Appendix 1 **Progress against Commissioning Framework for Dementia (2013-14)**

The Red, Amber, Green ratings correspond with progress against expectations set out in the National Commissioning Framework for Dementia and NICE Quality Standards.

Red Falling short of expectations

Amber Partially meeting expectations

Green Meeting expectations

Commissioning Framework Phase	Outcomes/NICE Quality Standard	National Dementia Strategy Objective	What people should expect:
Phase 1 When memory problems have prompted me, and/or my carer/family to approach my GP or other primary care practitioner with concerns.	Outcomes/NICE Quality Standard 1,2,3 • I am confident that my primary health care worker/GP has taken my concerns seriously. S/he understands the nature and cause of memory problems and will refer me quickly for an appropriate assessment if needed. • I can access a range of information and guidance in the community about memory problems, as well as resources to support me and my family. • My GP/primary health care worker work with me to help me to stay well and live well.	Objective 1: Improved public and professional awareness and understanding of dementia	GPs and primary health care teams: 1. Have a comprehensive understanding of memory problems and dementia – and appreciate the value of early diagnosis and are aware of the assessment and treatment options as well as the potential for living well with dementia. 2. Know how to promote living well with dementia 3. Understand and recognise the role and support needs of carers. 4. Ensure that there is prompt referral and easy access to a memory service. 5. Has access to an up-to-date directory of community services and support, which is provided in a range of media. 6. Supports dementia awareness which is actively promoted in the local community.
Achievements (2012-2013):		**RAG Rating**	**Proposed remaining actions for 2013:**
Promoting local information on dementia services, (Key Commitment 5 of the Prime Minister's Challenge on dementia) • Dementia Awareness Week (20th-24th May, 2013). 'Worrying changes nothing, talking changes everything', campaign. • Intergenerational Project (Age UK) delivering education and awareness in schools throughout Telford & Wrekin. This includes development of an age-appropriate leaflet. • Telford Football Club, first dementia-friendly football club in the country, now signed up to the Dementia Action Alliance. 'Fighting Dementia' Campaign. (March, 2013)			Review existing Primary Care Liaison Role (SSSFT) and associated GP Programme of support and education. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, Telford & Wrekin CCG** Review outcomes of the RAID Service, (as part of external evaluation by Staffordshire University). **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, Telford & Wrekin CCG** Review Impact of Dementia Leadership Programme on cultural and organisational change in care settings, in partnership with Staffordshire University.

• In partnership with the Carers' Centre, launched the 'Who I am' Dementia Passport, to support person centred care in care settings. • Publication of the Telford & Wrekin, Dementia Services Directory, (April, 2013) • Development of Information Portal for Dementia, (June 2013). The portal is now live at: http://ourhealth.westmidlands.nhs.uk/dementia-care.html Specific initiatives, commissioned within the Dementia Pathway focus on sustained public and professional education and awareness-raising, these include, but are not limited to: • Expansion of the Admiral Nurse Service (Shropshire Community Health NHS Trust). These two posts have a dual role of providing specialist support to carers of people with dementia and delivering professional education. Strategic planning of professional education and delivery is facilitated through the Admiral Nurse Steering Group. • Development of Rapid Assessment Interface Discharge (RAID) initiative with South Staffordshire and Shropshire NHS Foundation Trust within Shrewsbury & Telford Hospitals NHS Trust to deliver, assessment, professional awareness and education. • In partnership with Shropshire Partners in Care, commissioned Worcester University to deliver a Leadership in Dementia Course across health, social care, independent and voluntary sector to improve professional awareness and drive improvements in quality of care. • Primary Care Pathway for Dementia has been drafted and will be consulted on and approved through the Long Term Conditions Group for Dementia. (July 2013 – July 2014) Other commissioned services will continue to deliver information, advice and professional education to public and professionals. These include; Dementia Advisor, Nurse Advisor Role within the Independent Sector, Primary Care Liaison Nurse, Speech and Language Therapy Service and Age UK Neighbourhood Contact Officer.		**Responsible Officer: Kim Grosvenor, Specialist Commissioner, T&W Council** Embed Primary Care Dementia Pathway and coordinate a programme of Primary Care Education. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children and implemented through the Long Term Conditions Group for Dementia.** Integrate Dementia information into Telford & Wrekin NHS Clinical Commissioning Group Website and Telford & Wrekin Council's MyLife portal. **Responsible Officer: Kim Grosvenor, Specialist Commissioner, T&W Council in partnership with Staffordshire Commissioning Support Unit, (CSU) and MyLife Project Officer.**

