Enhanced Health in Care Homes (EHCH)

Vanguard learning guide

EHCH element 4.2

High-quality dementia care

This guide was co-produced by:
• Newcastle Gateshead CCG
• East and North Hertfordshire CCG
• Nottingham City CCG
• Sutton Homes of Care

November 2017

Please note this is an uncontrolled copy of the learning guide. The controlled version can be found on the FutureNHS collaboration platform here: https://future.nhs.uk/connect.ti/carehomes/view?objectId=9277968
<table>
<thead>
<tr>
<th>Contents and introduction</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>About dementia care</td>
<td>2</td>
</tr>
<tr>
<td>Vanguard service models</td>
<td>3</td>
</tr>
<tr>
<td>Before you start</td>
<td>4</td>
</tr>
<tr>
<td>Benefits and impacts</td>
<td>5</td>
</tr>
<tr>
<td>Using your resources well</td>
<td>6</td>
</tr>
<tr>
<td>Things to consider:</td>
<td>7</td>
</tr>
<tr>
<td>Diagnosis and transition</td>
<td>8</td>
</tr>
<tr>
<td>Excellent care and support</td>
<td>9</td>
</tr>
<tr>
<td>Using your team wisely</td>
<td>10</td>
</tr>
<tr>
<td>Levers for change</td>
<td>11</td>
</tr>
<tr>
<td>Materials to support you</td>
<td>12</td>
</tr>
<tr>
<td>To do list and thanks</td>
<td>13</td>
</tr>
</tbody>
</table>

**Contents**

<table>
<thead>
<tr>
<th>What do the vanguard learning guides do?</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality dementia care in care homes</td>
<td>4</td>
</tr>
<tr>
<td>How does it contribute to the EHCH care model?</td>
<td>5</td>
</tr>
<tr>
<td>What does high quality dementia care need to provide?</td>
<td>6</td>
</tr>
<tr>
<td>Vanguard service models</td>
<td>7</td>
</tr>
<tr>
<td>Before you start...</td>
<td>8</td>
</tr>
<tr>
<td>Benefits and impact</td>
<td>9</td>
</tr>
<tr>
<td>Using your resources well</td>
<td>10</td>
</tr>
<tr>
<td>Things to consider – diagnosis and transition</td>
<td>11</td>
</tr>
<tr>
<td>Things to consider – providing excellent care and support</td>
<td>12</td>
</tr>
<tr>
<td>Things to consider – using your team wisely</td>
<td>13</td>
</tr>
<tr>
<td>Things to consider - levers for change</td>
<td>14</td>
</tr>
<tr>
<td>Materials to support your implementation</td>
<td>15</td>
</tr>
<tr>
<td>Your ‘to do’ list</td>
<td>16</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>17</td>
</tr>
</tbody>
</table>
What do the ‘vanguard learning guides’ do?

• Focus on a key element or sub-element of the Enhanced Health in Care Homes (EHCH) care model.

• Identify interventions put in place by the enhanced health in care home vanguards that have worked particularly well, and which could be readily replicated at clinical commissioning group (CCG), local authority, Sustainability and Transformation Partnership (STP) and/or regional level.

• Reference learning from relevant good work going on outside of the vanguards, where it is improving the lives of care home residents (includes residential, nursing and other settings).

• Describe a step-by-step approach to support implementation in non-vanguard areas, including first steps, roles and responsibilities, things to consider and the resourcing and benefits associated with these interventions.

• Support a consistent implementation of the core elements of the EHCH care model.

• Include practical materials such as job descriptions, referral criteria and operating models that can be easily adapted and adopted by other areas.

• Set out the key practical challenges arising from implementation of the care model, together with learning from the vanguards to help you overcome them.

• Link to national guidance and NHS England’s series of ‘Quick Guides’ where relevant.
High-quality dementia care in care homes

Description of intervention

• High quality dementia care ensures that people living with dementia have equal access to the services and support that they require. High quality dementia care is good care.

Why is this important?

• Providing person-centred care for residents is at the heart of what care homes should be providing, supported by their health, social care and voluntary sector partners. For those living with dementia this means wrap-around care which is person-centred and responds to each individual’s needs and goals, as well as those of their family and carers.

• Care home care is dementia care. As the population ages, and the complexity of need amongst residents of care and nursing homes grows, dementia and cognitive impairment are now the norm rather than the exception in 24 hour care settings, with expected rates of cognitive impairment at 70-80 per cent.

• People living with dementia and cognitive impairment are therefore ‘core business’ in care homes of all kinds and not just specialist dementia units. If the local system can get care right for residents with dementia, it’s more than likely you’ll get it right for all your care and nursing home residents. Furthermore supporting people with dementia in non-specialist homes can enable them to stay there, rather than be moved to more intensive settings for support.

