Staffordshire County Council

NHS
Cannock Chase
Clinical Commissioning Group

Living Well With Dementia: A Strategy for Southern Staffordshire

2013-16

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Date Authorised	
Version Control	1
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Dementia carer group foreword

We represent those suffering Dementia and those who care.

We were privileged to be able to attend a workshop, or be kept informed, on the strategy to update Dementia Services in South Staffordshire. The privilege was the platform that allowed us to express the impact on our lives of the implementation of the national dementia strategy 2010.We were being listened to.

We continue to feel honoured and usefully representing all sufferers and carers with our input to the commissioning group

The effect of the changes 2010/2011 was the success of the raising of awareness of Dementia and the need for early diagnosis but the consequences were a weak system providing negligible support and consequently it was not possible to live well with Dementia.

Strong supportive friendships have evolved amongst us with a determination to contribute in a positive way to difficult decisions about where to allocate precious diminishing funds.

A comfortable way has been facilitated for us to express our concerns distress and fears for the future and allowed us to contribute and feel worthy.

Good luck to those tasked with implementing future happenings and Thank you.

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Living Well with Dementia, Southern Staffordshire - Executive Summary

This refreshed strategy document has been written with people in mind, the people living with Dementia living in Southern Staffordshire, and when we say 'southern Staffordshire' we are referring to all districts within the region; Stafford & Surrounds, Cannock, Lichfield, Tamworth, East Staffs and the Seisdon Peninsula.

In order to achieve the aims of the national dementia strategy (2009) and to meet the needs of local demographic challenges facing the country, this refreshed strategy document has been developed in partnership, involving various stakeholders.

Within Southern Staffordshire, we have a pathway for people who either suspect a cognitive impairment or have a confirmed diagnosis of Dementia, however that pathway requires improvement. On 13th September 2012, a stakeholder workshop took place which involved all those who are part of the Dementia Pathway in order to understand and agree future investment and development of services. A gap analysis for Southern Staffordshire had already been undertaken and so the purpose of the event was to examine those gaps, prioritise them and develop initial action plans. The outcomes from this workshop have now been used to draft this document for Southern Staffordshire health economy.

Following the stakeholder event, a group was established in order to reflect on the outcomes of the recent event and help produce this refreshed dementia strategy. The group includes carers and people with dementia who were involved in the stakeholder event and expressed an interest in supporting commissioners to develop current and future plans for services for people with Dementia.

The ethos supporting the development and implementation of this refreshed strategy rests on delivering positive personable outcomes for people living with Dementia, and their carers/families. There is a need, when commissioning services, to focus on delivery of person centred outcomes rather than outputs, allowing service providers to work together in order to ensure that those outcomes are achieved.

We also feel that the successful development of services which support people to live well with dementia following early diagnosis along with good information and support which is consistent and responsive, is the basis of this documents and organisations need to work together in order to see this happen.

The principles that underpin this strategy are integrated working, shared decision making, and involvement from people living with dementia, so that we can ensure personalised care and quality of life.

This document has been written to support and refresh the Dementia Strategy produced in 2008. It does not rewrite the original strategy but adds to it based on the changing context, knowledge about what works and the significant need to increase investment in an area of service which until recently had been given a limited profile.

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1.0 Introduction

Like most of the country, Southern Staffordshire is experiencing a continuing rapid increase in the proportion of older people in the population. Most older people enjoy good health, including mental health, and older people are a great asset to their communities through their many contributions to local organisations, neighbourhoods and their own families. Nevertheless, this increasing proportion of older people in the population will make increasing demands on health and social care services. Positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home as long as possible and that crises and unnecessary use of intensive services are minimised.

2.0 What is dementia?

The term 'dementia' describes a set of symptoms, which include loss of memory, mood changes, and problems with communication and reasoning. The majority of people who are diagnosed with dementia have either Alzheimer's disease or vascular dementia. There is no cure currently and it is defined as a long-term condition, characterised by some fluctuations but steady decline, which needs ongoing support and management.

Dementia presents a huge challenge to society, both now and increasingly in the future[1]. It is a common condition, which has a large impact on carers and society with an increasing cost attached to caring for people within the community. Dementia currently costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year[2].

The majority (two thirds) of people with dementia live in the community, and the remainder live in care homes. Risk factors for dementia include vascular problems (particularly hypertension), diabetes, smoking, poor diet, excessive alcohol intake and family history *(2009, National Dementia Strategy)*

Although dementia can occur at any age it is rare below the age of 60. It is estimated that after the age of 60 the prevalence of dementia doubles for every five years so that about 1 in 20 aged 65 has some form of dementia, rising to 1 in 4 at aged 85. With increasing numbers of people living longer lives, so the proportions in the population increase. *(2009, National Dementia Strategy)*

3.0 Context

'Living Well with Dementia: a National Dementia Strategy' was published by the Department of Health on 3rd February 2009. It had been under development since

[1] National Dementia Strategy, 2009
[2] National Dementia Strategy, 2009

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August 2007. The Department of Health published a consultation draft in June 2008 and undertook widespread consultation before and after that. The work on the strategy was informed by External Reference Groups, reflecting a very wide range of 'stakeholders', including statutory and voluntary and community organisations, people with dementia and carers. Implementation locally will also need to reflect that partnership approach.