Commissioning Framework Phase	Outcomes/NICE Quality Standard	National Dementia Strategy Objective	What people should expect:
Phase 2 Learning that the condition is dementia.	Outcomes/NICE Quality Standard 3,4 • I don't have to wait long for an assessment, and I have the option of having the assessment at home. • I am confident that any tests that I have are necessary. • I have a choice about whether I receive a formal diagnosis. • If I am given a diagnosis, it is delivered with sensitivity. • I am able to discuss the condition (and possible diagnosis) with a health professional; my questions and concerns are addressed; and I receive relevant information at the right time for me and in the right way for me. • As a carer/family member, my contribution and experience inform the assessment, and next steps. My own information and support needs are considered and addressed.	Objective 2: Good quality early diagnosis and intervention for all	1. Prompt access to skilled professionals for people with advanced and/or complex presentations. 2. Assessment where required, in preferred place (including home). 3. Investigations to inform assessment. 4. Timely diagnosis delivered with respect and sensitivity. 5. Information and support to establish what the next steps will be. 6. Signposting to resources. 7. The GP to be informed and involved in continuing and longer-term review and management.
Achievements (2012-13)		**RAG Rating**	**Proposed remaining actions for 2013:**
Increasing diagnosis rates through regular checks for the over-65s (Key commitment 1 of the Prime Minister's Challenge on dementia) • Telford & Wrekin Clinical Commissioning Group is showing one of the best accelerated rates of improvement for increasing diagnosis rates in the country with a 3.7% increase in diagnosis rates for 2010-11 *(Improvement ranking of 29 (1=most improved, 163= least improved, Alzheimer's Society, PCT dementia prevalence and diagnosis rates).*			Increasing diagnosis rates will require a revised approach to early identification and assessment and a rapid review of demand and capacity, as well as alternative service models, which will be considered as part of the Long Term Conditions Group for Dementia. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children in partnership with Public Health colleagues and delivered through the Long Term Conditions Group for Dementia.** Embed the Primary Care Pathway for Dementia supported by a comprehensive programme of education for Primary Care staff. Maximise opportunities for screening risk factors such as coronary heart disease, stroke and diabetes, during a patients' annual review. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for**

			Mental Health & Children in partnership with Public Health colleagues and delivered through the Long Term Conditions Group for Dementia. Consider a model of service delivery which maximises use of available resources, including Public Health Screening and IAPT service provision, (Evidence-based) in the identification and management of Mild Cognitive Impairment. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children in partnership with Public Health colleagues and delivered through the Long Term Conditions Group for Dementia.**
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 3 Learning more about the disease, options for treatment and care, self-management and support for me and my carer/family.	Outcomes/Nice Quality Standard 4,5,6 • My personal circumstances, and my needs, preferences, strengths and assets are acknowledged and understood. • My carer's/family's needs and concerns are considered and advice, support and help are available to them. • I am helped to understand what I need to know and want to know about the disease, treatment options, and support available to me and my carer/family. • I know who to contact for more information, guidance and support as my needs change. • I feel confident that effective help and support is available to me now and as my condition develops, to help me live life as fully as possible. • I know what the next steps are; and I have a care plan that reflects my strengths, wishes, preferences and lifestyle, as well as my needs. • I understand the range of issues I need to think about and plan for and what to do to ensure that my wishes for future care options are respected. • My GP is informed about my condition, s/he	Objective 3: Good quality information for those diagnosed with dementia and their carers Objective 4: easy access to care, support and advice following diagnosis facilitated by a dementia advisor	1. A knowledgeable, skilled practitioner will assess people's needs, strengths and aspirations. 2. A care plan based on this assessment will be developed collaboratively with the knowledgeable practitioner, the person with dementia and the family, and the care plan will be shared with the GP. 3. GPs and primary health care teams: a. are aware of and involved in the assessment and treatment plans and in longer-term review and management; they know how to promote living well with dementia b. understand and recognise the role and support needs of carers. 4. Carers' needs will be assessed, including the need to stay in employment and the time, availability and other constraints that employment might involve. 5. There is a single point of access to specialist help and advice when needed, with clear contact details using a variety of methods (email, internet, phone etc) and help is available 24/7. 6. Access to up-to-date information about community services and support, provided in a range of media. 7. Dementia awareness is actively promoted in the local community. 8. Signposting to resources and community activities/groups. 9. Carers have access to education and support.