• Addressing prejudice and inertia around people living with dementia and in care homes, and building on existing good work in the community is key. Many areas already have high-quality dementia and end-of-life care services. Care home residents have the same entitlement to these types of assessment and holistic support as everyone else.

• Care home staff, healthcare staff as well as volunteers and community organisations will need to build the skills, understanding and confidence to provide high-quality dementia care to a large and growing care home population.
How does high-quality dementia care support the EHCH care model?

- This vanguard learning guide focuses on sub-element 4.2: High-quality dementia care.
- Dementia and cognitive impairment is estimated to affect around 80 per cent of care home residents. More widely there are 850,000 people living with dementia in the UK today, and this is expected to rise to over one million by 2025.
- The EHCH models seeks to overcome some of the challenges faced by these people by improving health care support within care homes and by improving access to secondary care and to mental health services in the community.
- Vanguards have also found that high-quality dementia care supports and is supported by effective provision of care in the following areas:
  - End of life
  - Nutrition and hydration
  - Medicines – especially around covert meds
  - Enhanced primary care – upskilling care home staff and ensuring that mental health staff are part of the MDT team
  - Workforce and education – competency based frameworks
What does high-quality dementia care in care homes need to provide?

**Person-centred care, supported by:**

A. *Timely diagnosis of dementia* – to get a better understanding of a person’s behaviours and help facilitate advanced care planning.

B. *Shared advance care planning* - of paramount importance in delivering high-quality, personalised care planning, end of life care, and for ensuring timely access to secondary care and to specialised mental health services.

C. *Holistic care planning*, using personalisation tools such as the ‘This is Me’ as a foundation. These enable healthcare professionals to understand the person’s wishes and values and appreciate an individual’s life experiences prior to dementia. This helps both care providers and NHS services ensure that all care home residents’ needs are met, both when NHS staff attend the care home and when residents attend NHS services as outpatients, day patients, or in-patients.

D. *Education, training and professional development* – to help ensure that carers, families, and staff employed by social care providers feel supported. The voluntary sector plays an important role in providing dementia services in the community and in offering ongoing support for individuals and their carers and families. These organisations provide invaluable information advice and support, ranging from advocacy services and support groups, through to activity clubs and respite days.

E. *Medication reviews* - particularly important for people living with dementia and should focus on reducing polypharmacy and optimising psychotropics and minimising antipsychotic medication. It is important that these are undertaken by the multidisciplinary team.

F. *Stimulating and well-designed environment* - Care home managers, staff and commissioners and health professionals should pay close attention to the physical environment for residents. Well-designed facilities, such as sensory environments and home environments, have been shown to improve the quality of life for persons living with dementia, as have activities and therapies such as animal assisted therapy.
Vanguard service models – Sutton

Service model and resourcing:

• **Alzheimer’s Society dementia support workers (DSW)** have been commissioned by the vanguard, with care home staff also receiving training on dementia using the resource ‘Barbara’s Story’ and this includes dementia friends.

• Each DSW works with family members to provide 1:1 support and to give families a better understanding of disease progression and how it will affect their loved ones.

• The DSW team also carry out environment assessments for care homes in response to the care homes identified need. DSWs also provide support for activities in care homes to provide a fun and stimulating environment for residents.

• Sutton use the **Dear-GP tool**, a case finding tool, in care homes for assessment and care planning. It includes four prompt questions, which allow care homes to identify changes in the resident that may be associated with dementia. A pathway has been developed so that ‘link’ nurses undertake a blood test and this information is sent to the GP for assessment and diagnosis. This recognises the importance of whole-life planning for individuals, recognising their needs and goals beyond medical conditions.

• This service recognises the importance of whole-life planning for individuals, recognising their needs and goals beyond medical conditions.

• **A challenging behaviour team** – This service was commissioned from South West London and St Georges Mental Health Trust in 2008 by the CCG based on the evidenced based biopsychosocial Newcastle model.

• The service provides support to care homes to assess and treat people with behavioural and psychological symptoms in the context of dementia. The service undertakes holistic assessments of individual residents and develops strategies for the care home staff, upskilling and empowering staff so that they can better manage the resident as well as more low level behavioural changes. Referral is via GPs to ensure physical concerns are properly screened and responded to, along with psychological, cognitive and behavioural issues.

Evolving the service:

• Developing the relationships and partnership working between the services that provide support to people living with dementia in care homes.

Ideas to consider:

• Music Mirrors is a simple reminiscence resource tool, linking life stories told in people's own words to recorded sound and music to facilitate person centred care. A train the trainer approach has been developed to roll Music Mirrors out across south-west London.