The Strategy is outcome focused and these outcomes are divided in to three broad themes:

- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

Since the publication of the national dementia strategy, a further document was, released entitled the 'Prime Ministers Dementia Challenge'. In March 2012 the Prime Minister launched this programme of work which aimed to deliver major improvements in dementia care and research by 2015. The publication also set out the government's commitment to continue with the aims and objectives set out in the strategy, and help to develop new innovative initiatives in order to support both health and social care services to deliver improvements in dementia care.

NICE/SCIE Guidance 42 2006 - Supporting People with dementia and their carers

This guidance was reflected in the recommendations of the above strategies. It stated several imperatives in its recommendations, with considerable specificity:

- 'Memory assessment services should be the single point of reference for all people with a possible diagnosis of dementia'....
- ' Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities.'....
- 'Acute and general hospital trusts should plan and provide services that address the specific personal and social care needs and the mental and physical health of people with dementia who use acute hospital facilities for any reason.' ....
- 'Carers of people with dementia who experience psychological distress and negative psychological impact should be offered psychological therapy'....
- 'Care managers and care co-ordinators should ensure the co-ordinated delivery of health and social care services for people with dementia.'....

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- 'People with mild to moderate dementia of all types should be given the opportunity to participate in a structured group cognitive stimulation programme'

- Older people may often suffer from physical conditions and increasing frailty as well as mental ill health. Older people with supportive and extensive social networks tend to be less likely to suffer from mental disorders.

NHS Outcomes Framework 2013/14

Domain 2: Enhancing quality of life for people with long-term conditions

- The placeholder indicator **2.6 'Enhancing the quality of life for people with dementia'** has been updated and extended. As set out in the mandate, the Government's goal is to be among the best in Europe in ensuring people with dementia receive a timely diagnosis and that they receive the best available treatment and care, including support for carers.

- Since the publication of last year's framework, the Prime Minister announced a 'dementia challenge' focused on boosting diagnosis rates, improving research and creating dementia friendly communities.

- In support of the PM Challenge on Dementia[10], for 2013/14, the framework includes the two-part indicator, which measures diagnosis rate for people with dementia, there being evidence that receiving early diagnosis is an important outcome for people living with dementia, enabling them to better cope with their condition.

- As diagnosis rate is not a direct measure of the outcome sought, a second complementary measure is being developed which will measure the effectiveness post-diagnosis care in sustaining independence and improving quality of life. This indicator will be shared with the Adult Social Care Outcomes Framework.

This new framework seeks to achieve continuous improvement by supporting clinical commissioning groups (CCGs) to achieve these outcomes whilst maintaining levels of quality, and working to eliminate health inequalities. The introduction of the new NHS Operating Framework 'Everybody Counts: Planning for Patients 2013/14' also states that CCGs will be expected to increase the rate of dementia diagnosis as part of their assessment by their NHS Commissioning Board.

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4.0 Prevalence

Nationally

- There are currently 800,000 people with dementia in the UK.
- There are 670,000 carers of people with dementia in the UK
- The proportion of people with dementia doubles for every 5 year age group
- One third of people over 95 have dementia.
- 64% of people living in care homes have some form of dementia

Southern Staffordshire

- Number of people (all age) predicted to be living with Dementia in Southern Staffordshire currently (2012) is 7,673
- That figure for 2012, is due to increase to 11,335 by 2021
- Number of people that have received a diagnosis of Dementia within Southern Staffordshire is 3,131 which is approximately 38% percent of people who are living with dementia – leaving up to 5,012 people without a diagnosis

Table 1: Summary of current, expected and projected prevalence for dementia

	Recorded prevalence (QOF 2011/12)	**Expected prevalence (2011/12)**	**Estimated under recording (percentage)**	**Projected prevalence based on expected prevalence**			
				2014	**2015**	**2016**	**2021**
Cannock Chase	675 (0.5%)	1,510 (1.1%)	55%	1,646 (1.2%)	1,699 (1.3%)	1,743 (1.3%)	2,055 (1.5%)
East Staffordshire	709 (0.5%)	1,608 (1.2%)	56%	1,768 (1.3%)	1,826 (1.3%)	1,885 (1.3%)	2,236 (1.5%)
Seisdon Peninsula	307 (0.6%)	778 (1.5%)	61%	854 (1.6%)	892 (1.7%)	927 (1.8%)	1,130 (2.1%)
South East Staffordshire	717 (0.5%)	1,789 (1.1%)	60%	1,983 (1.2%)	2,064 (1.3%)	2,144 (1.3%)	2,643 (1.5%)
Stafford and Surrounds	723 (0.5%)	1,988 (1.4%)	64%	2,157 (1.5%)	2,219 (1.5%)	2,282 (1.5%)	2,705 (1.8%)
Staffordshire CCGs	**3,131 (0.5%)**	**7,673 (1.3%)**	**59%**	**8,407 (1.4%)**	**8,700 (1.4%)**	**8,981 (1.4%)**	**10,769 (1.7%)**