	contributes to my care plan, and we review my needs regularly to help me to stay well and live well.		
Achievements (2012-13)		**RAG Rating**	**Proposed remaining actions for 2013:**
• In partnership with the Alzheimer's Society, the Dementia Advisor Service has been re-designed, to provide information and support at an earlier stage of memory problems in the dementia pathway, including pre-diagnosis. • Specific initiatives, commissioned within the Dementia Pathway focus on a continued programme of professional education and awareness raising, these include, but are not limited to; the Primary Care Liaison Nurse, (SSSFT), Admiral Nurse Service (Shropshire Community Health NHS Trust), Care Home Liaison, (SSSFT), Speech and Language Therapy Service, (Shrewsbury and Telford Hospitals Trust), and the RAID (SSSFT) initiative within Shrewsbury & Telford Hospitals NHS Trust. • Education and training for carers and people with dementia, tailored to particular groups is commissioned through the Alzheimer's Society, Age UK, Carers' Centre and Admiral Nurse Service. • In partnership with the Carers' Centre, launched the 'Who I am' Dementia Passport, to support person centred care in care settings. • Publication of the Telford & Wrekin, Dementia Services Directory, (April, 2013) • Development of Information Portal for Dementia, (June 2013). The portal is now live at: http://ourhealth.westmidlands.nhs.uk/dementia-care.html			Review Information provision within the Transformation Work-Stream (T&W Council). **Responsible Officer: Christine Harrison, Service Delivery Manager, T&W Council** Information Portal of information for people with Dementia to be developed and accessed via Clinical Commissioning Group website and Telford & Wrekin Council's website. **Responsible Office: Kim Grosvenor, Specialist Commissioner, T&W Council** Post-diagnosis information, care and support to be externally re-evaluated as part of evaluation of Memory Services, (Royal College of Psychiatrists). **Responsible Officer: Gill Foster, Operational Manager, South Staffordshire and Shropshire NHS Foundation Trust**
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 4 Getting the right help at the right time to live well with dementia,	Outcomes/NICE Quality Standard 1,6,7,8,10 • I can access a range of services to enable me to remain at home as long as possible. • People who support me at home	Objective 5: Structured peer support and learning networks	1. GPs, primary care teams and social care services: a. have a comprehensive understanding about memory problems and dementia b. are aware of the assessment and treatment options and of the potential for living well with dementia

prevent crises and manage together.	understand my condition and know how to help prevent, modify or make adjustments to manage any behaviours that challenge. • People who support me help me to live as independently and actively as possible. • I can remain involved with my friends and my community. I enjoy life. • My choices and preferences for living my life are respected and I am involved in decisions about my life. • I can access a range of information and guidance in the community about memory problems and resources to support me and my family. • My GP/primary health care worker will work with me to help me to stay well and live well. • As a carer, I can access support, including training, to help cope with the ongoing role of caring for a person with dementia. • As a carer, I have early and flexible access to different types of respite. The respite options suit me and the person I am caring for. • They enable me to live well, to continue to provide care and for the person I care for to continue to live at home. • As a carer, I know who to contact in an emergency.	Objective 6: Community personal support services Objective 7: Services within the Carers' Strategy Objective 13: an informed and effective workforce across all services	c. know how to promote living well with dementia d. recognise the changing needs of people with dementia as the condition progresses and know how to access specialist dementia help, when required, to manage those needs effectively e. understand and recognise the role and support needs of carers as dementia progresses and can respond effectively. 2. Specialist dementia therapies and treatment options are available and accessible. 3. There is a range of practical support including respite, social care and assistive technology for people with dementia and carers. 4. There is access to an up-to-date directory of community services and support which is provided in a range of media. 5. Dementia awareness is actively promoted in the local community.
Achievements: (2012-13)		**RAG Rating**	**Proposed remaining actions for 2013:**
Dementia-friendly communities across the country (Key commitment 6 of the Prime Minister's Challenge on dementia) • Up-dated the Telford & Wrekin Carers' Strategy, which was widely consulted on and has been approved by both T&W Council & T&W NHS Clinical Commissioning Group, (June 2013). • Commissioned a validated well-being tool to capture a robust evidence-base for the benefit of creativity contributing to wellbeing for people with dementia and their family carers. This will now be used to evidence improved outcomes in the 'Art on Prescription' Project.			Telford & Wrekin Council and NHS Clinical Commissioning Group to sign-up to the Dementia Action Alliance and submit an action plan in support of registration. **Responsible Officer: Kim Grosvenor, Specialist Commissioner, T&W Council** To integrate the dementia-friendly communities model, (Piloted at The Place, Oakengates) within the wider community and to develop the 'creative-space' concept for carers and people with dementia, at the Theatre. **Responsible Officer: Kim Grosvenor, Specialist Commissioner, T&W Council in Partnership with the Commissioning Officer for Carers**