• An e-learning module on dementia has been developed by health for care staff to access as part of the Local Authority e-learning platform.

• Reference cards – these allow staff in Sutton’s care homes to focus training on specific topics i.e. dementia.

• The Sutton ‘Red Bag’ hospital transfer pathway has a ‘This is me’ form specific to patients living with dementia.
Service model and resourcing:

- A dementia outreach team is commissioned by the CCG and provided by the Mental Health Trust, specifically for care homes.
- The team has 8 Community Psychiatric Nurses (at Band 6), 4 Senior Occupational Therapists (Band 6), 2 Specialist Physiotherapists (Band 6), 1 Assistant Practitioner (Band 4) and 3 Community Support Workers (Band 3) and a Head of service (Band 7). The team currently support 50 care homes, and 400 - 450 residents with complex needs at any one time.
- The team benefits from dedicated Consultant Psychiatrist input – 4 visits per week jointly with a clinician.
- Referrals are via the GP, Continuing Care Team or In patient mental health wards
- All patients in receipt of CHC are case managed by the nurses – this is for as long as funding is in place.
- All other patients may remain on caseload medium or long term as determined by patient need.
- The dementia outreach team provide training to care homes on dementia-related care and also co-ordinate a care home forum with care provider staff and a forum for activity co-ordinators.
- There is no third sector input into team directly, but the CCG have commissioned Age UK to support all their care homes.
- This team delivers mental health support to patients with organic mental health needs.

Evolving the service:

- Currently the range of dementia services provided across the health and care system for care homes aren’t as aligned as they could be, so the CCG is working with partners to undertake a procurement in order to use a system wide approach.

Learning points:

- A big success has been the nurses from the team co-ordinating a care home forum for local staff.
- However there is a challenge to avoid overly focusing this forum on dementia.

Feedback and impact:

- The dementia outreach team is really valued and relied upon by care homes.
- Service is currently being evaluated.
Vanguard service models – Newcastle Gateshead

Service model and resourcing

**Gateshead**
- **Old age psychiatrist as part of the vanguard led virtual ward MDT** and covers homes with dementia nursing care. Proactive co-working with primary care and community geriatricians. Other care homes obtain mental health input from a locality-based consultant and the community mental health trust.
- **Community Challenging Behaviour Service** (2 x B6, 1 x B5, 2.2 B3 nurses) works into all care homes [plus people in their own homes]. Homes can refer directly.
- **Dementia champions and activity coordinators** in every care home with funded training and support forum.

**Newcastle**
- **Challenging Behaviour Team** (6.5 WTE nurses) work into all care homes integrated with MDT and aligned GP approach.
- Dementia diagnoses via usual memory assessment and management service (MAMS). Input from CMHT to care homes via GP referral.

Evolving the service:
- Aim to bring mental health into Newcastle virtual ward when formed.
- Aim in Gateshead to increase access via virtual ward by increasing MH input to MDT.
- Pilot primary care diagnostic pathway using DIADEEM tool, with support through virtual ward and visiting mental health staff.
- Work to raise value of diagnosis in 24 hour care, to raise importance of activities and meaningful interactions, to expand and support dementia champion role.
- Dementia knowledge and skills a core part of competency based education framework.

Key themes
- Dementia is the norm rather than the exception in care homes.
- Dementia rarely travels alone, most people have multimorbidities.
- Moving into care - “it’s just a change of address”. Residents are entitled to the same services they would receive in their individual homes.
- There is already lots of excellent practice in many homes - celebrate it.

Some of our most powerful work has been with the third sector
- Working with Equal Arts to further develop a wider variety of meaningful activities and promote meaningful interactions.
- Promoting John’s Campaign to help raise profile of families.
Vanguard service models – East and North Hertfordshire

Background
• The Hertfordshire Dementia Strategy is managed county wide by Hertfordshire County Council (HCC).
• Hertfordshire County Council’s Dementia Care Accreditation Scheme is an accreditation process for those care and nursing homes in Hertfordshire that provide a higher standard of person centred residential or nursing service to Service Users with a dementia. There are 83 residential care homes in Hertfordshire. 52 homes have dementia accreditation (from HCC).
• Within Hertfordshire Partnership NHS Foundation Trust (HPFT) there has been an extensive inpatient unit refurbishment programme over the past three years which will continue until 2019, specifically aligned around the needs of Dementia care patients.
• 57 Dementia Champions have been trained as part of Complex Care training programme.