Source: NHS Doncaster QOF Benchmarking Tool, Quality and Outcomes Framework (QOF) for April 2011 to March 2012, Quality Management and Analysis System (QMAS) database – 2011/12 data as at end of July 2012, Copyright 2012, The Health and Social Care Information Centre, Prescribing and Primary Care Services. All rights reserved, GP registered populations and 2011-based interim population projections, Office for National Statistics, Crown copyright

* figures above to be update in line with national predictions

This information show that there is a big difference between the number of people that are being identified as living withy dementia i.e. receiving a formal diagnosis, and those that have not (based on prevalence figures).

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5.0 Aims of this Refreshed Strategy Document

The aim of this refreshed strategy document is to enhance the strategy and the work undertaken and set out a vision for the next three years which is:

Our Vision…..

"Over the next 3 years, we aim to ensure that all people with a suspected or confirmed diagnosis of dementia will have access to a responsive, community based and integrated services. We want to work towards delivery of a person centred and high quality service which is considerate of people's needs and supports carers of people with dementia."

This is reinforced by the appointment of Alistair Burns, the National Clinical Director for Dementia. He is leading this agenda due to the significant and urgent challenge that Dementia presents to health and social care both in terms of the number of people affected and the cost of care.

A response to this challenge is set out in the National Dementia Strategy and the associated outcomes focused implementation plan. The plan and the strategy combined, highlight four main areas for immediate action which we in Staffordshire will aim to address:

1. Early diagnosis and interventions:
2. Better care at home or care home;
3. Better care in hospital;
4. Appropriate use of antipsychotic medication

Appendix 3, which sets out our vision and strategy on a page and how we intend to work together in order to keep people living at home (should they wish to), within the community for longer and avoid a number of unplanned interventions.

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6.0 Refreshed Strategy Development

In order to further develop the current dementia pathway in Southern Staffordshire, local services have been reviewed and a mapping exercise has been carried out.

MARCH 2012 - Early in 2012 commissioners discovered that there were significant capacity issues within the current dementia pathway, which needed to be tackled imminently.

APRIL 2012 - Soon after, a multi-agency task and finish group was established in order to identify the key issues and come up with a series of solutions

JUNE 2012 – After a great deal of integrated working between health and social care commissioners, mental health provider organisation, 3rd sector organisations and carer representation, these solutions were enacted which brought stability to the pathway.

SEPTEMBER 2012 – By early autumn, the immediate issues had been resolved and commissioners were confident that patients were being safely supported.

At the same time, we knew that more work needed to be done in order to design a care pathway which was able to respond to the current and growing demand for dementia health and social care services. Plans were then made for a stakeholder engagement workshop to take place, in order to develop a future commissioning strategy with real commissioning intentions that set out our commitments to the people of South Staffordshire.

Stakeholder Workshop – 13th September 2012
Approximately 78 people attended the workshop, which included various tasks that were given to each table in order to try and gain a common understand of the current pathway, the current issues and what can be done in the future to resolve them. The gaps (8) within the pathway had already been identified by commissioners, and the delegates where then asked to undergo a voting exercise (using poker chips) in order to prioritise those gaps and help the group to see which 5 were seen as most important.

A long list of gaps were identified within the pathway, however in order to ensure some realistic changes we felt that a prioritisation process had to be done in order to identify the top 5 areas for development and change. Those 5 priority areas are as follows:

Post diagnostic support	Staff Training	Community Mental Health Teams	Creating dementia friendly communities	Developing a suitable crisis service
83 votes	65 votes	45 votes	41 votes	39 votes

