ENFIELD JOINT DEMENTIA STRATEGY 2011 – 2016

CONTENTS

1. Executive Summary

- Dementia has a major impact on the lives of people with dementia and on their families. Family members who care for people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life.

- Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include loss of memory, mood changes, a decline in reasoning and communication skills as well as a gradual loss of skills needed to carry out daily functions and activities. Alzheimer's disease is the most common form of dementia and age is the main risk factor in dementia. Vascular dementia is the second most common form of dementia and can develop following a stroke or if there is blood vessel damage that interrupts the supply blood to your brain.

- Dementia is a terminal condition and people generally live with it for 7–12 years after diagnosis. There are however a number of different psychological treatments that can be used to help people cope with the symptoms of dementia and slow down the symptoms. In addition, medication can be used to treat dementia. Early diagnosis is therefore important in managing the disease and assists in getting appropriate support.

- Living a healthy lifestyle that protects cardiovascular health has been shown to reduce the risk of developing dementia.

- It is estimated that the number of people in Enfield with late onset dementia (ie in people aged over 65) is 2706 and that this is set to increase by 44% in the next 20 years. This presents a significant and urgent challenge to health and social care in terms of both the growing numbers of people affected by dementia and the increasing cost of providing good quality services to enable people with dementia and their carers to live well.

- The Alzheimer Society (2007)[1] found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). Applying these figures to Enfield would mean that the current cost of late-onset dementia in Enfield is an estimated £68.9 million per year, and by 2030 the annual cost of dementia in Enfield will have increased to over £99.5 million.

- In 2009 the Department of Health published *Living Well with Dementia: A National Dementia Strategy* which aims to ensure that significant improvements are made to dementia services across three key areas:

[1] Alzheimer's Society (2007). *Dementia UK.*

improved awareness, earlier diagnosis and intervention, and a higher quality of care.

- This strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 5 years (2011-16). It outlines 11 key strategic objectives that were developed in consultation with local stakeholders. Each of the objectives is aligned with the National Dementia Strategy and each is supported by a robust rationale.

- This strategy has been developed in the context of an extremely challenging financial environment. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial positions and reduce their deficits. The Department of Health expects implementation of the National Dementia Strategy to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention. Any new investment in local dementia services will necessarily be funded through efficiency savings and/or reconfiguration of existing resources.

STRATEGIC OBJECTIVES:

1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA

Raising awareness and understanding of dementia will encourage people to engage with services earlier and lead to improved outcomes and quality of life.

Improving the cerebrovascular health of our population may contribute to preventing or minimising vascular dementia.

Develop a targeted local awareness campaign that aims to raise public and professional understanding of dementia and the stigma associated with it. The awareness campaign will focus on encouraging people to seek early diagnosis and care and increasing people's knowledge of how to reduce their risk of developing dementia through making healthy lifestyle choices.

Engage with local employers of public-facing staff to gain advice on how best to develop staff awareness including access to local resources for staff.

Dementia awareness will be included in all induction training for employees within the NHS, Council and partner organisations working with adults and older people.

Link with existing health promotion activities and awareness campaigns to improve awareness of the link between healthy lifestyles and reduced risk of vascular dementia.

Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life and ensure that people with dementia, carers and health and social care professionals are aware of this pathway

2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF DEMENTIA

Research suggests that early identification and treatment of dementia is effective in terms of quality of life and overall cost effectiveness.

Reconfigure the current Memory Treatment Clinic model in line with NICE guidance to enable it to have a greater role in early diagnosis and to better manage existing and future demand, including the capacity to meet the needs of the growing population of older people with dementia from Black and Minority Ethnic groups. This will include exploring the option of direct referral to the clinic from primary care and assessing the benefits of providing assessment and treatment as part of the service.

Establish processes to ensure that GP practices are notified when one of their patients is admitted to hospital with a diagnosis of dementia.

3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE OPTIONS

Support for carers plays a significant role in reducing admissions to residential care and enabling people with dementia to live in the community for as long as possible.

Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers.

Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers.

Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs.

Ensure that the need for respite is an integral part of people's assessment and care package and that the rights of carers to an assessment of needs are upheld.

Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.

4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.