Service offering
• **Diagnosis** is provided by Hertfordshire Partnership Trust (HPFT) Mental Health Trust in Hertfordshire which covers all age groups, including those in Care homes. The service offer is called Early Memory and Diagnosis Support Service (EMDASS).

- **Post diagnosis support** services include:
  - Initial post diagnosis support is provided by Mental Health Trust (HPFT).
  - Activities, peer support and single point of access, available 7 days a week, including evenings and across the county and is led by Age UK Hertfordshire and a range of partners, including Carers in Herts, Herts Independent Living, Herts Mind Network and many more local organisations. A range of group services, 1-2-1 support and training. E.g. Group activity may include music, craft, singing, outdoor activity, peer support etc.
  - One to one support is provided by Alzheimer’s Society and available to any newly diagnosed person with dementia and their carer for six months. Also available for people after their diagnosis for as long as the support is needed. Support can include home visits, information, training and guidance, care through bereavement or creating support plans.
  - Specialist dementia carer mental health support is provided by Carers in Hertfordshire and Dementia UK and includes Intensive mental health support for carers in crisis, or near crisis, therapy, tailored training, relationship management and specific mental health support.

- **Acute crisis and End of Life care**
  - Across the whole of Hertfordshire, short term Acute crisis care is provided by 5 care homes, including 48 complex care CHC Beds and around 70 Non-complex care nursing beds.
  - Specialist Mental Health Team for Older People (SMHTOP) works across county with GP, Palliative team on EoL care.
  - Rapid Assessment Intervention Discharge (RAID) team works within the Acute Trust to provide in-reach help for dementia patients in crisis in a physical health care setting.

Ideas to consider:
• A Dementia Strategy Group with representation across health and social care partners is crucial as it provides a forum for all stakeholders to review performance and consider future commissioning needs.
• Engagement between providers is critical, contracts help formalise relationships and outcomes.
• As training evolves, a training needs analysis provides an opportunity for a stocktake and determine future training needs.
### Before you start...

<table>
<thead>
<tr>
<th>Build support and engage</th>
<th>Include all care homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be clear and honest – set out your offer to care homes, its limitations and how you want to develop together.</td>
<td>Be explicit that we’re talking about everybody – not just homes who self-describe as dementia homes or otherwise.</td>
</tr>
<tr>
<td>Consider working with a group of providers to develop a partnership agreement.</td>
<td>Consider your approach for homes which are already very high-quality. These will still need engagement and support to maintain standards, but what they need and the intensity of support will be different to those who are struggling.</td>
</tr>
<tr>
<td>Talk to care home managers to see if they want to be involved.</td>
<td>Consider what implementation approach works best for your care homes and staff. You may wish to start with all homes at once, or work with a small group as a rapid pilot/test at first. Choose a pace which works for the whole system – care homes, primary care, community care and the specialist teams you will employ.</td>
</tr>
<tr>
<td>Consider a contract with the care home managers to encourage engagement. The signing of such a contract will give a sense of responsibility to the care home to be involved due to the psychology of signing a contract even though the contract is not legally binding.</td>
<td></td>
</tr>
<tr>
<td>Work to address concerns within health or care around ‘double-funding’ nursing homes for this care directly and openly.</td>
<td></td>
</tr>
</tbody>
</table>

### Make it person-centred

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember as you are planning that it is not so much what you do, but how you do it. High quality dementia care, and care in a care home in general (whether it be music therapy an embroidery class or encouraging people out into the garden) should be about building up blocks of person centred care rather than an end in itself.</td>
</tr>
<tr>
<td>Consider the little changes that you can encourage by working as a system, as well as the larger interventions – making care for those living with dementia more joined-up and personalised does not need to cost huge amounts of money.</td>
</tr>
</tbody>
</table>

### Map and involve the whole system

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Try to have a conversation system-wide - not just one commissioner and one care home.</td>
</tr>
<tr>
<td>Be clear what’s already being delivered to care homes across all the services they receive and are part of - a lot of this may not be through statutory services – so make sure to include the voluntary sector. Identify areas where there is good practice already happening and engage with colleagues in these areas to understand what can be replicated.</td>
</tr>
<tr>
<td>Try to also map out areas for development and improvement.</td>
</tr>
<tr>
<td>There are people living with dementia in all settings – whether community, acute, nursing or residential – where is the expertise you can build upon?</td>
</tr>
</tbody>
</table>
Benefits and impact for individuals and families

**For families and carers:**
- A better understanding of dementia, what the condition entails, what to expect and ability to plan
- More understanding of the care being provided to their loved one, and more meaningful engagement with staff providing care
- Greater confidence in the staff who are giving care
- Families empowered to be partners in care