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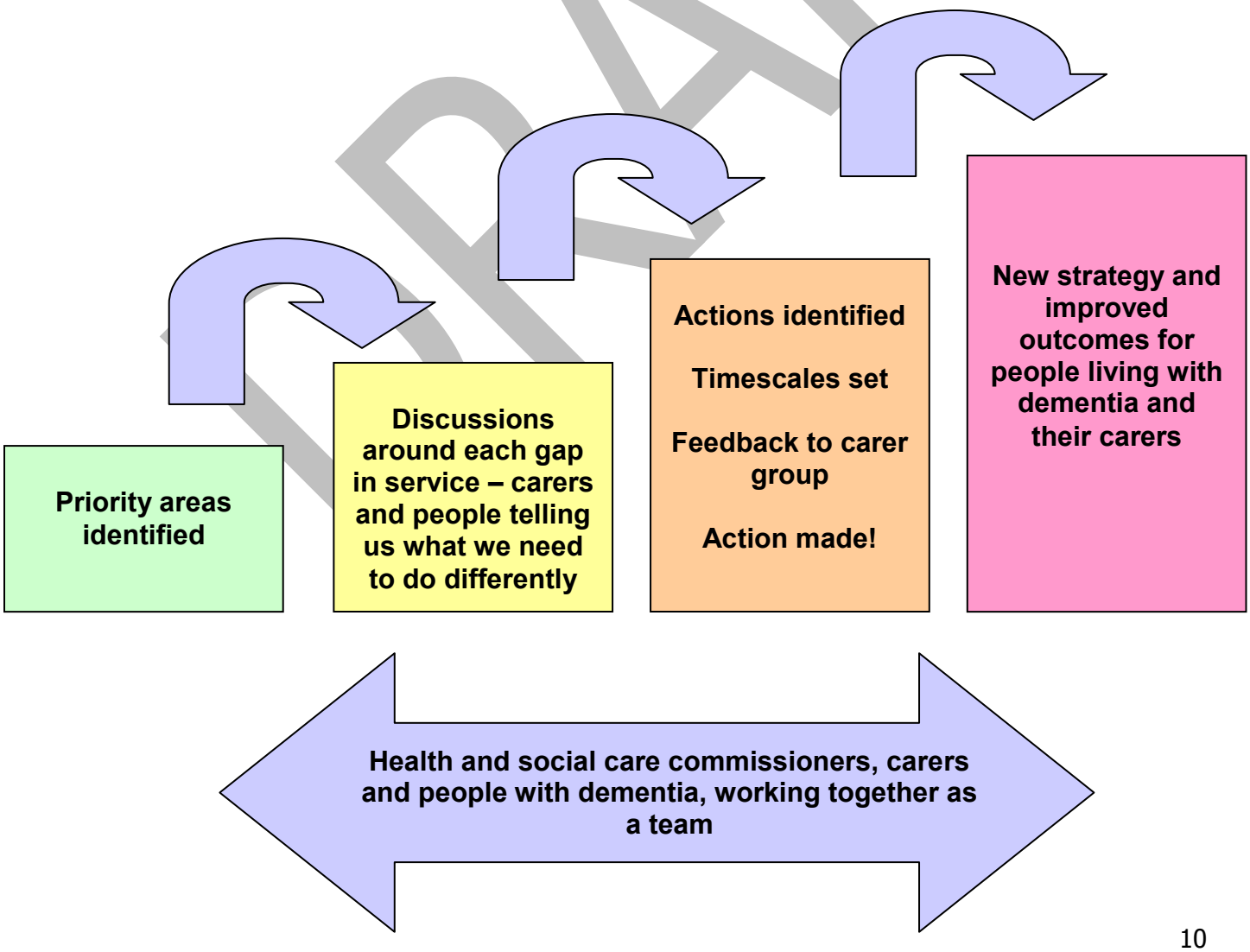
Key Messages from the event were…..

- Need for more resources
- Need for services to be community based
- Need for more carers support
- Need for better staff training and for staff to be made more aware of Dementia and the impact it has
- Need to plan for the future and growing demand
- Need for services to be more flexible and person centred
- Need joined up thinking and strong communication between organisations

Dementia Strategy Carer Group
Following the work to define the key issues as defined by Stakeholders a group comprising of users, carers and commissioners was convened to develop a refreshed strategy and implementation plan. This process has followed a number of stages, and will continue as a way of ensuring outcome focused commissioning, based on what people need and value from a service.



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Regular meetings have taken place, ensuring that carers and people with dementia are involved in the commissioning and service design process. This group will also act as a way of holding commissioners to account for their actions, and allowing for open communication when things need to be changed or improved testing the strategy with a wider group.

7.0 Priority Areas for commissioning

1. **Care Co-ordination**
   A patient centred service which provides mutil-disciplinary teams and consistency of staff

Therefore we will:

- Work together to ensure truly integrated commissioning of person centred dementia care services, across health and social care
- Work together to develop a model of care which puts the patient and the carer/family at the centre of the process
- Work together to explore the potential of a 'prime provider' model which is able to deliver a responsive and high quality service.

2. **Post Diagnostic Support**

Counselling services and Cognitive Behavioural Stimulation Therapy

Therefore we will:

- Review the services which are currently available, including the dementia café service, dementia advisory service and other support services available. Commissioners will then investigate future development of those services.
- Understand which services would be most appropriate in order to support a person after diagnosis, and their carer(s)/family
- Support the development of a holistic and responsive set of services which are made available post diagnosis
- Provide people living with dementia or carers or members of the public, with a way of submitting ideas on service delivery improvements, to a central hub which will be responded to by the most appropriate person.

3. **Staff Training**

GP education/training and Life story work/support planning

Therefore we will:

- Identify a GP or group of GPs who have a special interest in dementia
- Review current Dementia training which is available to both health and social care staff
- Develop and deliver a training programme during 2013-16 for GPs, and all key health and social care professionals (including private and secondary care partners) which equips them with the skills and knowledge needed in order to support people with dementia, within various environments.

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4. **Community Mental Health Teams**

A Mutil-disciplinary service which provides support in the community for people with low-moderate needs

Therefore we will:

- Research good practice examples elsewhere in the country
- Develop a service specification which is outcomes led and responsive
- Link in with colleagues currently providing a community mental health service for those with complex and challenging needs – in order to ensure a joined up service.

