advisory Group (AAG). Tender to be raised.
3.3	Focus within ASC on personalisation outcomes to enable the development of more innovative, flexible support planning to better meet the needs of people with dementia and their carers through the on-going use of creative Individual Budgets.	Team Manager Adult Social Care and Dementia Champion ,	On-going, but with specific reference to dementia , for feedback	To develop pathways for Dementia support with provider agencies and with Penderels brokerage agents.

Ref	Action	Lead	Timescale	Update
			November 2013	
3.4	Ensure that the need for respite is an integral part of people's assessment and care planning and that the rights of carers to an assessment of needs are upheld.	ASC team in collaboration with primary health and dementia advisor and champion	Feedback in November 2013	

4. Develop services that support people to maximise their independence

Outcome: *Good-quality, flexible home care services will contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.*

Encouraging residents to participate and engage with services will inform the commissioning processes and thereby improve the range and quality of services available in the City.

Ref	Action	Lead	Timescale	Update
Best Practice				
4.1	Review models of similar nature carried out elsewhere, particularly in neighbouring boroughs, for good practice examples and explore whether it can have a "City fit"	TBC at initial strategy group when Terms of reference are agreed	November2013	
4.2	Develop partnership working with City and Hackney CCG to plan clear care pathways that offer appropriate intermediate care to all COL residents.	CCG, MHCOP, Primary Care Leads, ASC and Reablement	December 2013	Work has been going on throughout the year, looking at intermediate care in the round. This group will need to look at the specific needs of people with dementia
4.3	Explore a shared care model between CCG, primary and secondary care adult social care and dementia advisor and users of dementia services to ensure co-production is explored, in order to provide a seamless service with a continuum of care and support.	TBC at initial meeting stage	December 2013	

Ref	Action	Lead	Timescale	Update
4.4	ASC to work with commissioning on a review of contracts and to revisit the option of commissioning a dementia specialist community home care "service" rather than commission a number of hours.	Dementia Champion and Commissioning officer	November 2013	At provider's forum in July, issue was addressed, and all agencies at this time wanted to undertake dementia training with skills for care. This to be explored as part of commissioning process.
Housing and assistive technologies				
4.6	The Supported living review to incorporate the specialist needs of people with dementia into its on-going dialogue and planning and review process.	Housing and adult social care	November 2013, to update at initial strategy meeting	
4.7	Increase investment in assistive technology to support people to remain in their own homes and ensure that appropriate housing related support is available to people with dementia and family members to be supported to look after them safely.	Housing Adult Social care and London Fire Brigade	November 2013	Telecare is currently used as an integral part of an individual budget, and is often implemented as part of early intervention and prevention. ASC and LFB have been working together on risk assessing our most vulnerable service users , who may also be people identified as living with Dementia

Ref	Action	Lead	Timescale	Update
4.8	Develop a dialogue within the City between ASC and Housing regarding a range of housing options that better meet the specialist needs of people with Dementia, in relation to extra care settings in the community, that meets the additional needs of people with learning difficulties, mental health, and alcohol related Dementia (Korsakoffs) as well as the needs of the elderly with dementia.	Housing and Adult social care	November 2013	In addition to what future "extra support" there might be, housing have rolled out 2 "good neighbour" schemes, which have an excellent protective factor to older more isolated residents and possibly those with early and undiagnosed dementia
Consultation and Participation				
4.9	People with dementia will be supported to engage in meaningful activity, doing something that they enjoy or are interested in. This can be as simple as undertaking everyday tasks such as cleaning or cooking together or more formal activities – for example, participating in a choir or swimming group	TBC	November 2013	To look at community assets around Guildhall school of music, dance and theatre opportunities as well as Spice Credits where applicable.
4.10	Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.			

Ref	Action	Lead	Timescale	Update
4.11	Dementia Champion to undertake Dementia Friends training and Dementia Friendly community initiative, in conjunction with The Alzheimers Society and Skills for care	TBC	November 2013	To extend dementia champion training to encompass other city retailers as well as GP reception staff, libraries (Barbican and Artizan st)
4.12	Highlight ways that people with dementia and their families and carers can be involved in decisions about their care or in their community	Dementia Champion	November 2012	
4.13	Undertake joint work as part of the partnership board in relation to dementia , seeking the views of service users at all times	Service manager ASC	December 2013	To utilise AAG, and providers such as Elders Voice, Toynbee 50 + , Crossroads, and CSV

5. Improve the skills and competencies of the workforce

Outcome: *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 learning more about dementia*

Improved skills and competencies of the workforce will improve the early diagnosis of the disease and improve the quality of life of those suffering with the disease and those who care for them.