**For people living with dementia:**
- Care which recognises each resident as an individual, with a life story and goals
- More structured stimulation and activities. Enriching environments
- Care which is coordinated and feels better joined-up
- Staff who take the time and who are equipped with the training and tools to better understand each individual’s strengths and weaknesses in context of dementia, and how these might develop over time
- Unnecessary medicine prescribing is reduced
Benefits and impact for staff and organisations

For care home staff:

• Improved understanding of responding to dementia and help to overcome the fear of getting it wrong – more empowered and able to intervene if there are challenges with deterioration, challenging behaviour or day-to-day care
• Staff supported to become more competent and more confident in using their skills
• Better morale, increased quality of life and staff satisfaction at work, together with a potential increase in retention rates.
• Access to expert advice both formally and informally

For CCGs, care providers and GPs:

• Increased dementia diagnosis rate
• Safe and effective future care planning based on a shared understanding of a person and how living with dementia may affect them is and may affect them – helping community and care home nurses with advance care planning
• Supports compliance with the Mental Capacity Act
• Foster an environment which recognises risk and responds appropriately, supporting quality of life and choice without unnecessarily restricting liberty

For the system:

• An effective use of resources to help improve care and outcomes in linked areas such as behaviour that challenges; fall prevention and reduction, hydration and nutrition and polypharmacy
• People are less likely to need to move if they can be successfully supported in their care home
Using your resources well

• Tap into existing resources across the health, social care and voluntary sectors.

• Interventions can be high cost – but can be low cost if designed well.

• Systematise sharing and learning amongst different staff groups and organisations.

• Value your whole workforce as contributors to excellent dementia care – from the care home chef, to the visiting GP, to volunteer care home visitors, including seizing on the potential of empowering residents’ family and friends.

• Support your community and voluntary sector to develop.

• Facilitate resources to network across the system and encouraging sharing knowledge.

• Value networking – establishing a culture which values it as a good use of time.
# Things to consider – diagnosis and transition into care

## Diagnosis

- **Bust myths!** The value of a dementia diagnosis in a care setting is often ignored. A diagnosis can help care home staff understand behaviour and enable the system to support the home via education and training.
- Some care home residents have mild or moderate dementia and symptoms which may be drugs or other factors. These diagnoses may be “missed” as they may appear to care home staff as relatively cognitively intact and present no challenges to care.
- Staff from the whole system should support a shared understanding of what the diagnosis means by the individual, carers and family.
- Some of those coming into residential or nursing home care will already have a diagnosis, your area should consider how to improve recognition and diagnostic process for those who don’t, or develop dementia whilst in care.
- Understand trends in your area around diagnosis and where there may be an opportunity to improve. Look for variation by GP practice or home. This can identify where there is poor communication of diagnosis between GP and homes (in both directions).
- Consider how to make diagnoses via GPs easier – e.g. by utilising tools (e.g. DIADEM), or as part of aligned GP ward rounds or virtual wards.
- Remember to keep families and carers involved in the discussions, as proceeding without their involvement can cause unnecessary upset and make care home staff and others nervous about the process.
- Take a look at the blogs by Alastair Burns, National Clinical Director for Dementia and Older Peoples’ Mental Health, NHS England, highlighting [GP’s role in diagnosing dementia amongst care home residents](https://www.england.nhs.uk/dementia/).  

## Transition into care

- It is important to recognise that the move into care is often poorly prepared - for numerous reasons. This could be as a result of an emergency, last-minute move from hospital as a bed becomes available, denial of the condition from the resident or family. Support should be tailored to the individual and their circumstances.
- Make sure you commission, contract and monitor as a whole system to avoid services ending upon admission. Existing care shouldn’t automatically stop upon admission. There need to be a needs-led transition and handover rather than discharge, including befriender and wellbeing activity as well as health care.
- Ensure there is adequate support around transition into care for individual and family.
- Work to raise awareness and expectations amongst families and carers on what they and the resident can expect.
- Keep people connected with communities – it’s the address that changes not the person.
- Focus effort of good communication and transfer of information, supported by agreed responsibilities across the system (including the local authority, acute trust and ambulance trust). Do you know whose responsibility it is tell others when a person with dementia moves into a care home? How are families and carers kept updated on progress and wellbeing of their loved one when people are transitioning into care?
### Meaningful activities, interactions and moments