5. **Creating dementia friendly communities**

Raising public awareness and involving local businesses

Therefore we will:

- Engage with private sector organisations and neighbouring public sector services i.e. Police and Fire, in order to develop a local dementia friendly communities campaign.
- Include hospitals (acute and community) as part of the campaign
- Use of existing communications and public relations resources in order to develop various information channels for both staffs and members of the public.
- Support the development of Dementia Centres of excellence and development of additional specialist dementia residential care
- Ensure that links are made with other areas of service development including day centres for dementia and other day opportunities
- Become part of the National Dementia Action Alliance in order to develop best practice standards within our communities and amongst service providers.

6. **Developing a suitable crisis service**

Accessible support (via telephone) which is available from 8am to 8pm and during the weekends.

Therefore we will:

- Work to understand the level of demand for this service
- Identify a dedicated single point of contact and communicate this appropriately
- Ensure that all partner organisations are involved in it's development and is aware of the services available

Four other pathway gaps were included in this exercise, and they will be addressed as part of the delivery of the strategy, details of which are included within the attached action plan (see appendix 1) those items which weren't identified as priorities were

- Holistic Diagnosis process
- Specialist end of life/palliative care
- Care home liaison team (low to moderate needs)
- Dementia centres of exellence

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8.0 Investment Plan

In order to realise the visions set out within this strategy, existing and future investment will need to be considered and agreed in order to achieve our own strategic aims and objectives for patients and carers. We also recognise that this strategy is being developed at a time of real financial pressures. In health and in social care, the scope for new investment is at best very limited and is generally dependent on savings being made in other areas.

The difficulty this context creates is that the National Dementia Strategy really requires 'invest to save' activity against the increasing and ultimately overwhelming demands which dementia will make on services, but there is currently precious little available funding to invest. Therefore implementation of change will have to be stepped, with the benefit of additional funding wherever possible through the reshaping of services and developing a care pathway which aims to avoid the need for secondary care services, or residential care for as long as possible. This will mean working together to provide those forms of support which are most effective for patients and carers, thereby reducing the need for high cost interventions.

Strategy Funding

Various elements of the strategy and implementation plan will require both 'one off' amounts of funding and recurring funding from the Clinical Commissioning Groups (CCG) and Staffordshire County Council, in order to encourage change and implement new systems. Therefore, to successfully support the delivery of the strategy, funding has been identified and ring fenced both with the County Council and the CCGs.

Across all CCGs, specific projects have been identified as a priority that would benefit from 'pump priming' in order to provide proof of concept for future funding commitment and a way of investing now to save for the future. Those projects include:

- Public and Professional Awareness (i.e. campaigning, working with community and voluntary organisations, as well as hosting GP education events)
- Reduction of the use of Anti-psychotic medication (i.e. hiring a temporary member of staff to undergo reviews and carry out dementia training in care homes)
- Support in the community (i.e. exploring the potential expansion of services in South Staffordshire)
- Good quality information for those diagnosed, and sign posting (i.e. Investment in the current dementia advisory service and training of health and social care staff)
- Identify opportunities for co-location of health and social care staff based within memory clinics
- Encourage the development of more community services as an alternative to traditional day centres and secondary care services

Over the life of the strategy, other parts of the implementation plan will be reviewed and future funding assigned in order to provide the best level of service and prepare the

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health and social care landscape for the ever increasing demand for dementia care within our society.

9.0 Developing Outcomes

This is a new outcomes-focused approach, and it is a key element to ensuring greater transparency and provision of information to individuals. This enables people to have a good understanding of their local services, how these compare to other services, and the level of quality that they can expect.

This strategy supports the idea of basing performance on outcomes, and there are a number of ways of doing that. One in particular is called the OSCAR Framework, which focuses on the following areas:

- **O**rganisation
- Patient **S**atisfaction
- **C**linical
- **A**ctivities
- **R**esource utilisation

This approach enables commissioners to understand all elements of the service, as well as elements of service delivery which may not have been intended or un-intended consequences in terms of patient outcomes, cost savings or health inequalities.

The Department of Health's revised, outcomes focused implementation plan 2010/11 for 'Living Well with Dementia" highlights 10 quality outcome statements for people with Dementia. It is therefore our aim to embed these outcomes across all commissioned services and work with providers to help measure and capture them, using the OSCAR framework approach. This therefore promotes more outcomes based commissioning, rather than just focusing on clinical activity.