Ref	Action	Lead	Timescale	Update
5.1	Adult Social Care and Skills for Care to hold a COL providers forum, where Dementia will be a key developmental topic for their staff groups.	ASC service manager and Skills for care	11/7/13	To provider regular forums for providers to meet as peers and share learning and development
5.2	Develop the ASC workforce plan to incorporate dementia skills that links to, and complements, the identified national workforce development initiatives.	ASC team manager and workforce development consultant	January 2014	To develop dementia training within Knowledge Transfer Partnership being developed with Goldsmiths university
5.3	Invest in targeted dementia training for ASC staff and use person-centred thinking tools with staff	As above	January 2014	
5.4	Organisations tap into and nurture skills in the wider community and unpaid 'workforce' – for example, linking with community groups such as "spice credits", and supporting families and carers.	TBC	February 2012	To engage Spice Credit coordinator, when strategy is embedded

Ref	Action	Lead	Timescale	Update
5.5	Ensure that ASC and other staff working with service users with Dementia have the skills to recognise and appropriately manage safeguarding risks.	See 5.2	January 2014	
5.6	Engage with the RAID liaison service with a view to expanding the role of the service to include responsibility for general hospital staff dementia training and education across COL.	CCG and health colleagues in secondary health care		To monitor and evaluate this work in relation to outcomes, and the work currently underway with tricordant

6. Improve access to support and advice following diagnosis for people with dementia and their carers

Outcome: *People with dementia and their carers will have a clear understanding of the support and advice available to them*

People with dementia and their carers will be given good-quality information about dementia and services:

- *At diagnosis*
- *During their care*

People with dementia and their carers will be able to see a dementia adviser who will help them throughout their care to find the right:

- *Information;*
- *Care;*
- *Support; and*
- *Advice.*

Ref	Action	Lead	Timescale	Update
Information				
6.1	Dementia champion, Carers Lead ASC to build a service specific directory / resource pack for people ensuring that literature is co-produced and ratified by users and carers of dementia services to be used by staff, service users and their carers	Dementia champion, team manager/Carers champion and , communications lead for COL	February 2014	To build upon the ASC Service Directory already in existence , with relevant Dementia inserts, for production in hard copy and on ASC web page
6.2	We will ensure that good quality dementia information materials and resources are accessible and available for all people with dementia and their carers.	As above		
6.3	Information about community activities, leisure and transport is available and accessible in a range of formats	Communications lead for COL and		

Ref	Action	Lead	Timescale	Update
		in conjunction with CCG lead for communications'		
Care				
6.5	Ensure that service users and their carers are able to access good quality accessible information and advice about care options	CCG and ASC	March 2014	To update all information to create a smooth communication pathway between health and social care for people affected by dementia
6.6	Ensure that agencies we use have specialist skills in dementia care	ASC Commissioning lead , CCG and ASC	January 2014	To convene another ASC providers forum follow up for a skills audit and dementia stocktake.
6.7	Explore the options of Admiral Nurse specialists in the community	CCG and ASC MHCOP	March 2014	Admiral Nurses are specialist mental health nurses specialising in dementia.
Support				
6.8	Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia is available to help maintain their wellbeing. These services will be appropriate for people at different stages of the disease.	All partners and stakeholders	January 2014	

Ref	Action	Lead	Timescale	Update
6.9	High quality support planning and advocacy is available from diagnosis	All partners and stakeholders	January 2013	
6.10	Develop partnership working with primary care to provide an integrated hub for support in the form of a 'Dementia Café'	Primary health partners in city, tower hamlets and Islington.	November 2013	
Advice				
6.11	There is a strategic approach to providing information as part of creating a dementia-friendly community. This involves making all information that people need to live an independent life accessible.	COL partners and stakeholders	January 2014	To consider the role and funding of a consultant to oversee the development of a dementia friendly city of London.

7. Reduce avoidable hospital and care home admissions and decrease hospital length of stay

Outcome: *Improved outcomes in terms of length of stay, mortality and institutionalisation by reducing avoidable hospital and care home admissions*

Ref	Action	Lead	Timescale	Update
7.1	Identify dementia care leads in hospital settings wherever possible and to liaise regarding the care pathway and aftercare needs on discharge.	Dementia Champion Alzheimer's Dementia Advisor for Neaman Practice CCG/MHCOP	December 2013	
7.2	Establish partnership processes to ensure that GP practices are notified when one of their patients is admitted to hospital with a diagnosis of dementia	CCG / Dementia Advisors		
7.3	Commissioned organisation have been tasked with the key outcome to work with the main hospitals used by COL residents and seek to raise awareness of dementia , especially when person is known to community services and person has been admitted for a non-overtly dementia related condition.	Toynbee 50+ Dementia Champion	November 2013	
7.4	Use the revised Review form to audit admissions to hospital for people with dementia.	ASC Team Manager, and review Social worker	December 2013	Review Document is the statutory Community care review undertaken by ASC to review any service or placement that is funded

Ref	Action	Lead	Timescale	Update
				by the local authority, this is currently under review in conjunction with the implementation of the new ESCR, and will reflect need for quality review mechanism in light of Winterbourne findings

8. Improve the quality of dementia care in care homes, hospitals and support in people's homes

Outcome: *Services will work to ensure:*

- *Better care for people with dementia*
- *Clear responsibility for dementia*
- *A clear description of how people will be cared for*
- *Visits from specialist mental health teams*
- *Better checking of care homes, hospitals and services provided to people with dementia*