- Not just a 'nice to do' – this is the ‘treatment’ for dementia in care settings.
- We need concepts of meaningful interactions and meaningful moments especially for those who are less able – can often be excluded by traditional ‘activities’.
- Dementia care is as important as hydration, nutrition and medicine management – all are essential.
- Recognise the close parallel to nutrition and hydration – like food and eating/drinking, professionals should be supported to personalise dementia care to a person’s situation.
- Build a culture where both care homes and families support cognitive stimulation.
- Involve outside agencies and the community and voluntary sector. Draw upon the energy and expertise of community groups and ‘bring the outside world in’.
- Keep care personalised – “meaningful for me”.
- **Creative Guide for Staff and Families Communicating with People Living with Dementia – Recipe Cards** - Newcastle Gateshead EHCH Vanguard Programme has worked with Equal Arts and local Care Homes to develop a guide is aimed at care staff to help them use creative methods of engagement to help those living with dementia enjoy meaningful activities. With feedback from staff the communication guide will look like ‘Recipe Cards’. It is hoped these cards will also be used by family members and domiciliary care staff in future.

### Support for families and carers

- Work with community groups, advocates as well as health and care services to raise public awareness of what outstanding dementia care looks like and build an expectation that it will be available in your area.
- Embed a culture of viewing families and carers as partners in care, through co-production and feedback at a system level, and involvement in holistic care planning at individual level.
- Look at how families and carers can access information - ensure signposting is in place to help people access care and support. Is there a role for local dementia champions in this?
- Put in place support for families and carers throughout their journey.
- Work with families and carers to help maintain relationships between them and their loved ones as dementia worsens (see meaningful interactions across the page).
- John’s Campaign – encourage homes to sign up.
## Things to consider – providing excellent care and support

<table>
<thead>
<tr>
<th>Dementia and hydration and nutrition</th>
<th>Culture and leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>• It is important never to assume that the patient/resident does not want to eat even if they appear to be refusing.</td>
<td>• High-quality dementia care requires education at a manager, leader and home owner level.</td>
</tr>
<tr>
<td>• Always wait then offer food/drink a second time.</td>
<td>• Consider using both care home managers and owners forums to share and value best practice.</td>
</tr>
<tr>
<td>• Environment and social setting is crucial. Ensure that the dining room reflects what your dementia resident needs (e.g. is it quiet and free from clashing colours and patterns?)</td>
<td>• Dementia champions have a big role and can be hugely influential in changing cultures.</td>
</tr>
<tr>
<td>• Be creative and think about people’s previous life experience – e.g. some people may not be used to sit down meals at lunch due to experiences during their working life – could you consider using a lunchbox to help them feel relaxed.</td>
<td>• Ensure shared values and coordinated action across the wider system. This means from the STP lead, councillors and commissioners to the MDT and registered managers.</td>
</tr>
<tr>
<td>• Do not worry about the resident’s possible preference for strange combinations of foods. Reassure family about this. As long as they’re eating, it doesn’t matter.</td>
<td>• Recognise that there are many levers to raise the profile and importance of high quality dementia care. Raise public awareness of what outstanding dementia care looks like and build an expectation that it will be available in your area.</td>
</tr>
<tr>
<td>• Some dementia patients do better with a series of finger foods instead of a traditional meal. Try to adapt and provide this if possible.</td>
<td>• Involve your community and voluntary organisations – they have expertise, assets and can assist with this too.</td>
</tr>
<tr>
<td>• The Alzheimer’s Society UK website has a detailed ‘eating and drinking’ section useful for care home staff, families, commissioners and carers.</td>
<td>• Consider how you can work with homes and community groups to ‘open up’ care homes to community and cultural activities, and help staff and residents to feel more part of the community.</td>
</tr>
<tr>
<td>• A dietician may need to be involved – vanguard experience has been that this is often beneficial.</td>
<td>• See our <a href="#">hydration and nutrition learning guide</a> for further information.</td>
</tr>
<tr>
<td>• See our <a href="#">hydration and nutrition learning guide</a> for further information.</td>
<td></td>
</tr>
</tbody>
</table>
**Things to consider – providing excellent care and support**