These are:

1. I was diagnosed early
2. I understand, so I make good decisions and provide for future decision making
3. I get the treatment and support which are best for my dementia, and my life
4. Those around me and looking after me are well supported
5. I am treated with dignity and respect
6. I know what I can do to help myself and who else can help me
7. I can enjoy life
8. I feel part of a community and I'm inspired to give something back
9. I am confident my end of life wishes will be respected
10. I can expect a good death

Acknowledgments

- Carer group attendees (Michael Creek, Rosemary and Les Whittaker, Pat Walker, Alison and Egon Hansen and Dave and Margaret Sheldon)
- All those who took part in the Strategy stakeholder event (13th September 2012)
- Staffordshire LINk

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Appendix 1 – Plan on a Page

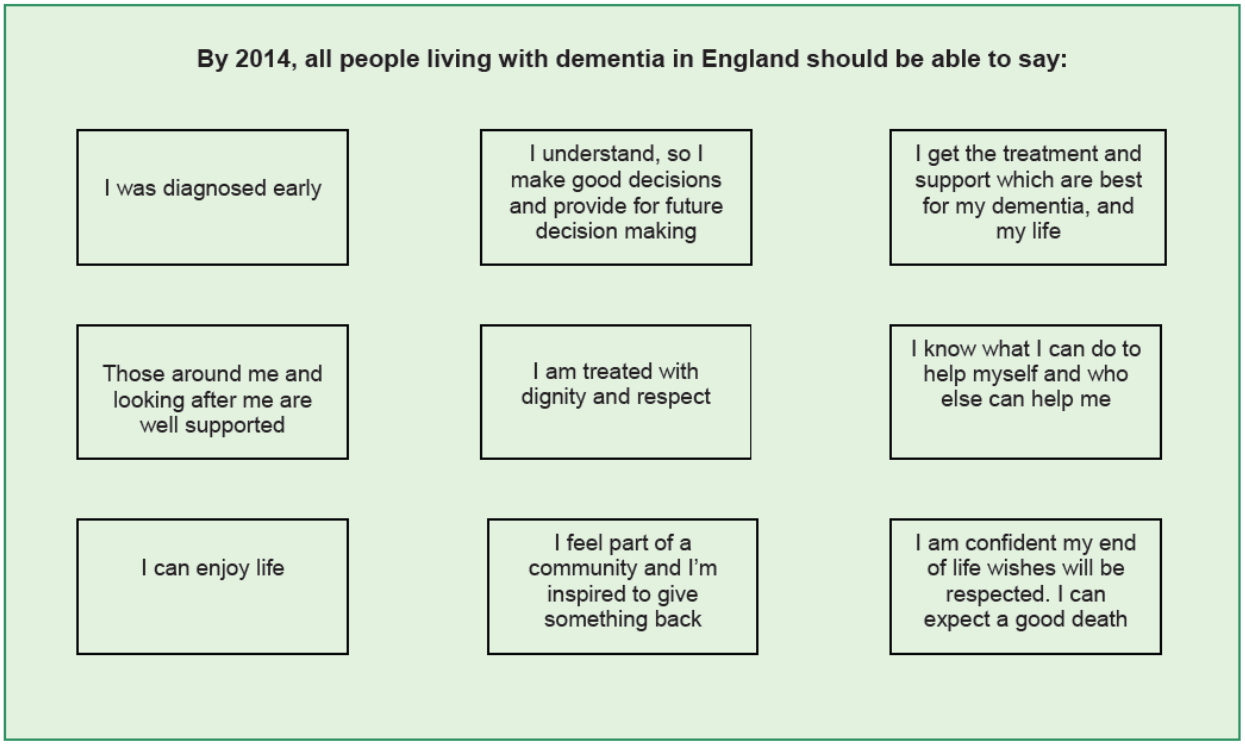
Vision – To deliver an integrated, high quality and person centred service to people living in Southern Staffordshire, with a suspected or confirmed diagnosis of dementia, as well as their carers/families

Goals

- Raise awareness and understanding of dementia amongst GPs and health/social care professionals, whilst also equipping them with the necessary skills and knowledge
- Increase the level of access to early diagnosis and support
- Develop key dementia support services and adequate capacity and resources
- Reduce the inappropriate use of anti-psychotic medication

Outcomes to be achieved

Department of Health, Outcomes for living well with Dementia are as follows:



Principles of Dementia Care

1. Continuity of staff who listen and get to know people
2. A responsive, proactive service
3. Treat each person as an individual by offering a personalised service
4. Partnership working
5. Integrated care
6. Care approach
7. Peer support
8. Care planning