• Telford & Wrekin Council has been commissioned to deliver a 'creativity in dementia' programme and to lead on the development of a model for 'Dementia-Friendly' Communities. A full evaluation of the work, which was externally validated can be found at:http://www.westmidlandsartshealthandwellbeing.org.uk/projects/dementia-care.html • New and better housing options are being developed in Telford & Wrekin, e.g. Extra Care Support which focus on inherent aspects of living well with dementia including, minimum transfers, avoidable hospital admissions and wrap-around care and support. This includes support from Community Nursing, Nurse Advisor post, Psychiatry-led 'Clinics' and the Care Home Liaison Service for example. • Assistive Technology has been main-streamed in Telford & Wrekin Council, building on the previous pilot projects undertaken to support people with dementia, living in their own home. An initial range of equipment has been identified. Work is ongoing with teams to develop and embed provision as a mainstream service. Key strands are operational procedures, workforce development, public information and performance monitoring. • NHS Telford & Wrekin undertook an audit of anti-psychotic prescribing in 2010 and subsequently, Medicine's Management, developed shared-care prescribing protocols. In 2012, the audit of anti-psychotic prescribing was undertaken again and some improvements have been made. A full action plan for the reduction of anti-psychotics features as part of the Health Economy Action Plan for accelerated improvement. • The Alzheimer's Society has been commissioned to deliver 'Singing for the Brain' sessions, as an evidence-based approach to supporting wellbeing in people with dementia. The Society is also currently undertaking a pilot in Cognitive Stimulation Therapy, (as per NICE guidance) and the evaluation will be considered as part of the prioritisation of future funding. The SSSFT also provides a variety of psychological therapies to support people with dementia, as part of their contractual obligations. • Wellington Road, Newport GP Practice is currently leading on a risk-stratification project, in partnership with the T&W NHS Clinical Commissioning Group and the West Midland's Public Health Observatory to identify people with dementia and their family carers at risk of deterioration in the community and to intervene with a 'Virtual		To develop a 24/7 Crisis Resolution and Home Treatment Team. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** Continue to support therapeutic interventions, which may support the reduction of anti-psychotic medication. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** Review and up-date the Health Economy Action Plan for Dementia and contribute to the Group's Annual Report, evidencing improvements in local services and quality of care. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** **and Kim Grosvenor, Specialist Commissioner, T&W Council** The training pathway for dementia needs to be reviewed, up-dated and publicised across the health, social care and independent sector. **Responsible Officer: Kim Grosvenor, Specialist Commissioner, T&W Council in partnership with Shropshire Partners in Care** Evaluation of the Cognitive Stimulation Pilot, (Alzheimer's Society) to be considered as part of prioritisation of funding for the future. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** Primary Care Management of people with Dementia living in the community, (including residential and nursing homes) and Evaluation of the risk-stratification pilot to be presented to the CCG for consideration of future funding and wider implementation. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG**