<table>
<thead>
<tr>
<th>Dementia and end of life care</th>
<th>Medicine and prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advanced care planning for those living with dementia, or recently diagnosed can support better quality of life and more personalised care over the last year of a person’s life.</td>
<td>• The Enhanced Health in Care Homes care model calls for assessment when a resident moves into a care home as part of their personalised holistic care planning, including an aspiration for areas to use ‘Comprehensive Geriatric Assessment’ (CGA).</td>
</tr>
<tr>
<td>• For people living with dementia a change of location or admission to hospital can be an unwittingly hostile clinical environment in their dying hours and days. Well-intentioned but often futile intervention is common and profoundly distressing for residents, their families and carers, who rarely have the benefit of previous discussion about health, prognosis and treatment preferences.</td>
<td>• Any medicines review should be done as part of an MDT approach to ensure that the right overall decision is taken – with input from family and carers, as a diagnosis of dementia may trigger a general review of a resident’s medication – and the stopping of drugs which may affect cognition adversely.</td>
</tr>
<tr>
<td>• Preferred place of death (PPOD) for people living with dementia - PPOD can be proxy for quality of life.</td>
<td>• Each medication should be reviewed according to national care homes guidance and any relevant local prescribing guidance issued by the area prescribing committee.</td>
</tr>
<tr>
<td>• Recognise that dementia is a terminal life limiting illness. Many people die with dementia from other causes but others die from dementia.</td>
<td>• Care home providers should be supported to have an effective ‘care home medicines policy’ that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.</td>
</tr>
<tr>
<td>• Advanced care planning and EOL planning are a dynamic process, not just a one-off.</td>
<td>• Care homes and GPs covering the homes could work together to set up a process whereby all new residents being admitted to care homes have a review to establish whether they have a diagnosis of dementia, ensure an anticipatory planning review of medication is carried out, and arrange baseline blood tests etc. If a diagnosis of dementia is made this can be recorded in the care home records and GP QOF Register.</td>
</tr>
<tr>
<td>• See our <a href="#">End of Life Care learning guide</a> for further information.</td>
<td>• Occasionally, covert medication may be considered. Steps can be taken prior to moving to covert medication which may remove the need.</td>
</tr>
<tr>
<td></td>
<td>• See our <a href="#">Medicines Review and Optimisation</a> learning guide for further information.</td>
</tr>
</tbody>
</table>
## Things to consider – using your team wisely

<table>
<thead>
<tr>
<th>Specialist input</th>
<th>Dementia champions and dementia friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the access for care home residents to mental health services? How can care home and MDT staff obtain advice and guidance?</td>
<td>Dementia champions and activity champions can be key enablers of excellent dementia care if your health and social care system can raise care home staff confidence, profile and support their training and development.</td>
</tr>
<tr>
<td>Have you mapped what services are available ‘in hours’ and ‘out of hours’?</td>
<td>However the championship model is just one approach - if your area does not use this there are other ways to ensure that this agenda is meaningfully embedded in care.</td>
</tr>
<tr>
<td>How can specialist input be integrated with physical health needs, primary and secondary care working together?</td>
<td>Find your allies and those who are passionate. What can you do to empower and help these people to spread a message and build networks of good dementia care?</td>
</tr>
<tr>
<td>Ensure against exclusion from other visiting services – again dementia is the norm rather than the exception in these settings.</td>
<td>Understand the expectation locally amongst commissioners and the current situation? Are there contractual or cultural barriers to overcome, working in partnership?</td>
</tr>
<tr>
<td>Services need to include access to specialist support for non-pharmacological strategies for ‘behaviours that challenge’.</td>
<td>Monitor impact and maintain support – staff often get trained up but then can feel disempowered and devalued once back in care homes if their knowledge and skills aren’t put into practice. Their skills should be recognised and valued within the home.</td>
</tr>
<tr>
<td>Services should include access to specialist input from pharmacists and other professionals regarding mental health medications and reviews of these.</td>
<td>How can the CCG, local authority and care providers in your area work together to promote the dementia friends agenda, and make links between care homes and local dementia friends networks?</td>
</tr>
<tr>
<td></td>
<td>Do you have a local forum in place with care home staff – how could you use this to raise the profile and priority of these roles?</td>
</tr>
</tbody>
</table>
**Evaluation and Metrics**

**Why is this important?**
- Ultimately we need to try to measure services according to the difference they make to the lives of people with dementia.
- Balance what's measurable and what's meaningful
- It is also important to include some measurement of ongoing support following training, as we know that training effect ‘drops off’ swiftly.

**Potential metrics to consider**
- Dementia Diagnosis rates.
- Reduction in antipsychotics.
- Measures of personalisation being.
- Life stories recorded and accessible to all staff.
- Availability of variety of activities.
- Evidence of activities being personalised and that attempts are made to engage those who are ‘hard to reach’.
- Numbers of staff who have had dementia training (although need to be mindful of what level of quality that training is and of turnover).