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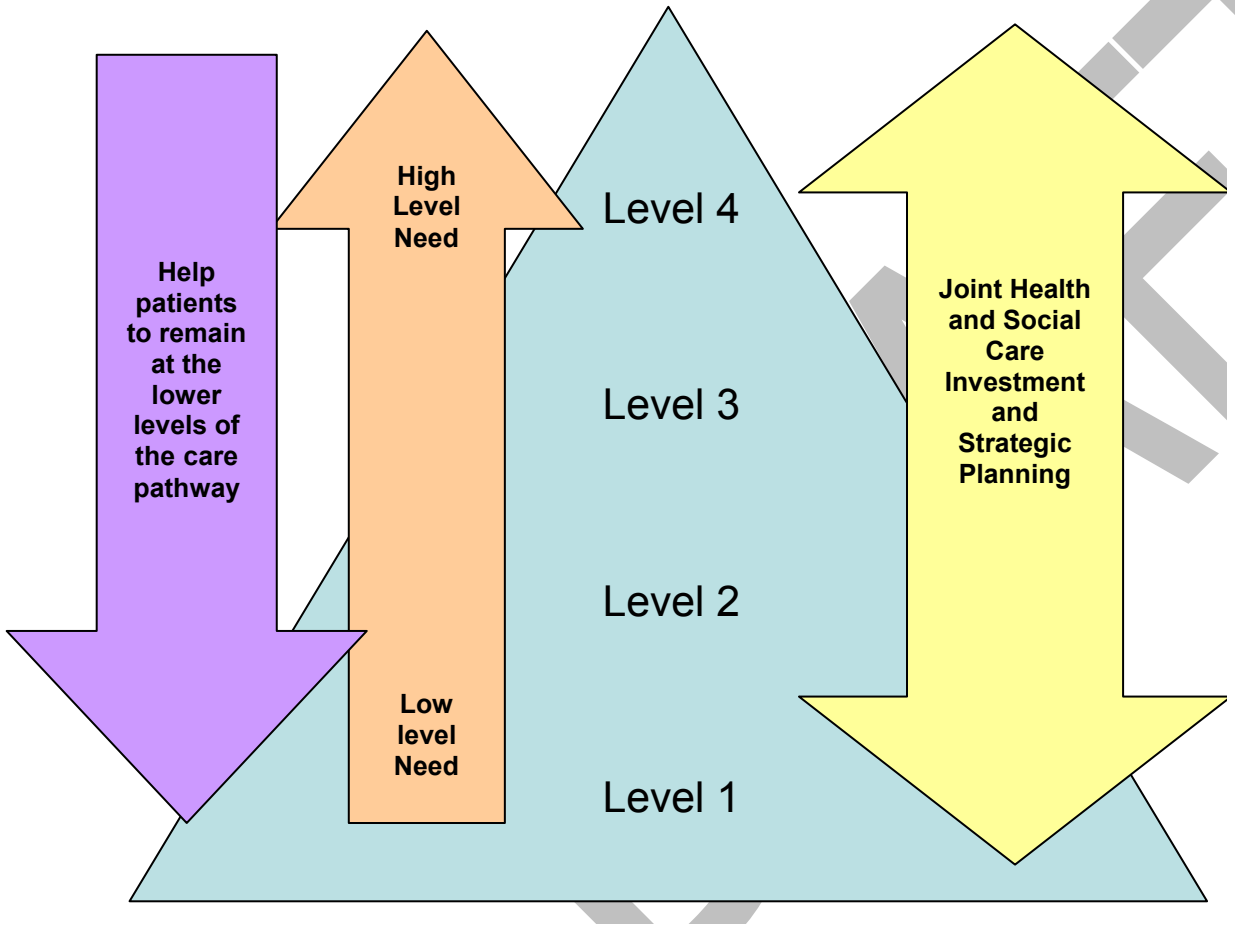
Appendix 2 – Vision on a Page



Level 4 Provision of Specialist Care, including residential/nursing, acute care, telehealth and good quality person centred end of life care

Level 3 Living well with Dementia – Providing continuity of support for people and their families/carers along with peer support and good quality care in secondary care

Level 2 Early diagnosis and Support for people with dementia and their families/carers via memory clinics and community based services.

Level 1 Improving public and professional awareness and understanding of dementia whilst also providing low level information and education for people and families.

Appendix 3 - Health and Social Care Commissioning Intentions 2012-16

Level	Service	Description/Current Activity	Timescales	Lead Officer(s)	Investment Needed
One	Improving Public and Professional Awareness of Dementia	Creation of a communications strategy which involves all existing forums i.e. carer groups, 3rd sector organisation, Patient Engagement, Communication teams within health and social care and local community and voluntary sector groups to help run local campaigns. We are also committed to engaging people with dementia and families so that they can help shape and inform services.	2012 - 14	Andy Donald	Use of existing resources
Two	Enhanced Assessment and Diagnosis Service	Ensure that there is a service in place which can meet the need and provide a holistic service which allows access for all people that need it, in order to support early diagnosis. Capacity management overview is currently being done in order to ensure that services are able to meet the expected demand	2012-14	Andy Donald	Initial analysis of memory service suggests maximum investment of £220k to meet the need Overall future investment of circa £1m over the next three years
All levels	Enhanced Community mental health teams and Crisis Support Service	Community teams to be made up to mental health nurses, social workers, Physiotherapists and Occupational Therapists to provide a crisis or emergency enhanced support service at a person's home. Review of current pathway and gap analysis to be carried out. Psychiatry services currently sit with the Dementia Teams as part of the Mental Health Trust and a review of the current pathway will need to be done to establish the level of need.	2012-13	Andy Donald & MH Trust	
Two & Three	Day opportunities and Cognitive Stimulation Therapy (CST)	Development of Dementia specific day opportunities which address the current gaps within certain localities. Also the provision of local information to be provided for people and their carers around activities and social events. Further investigation will be done regarding existing cognitive therapies within the community, with a view to developing these in the future.	2012-14	Andy Donald & Dawn Jennens	Budget currently being agreed as part of the Section 75 with the Partnership Trust