*People with dementia will be offered **good quality** appropriate treatment that will improve their quality of life and delay deterioration of their condition*

Ref	Action	Lead	Timescale	Update
8.1	ASC to amend their review forms to include specific focus on dementia and to ensure that staff have asked pertinent questions in relation to cognitive deterioration and in relation to medications used, in order to monitor quality and to ensure that anti-psychotic medications are used appropriately.	ASC, CCG , MHCOP, Primary care leads, Dementia Champion and Dementia Advisor	December 2013	To update document to ask relevant dementia specific questions.
8.2	Staff to be trained in understanding the appropriate use of anti-psychotic medication in order to monitor and document within the ASC Review.	ASC, CCG, MHCOP, Primary care leads, Dementia Advisors.	December 2013	
8.3	Ensure that ASC staff are scrupulous in their review of care homes with a sound understanding of good practice and care standards for people with dementia, particularly in relation to safeguarding and to the use of medications.	ASC , CCG MHCOP	December 2013	
8.4	As part of the statutory review of service users placed in care	ASC, CCG, MHCOP	December 2013	

Ref	Action	Lead	Timescale	Update
	homes, the ASC team will ensure that the needs of those with dementia are well catered for, that they are placed in a suitably registered home, and that they will document this clearly as part of the review process. They will ensure they have checked with CQC on any recent inspections and to request updated information at the time of the review.			
8.5	Ensure that family members are consulted and invited to the review meeting and that MHCOP team are aware of the person living with dementia in their locality, and invite them and the GP as appropriate. • To ensure all physical conditions are being followed up and person not solely treated as a person with dementia. • To have knowledge of the medications given and to take note to ensure the over use of anti-psychotics is not prevalent and being utilised regarding the person we may have placed.	ASC, CCG ,CQC, MHCOP	January 2013	
8.6	Social workers to request input of hospital MHCOP team in assessing consent, Capacity and Best Interest decisions in a timely manner at ward meetings, to ensure best possible care is given.	CCG, ASC, MHCOP	December 2013	Mental Capacity Act and Best Interests are understood and adhered to.
8.7	Establishment of quarterly meeting with the regional CQC lead, to look at the specific needs of the City and those we currently have placed	ASC , CQC	November 2013	
8.8	Ensure that all services, particularly commissioned services specify dementia training and core competencies that include, but are not limited to, the national minimum standards.	COL and CCG Commissioning	November 2013	

Ref	Action	Lead	Timescale	Update
8.9	Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from specialist Mental Health Care for Older People team.	COL Commissioning , MHCOP, ASC		
8.10	Carers' lead in ASC and commissioned carers organisations, to have a specific focus on the needs of family members and main carers of people with dementia throughout the progression of the condition.	Toynbee 50+, Elder Voice Crossroads care , Dementia Champion, ASC carers Champion	September 2013	In place as part of contract review mechanism

9. Improve end of life care for people with dementia

Outcome: *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

Ref	Action	Lead	Timescale	Update
9.1	Ensure that people with dementia have the same access to palliative care services as others.	CCG	November 2013	
9.2	Adult social care staff to be aware of local end of life care pathways for dementia	Dementia champion and Advisor	December 2013	
9.3	Raise awareness of the Mental Capacity Act amongst health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the Capacity to do so.	ASC, CCG, MHCOP , Primary health leads ,COL commissioned IMCA Service (Voiceability)	November 2013	
9.4	To study the NICE guidance on End of Life care. To provide an integrated service as and when required to compliment and support health colleagues so that people with advanced dementia can die at home if they and their family members so wish.	Dementia Champion, CCG		

10. Ensure that services meet the needs of people from vulnerable groups

Outcome: *People from vulnerable groups will be supported by staff who are aware of their needs and who will be advocating for them so that they are not subjected to safeguarding risks*

Ref	Action	Lead	Timescale	Update
10.1	Work with neighbouring local authorities and health commissioners in primary and secondary care and CCGS to ensure an Equality Impact Assessment is undertaken to gain a better understanding of the needs and current gaps in service provision, and whether current service provision is meeting need.	TBC Portsoken review Tower Hamlets primary care leads COL Public Health officer.	December 2013	
10.2	Ensure that health and social care staff working with younger people at risk of dementia receive training in dementia awareness.	ASC and COL commissioner and providers for ALD	January 2014	
10.3	Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia when required.	ASC, COL Commissioner and Providers. CCG LD Nurse Joint Commissioner LD CCG lead for LD	January 2014	

Ref	Action	Lead	Timescale	Update
10.4	Develop the skills of ASC staff and provider staff to recognise signs of abuse and neglect in a client with Dementia and to be able to manage the risks appropriately whilst safeguarding the interests of the client at all times.	COL/LBH Safeguarding Adults Managers in conjunction with CCG, Dementia Champion, MHCOP	October 2013	