**Contracts and inspection frameworks**
- Consider your approach to intelligence and quality assurance. Does it support and promote high quality dementia care?
- Is the CCG, local authority and CQC approach in sync?
- How can your local health and care system reduce the burden of inspections, whilst still driving quality?
- Contracts vary widely in their detail and thus potential impact. Does the CHC and/or local authority contracting arrangement support your aspirations around high-quality dementia care?
- Are their differences between the support in place for residential/nursing/continuing healthcare [CHC] placements and self-funders? How can you work as a system to provide equity of care, irrespective of setting or funding?
- Remember that not all community and voluntary sector services are commissioned by CCGs or local authorities – would a discussion with those who commissioning the local voluntary sector be useful to plan, develop and co-ordinate services?
### Material to support implementation

#### East and North Herts / HCPA – Complex Care Dementia champion documentation

- **East North Herts Vanguard Complex Care Premium Webinar 12th October**
- **Video of exercise class**
- **Video of Champions and Managers Talking**
- **Characteristics Document**
- **Champions Booklet**
- **Example Questionnaire for Dementia Pathway**
- **Example Impact Assessment For Dementia Pathway**
- **About HCPA**

#### Nottingham City - Dementia Outreach team

- **What carers and families say about the Dementia Outreach Team**
- **Poster - about the Dementia nurse-led care homes forum**
- **Poster - about specialist physiotherapists**
- **Poster - about the dementia outreach nurses**
- **Poster - about cognitive stimulation therapy**
- **Poster - about community support workers**
- **Webinar slides**

#### Music Mirrors – Sutton

- **About Music Mirrors - presentation**
- **HIN Music and Mirrors - FINAL REPORT**
- **Key points for MUSIC MIRRORS**

#### DeAR-GP implementation tools

- **DeAR-GP User Guide**
- **Dementia Assessment Referral to GP Form**
- **Guide for Care Home Managers**
- **Guide for Care Workers**
- **Training plan for Care Workers**
Material to support implementation

Newcastle Gateshead’s dementia work

- [http://johnscampaign.org.uk/](http://johnscampaign.org.uk/)
- Dementia poster - Collaboration through Pathways of Care Group
- Threading support and care for Dementia throughout the work of the vanguard
- Creative Guide for Staff and Families Communicating with People Living with Dementia – Recipe Cards project
- Communicating with People Living with

Tools and systems

- About Coordinate My Care
- This is Me (a simple form for anyone receiving professional care who is living with dementia or is experiencing delirium or other communication difficulties)
- DIADEM (Diagnosis of advanced dementia mandate in care homes)

National guidance, support and tools

- Dementia diagnosis and management: a brief pragmatic resource for general practitioners (NHSE)
- Dementia Revealed: what GPs need to know (NHSE)
- Gold Standard End of Life care framework
- The diagnosis of dementia for people in care homes - FAQs for GPs
- How organisations can get involved, Dementia friends
- Help with dementia care, Alzheimer’s Society
- Medicine Matters newsletters – information on Covert Administration of Medicines / Hydration and Medication, North of England commissioning support

Guidance and blogs on dementia diagnoses and care

- Don’t let care home residents slip through the dementia net
- GPs have a vital care home dementia role
- Improving dementia care: CQUINS and Enhanced Service
- Optimising care and support for people with dementia in care homes: The Barbican Consensus
- Supporting people with dementia in Care Homes
Implementing high-quality dementia care – to do list

1. Support diagnosis of dementia whatever the setting.
2. Include a focus on cognition during assessment, as part of your approach to Comprehensive Geriatric Assessment / holistic assessment. Consider how co-morbidities and medicines impact upon the person.
3. Consider how medicine reviews can take place.
4. Incorporate a process of advanced care planning and review, as part of your MDT approach.
5. Work with care homes to link to personalise care, improve the range and variety of stimulating activities available to residents, no matter how mobile they are, and
6. Consider how you can help connect homes to community assets such as dementia friends and voluntary groups.
7. Think personal – what small changes could really help a person’s quality of life?
8. Don’t forget hydration and nutrition.
9. Build education and training on dementia into your offer for care and health staff across the care provider and health sectors.
10. Ensure carers and families are kept involved and informed.
11. Consider introducing a hospital transfer pathway including a ‘This is me’ type form to accurately and simply record details of patients with dementia should they need acute care.
Acknowledgements

• Dr Karen Franks, Consultant in Old Age Psychiatry, QE Gateshead
• Paul Fenton, East and North Herts CCG
• Alistair Burns, NHS England
• Lesley Bainbridge, NHS Newcastle Gateshead CCG
• Lucy Anderson, Nottingham City CCG
• Viccie Nelson, NHS Sutton CCG
• Emma Dwyer, Hertfordshire County Council
• Gemma West, Nottingham City CCG
• Emma Williams, Hertfordshire County Council
• Jennifer Thrower, Alzheimer’s Society, Sutton
• John Buttery, Alzheimer’s Society, Newcastle and Gateshead
• Corinna White, NHS Sutton CCG
• Victoria Hill, NHS South West London, St Georges Trust
• Annie Amjad, Alzheimer’s Society, Sutton