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		Informal Carer Training provided by approach in order to support carers with understand of dementia as well as some coping mechanisms for themselves in their caring role – as well as helping to support their loved one living with dementia.			
Two & Three	Person Centred Community Services	Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences. A day Opportunities strategy is currently being developed with the aim to develop a range of high quality day services which support people with dementia to remain independent within the community. To include Dementia Advisor and Community Psychiatric Nurses who can help people access these services.	2012-13	Andy Donald and Dawn Jennens	To be decided
All levels	Carer Support	Respite care and carer activities which allow for chances to socialise and lead a normal life.	2012-13	Andy Donald	Circa £80k of existing resources
Three & Four	Dual Registered Residential Care	Provision of dual registered nursing and residential care which meets the need and caters for all elements of the pathway needed. A specific piece of work around development of new 'Dementia centres of excellence' is underway and currently at the business case stage. Additional Extra Care facilities are also required to achieve independent living for people living with Dementia and their family/carers.	2013-15	Andy Donald & Dawn Jennens	Developer Investment along with joint health and social care investment required

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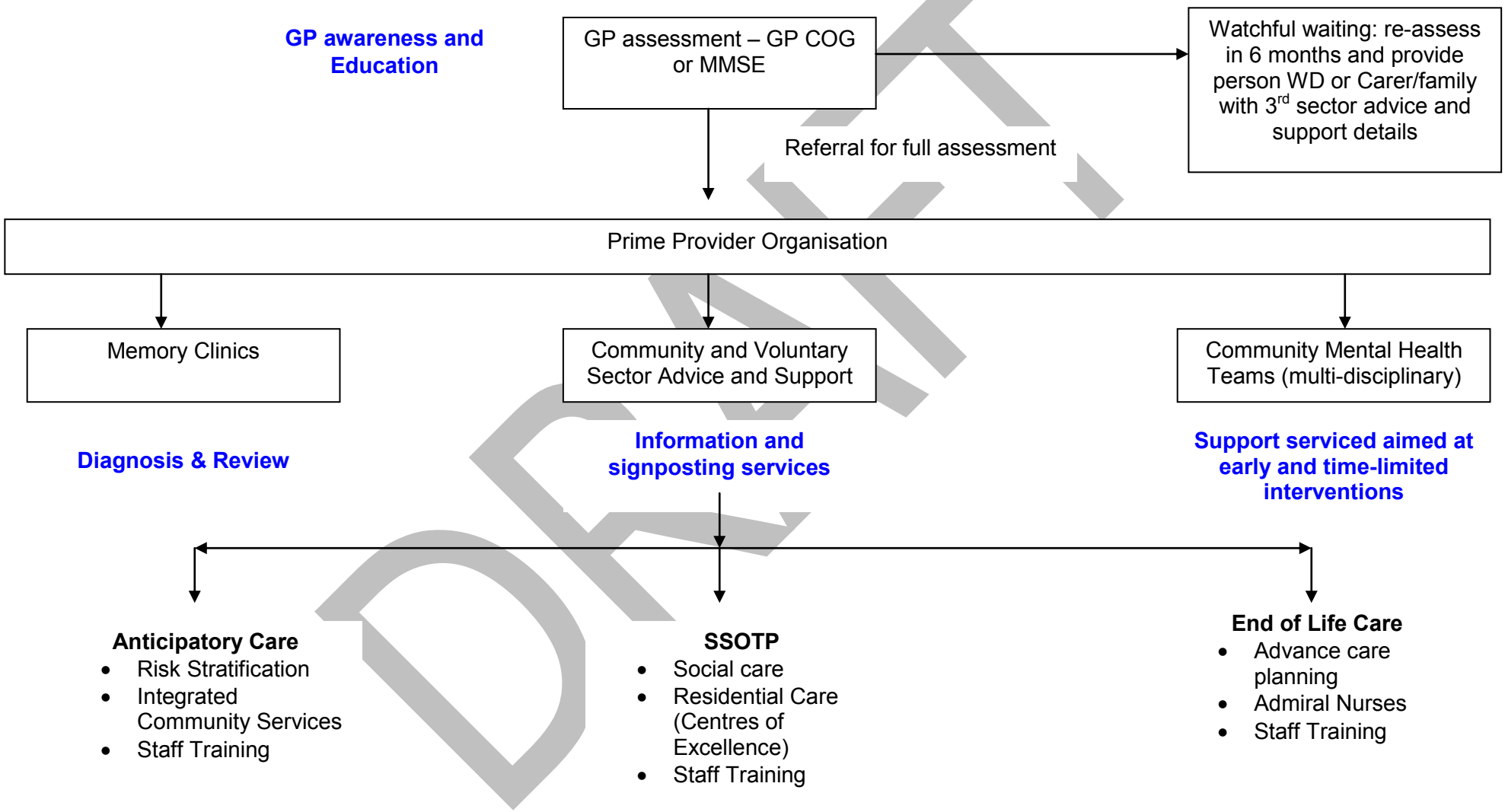
Appendix 4 – Proposed Future Care Pathway
(to be determined locally across Clinical Commissioning Groups)



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