Model' of wrap-around support services.			
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 5 Getting help if it is not possible to stay at home, or if hospital care is needed.	Outcomes/NICE Quality Standard 1,7,8 • I know what my options are, and I have had an opportunity to discuss this with someone who can advise me. • I know that I will be respected as a person, and that I will receive good quality care. • My rights, preferences, interests and culture will be respected. • People supporting me will understand my condition and care for me with compassion. I feel safe. • I feel understood by the people who are looking after me. • My physical and mental health needs are met; I am not taking any unnecessary medication. • I am able to return home when possible, as soon as it is possible. • Staff have the knowledge, skills and values to work with people with dementia. They understand dementia; what can help alleviate distress; how to manage different behaviours and prevent crisis. They are supported to work in this way. • Staff know how to get expert advice, and are able to access help and advice when they need it.	Objective 8: Good quality care within general hospitals	1. Hospital care, including inpatient psychiatric care, has a clear purpose for each person with dementia admitted and is time-limited. 2. Care options are safe and high quality.
Achievements (2012-13)		**RAG Rating**	**Proposed remaining actions 2013:**
Improving care in hospital (Key commitment 2, Prime Minister's Challenge on Dementia)			Embed Dementia Pathway and Composite Model of Care as part of contractual commitments with SaTH.

• A multi-agency Steering Group, (Pan Shropshire, Telford & Wrekin) has been set-up to drive forward an accelerated programme of improvement in dementia, including quality of care in the general hospital. Performance and accountability is to the Telford & Shropshire, Health and Wellbeing Boards respectively. • A Clinical Lead, Nurse Lead and Dementia Lead have been identified in SaTH to drive service improvement in the general hospital, while the Professor of Dignity at Staffordshire University has responsibility for leading the change agenda. • A dementia screening tool has been developed for clinicians in SaTH, as part of the CQUIN for improving quality of care in general hospital. • A dementia pathway has been developed and a 'dementia bundle of care' implemented, as part of the hourly comfort-rounds within SaTH. Further works needs to be undertaken on elements of the West Midlands 'composite model' such as the Dementia-Friendly Environment. • An information leaflet has been produced and education and training rolled-out. • The RAID initiative has been implemented and will be externally evaluated.			**Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** Review RAID and evaluate as part of evidence-base for prioritisation of future funding. **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG** Highlight the impact of unsuitable care environments for people with dementia and work with provider organisations to implement improvements using best practice evidence **Responsible Officer: Helen Swindlehurst, Lead Commissioner for Mental Health & Children, CCG**
Commissioning Framework Phase	**Outcomes/NICE Quality Standard**	**National Dementia Strategy Objective**	**What people should expect:**
Phase 6 Receiving care, compassion and support at the end of life.	Outcomes/NICE Quality Standard 1,6,9,10 • I am confident that everything will be done to ensure that I die where I want to, that I am well supported, and that my cultural needs and expectations will be respected. • My carer's/family's needs are respected and supported.	Objective 12: end of life care for people with dementia	• People with dementia have the opportunity to die with dignity at home or where they are living, if they so choose. • People with dementia and their carers/families receive support to achieve this, using advance planning where possible and appropriate. • Carers/families are involved and supported in the end of life care of the person with dementia to the extent that they chose to be. • People with dementia are kept as comfortable as possible, taking into account how discomfort and pain might be communicated and responding appropriately with treatment and care. • The cultural values and preferences of the person with dementia, and those of carers/families are taken into account, and reflected in after death care.

			• After-death care is in line with national guidance.
Achievements (2012-13)		**RAG Rating**	**Proposed remaining actions 2013:**
• A Preferred Priorities of Care initiative has been Piloted across the County and further work continues in rolling out the Programme. This has included working with Memory Services and supporting people with their long term choices, post-diagnosis. • Initial work is taking place to address End of Life care for the population of Telford & Wrekin.			Palliative Care Steering Group to Review End of Life Care in Telford & Wrekin and up-date Strategy and Action Plan to drive service improvement. **Responsible Officer: Michael Bennett, Head of Integrated Care, CCG** Review End of Life Care Pathway in General Hospitals. **Responsible Officer: Michael Bennett, Head of Integrated Care, CCG** Further investment to be sought through the prioritisation of funding process of the CCG, to embed initiatives which support advance care planning. **Responsible Officer: Michael Bennett, Head of Integrated Care, CCG**