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

Increase investment in assistive technology to support people to remain in their own homes and ensure that appropriate housing related support is available to people with dementia.

Commission a range of housing options that better meet the specialist needs of people with learning difficulties and dementia.

Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their well being. These services will be appropriate for people at different stages of the disease.

Commission training for carers on caring for someone with dementia.

5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE

Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer.

Develop a local dementia workforce plan that links to, and complements, the identified national workforce development initiatives.

Ensure that all services specify dementia training and core competencies that include, but are not limited to, the national minimum standards.

Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams.

6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS

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

Enfield is piloting a new service - the Enfield Dementia Demonstrator Pilot programme – which provides information, advice and support to people with

dementia and their carers. If evaluation of the pilot shows that it is achieving the desired outcomes then we will continue to commission the service.

We will ensure that dementia information materials and resources are available for all people with dementia and their carers.

7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY

People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.

Review the Hospital Mental Health Liaison Service with a view to expanding the role of the service to include responsibility for general hospital staff dementia training and education.

Ensure that people with dementia are able to access Intermediate care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff. In addition we will increase the capacity of Intermediate Care to provide in-reach to care homes in order to reduce avoidable hospital admissions.

Review the appropriateness of current arrangements for assessing people with dementia in general hospitals, including the appropriateness of current assessment environment.

Review the quality, range and provision of services for people who require continuing healthcare.

8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED

It is estimated that there are approximately 64 people in Enfield with early onset dementia and it is more prevalent amongst people with learning disabilities.

Ensure that health and social care staff working with people with learning disabilities and other younger people at risk of dementia receive training in dementia awareness.

Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia.

Explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey.

9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS

There is a high level of inappropriate prescribing of anti-psychotic drugs for people with dementia who are living in care homes.

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

Commission specialist older peoples mental health teams to provide in-reach service to support primary care in its work in care homes.

Commission primary care and pharmacy in-reach services to ensure more appropriate use of anti-psychotic medication.

Ensure distribution, promotion and implementation of the 'good practice resource pack' that is being developed by the National Dementia Strategy Implementation Team.

Develop collaborative partnerships with care home providers to encourage the development of local leaders who can demonstrate excellence in provision of services.

Identify a senior clinician within Chase Farm Acute Trust to take the lead for quality improvement and training in dementia care in hospital.

Review the current care pathway for the management and care of people with dementia in hospital, led by that senior clinician.

Explore the potential use of the commissioning for quality and innovation (CQUIN) payment framework, to incentivise general hospital providers to improve quality and innovation.

10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA

Evidence suggests that people with dementia receive poorer end of life care than those who are cognitively intact[2].

Ensure that people with dementia have the same access to palliative care services as others.

Develop local end of life care pathways for dementia consistent with the Gold Standard Framework as identified by the National End of Life Care Strategy.

Introduce quality payments to care homes that achieve the Gold Standard for End of Life Care.

[2] Living Well with Dementia: A National Dementia Strategy (DH 2009)

Commission a Gold Standard Framework Facilitator to work with care homes to assist them to implement the Gold Standard Framework.

Raise awareness of the Mental Capacity Act among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so.

11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS

Early-onset dementia is more common amongst black and minority ethnic groups and the number of people with late onset dementia is set to rise sharply.

We will review current service provision to assess whether it is meeting the needs of Black and Minority Ethnic groups and engage with the Black and Minority Ethnic community to gain a better understanding of their needs and current gaps in service provision.

2. Introduction

Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include decline in memory, reasoning and communication skills, and ability to carry out daily activities, and loss of control of basic bodily functions caused by structural and chemical changes in the brain. Alzheimer's disease is the most common form of dementia and age is the main risk factor in dementia. There are also a number of modifiable risk factors including smoking, excessive alcohol consumption and obesity.

The impact of dementia on people with the disease and on their families is profound. Family members who care for people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life.

The number of people in Enfield with late onset dementia is set to increase by 44%, from 2706 to 3906, in the next 20 years. This presents a significant and urgent challenge to health and social care in terms of both the growing numbers of people affected by dementia and the increasing cost of providing good quality services to enable people with dementia and their carers to live well. In order to meet the current and future needs of people with dementia we need to take a strategic approach to developing and redesigning the way that we provide services to people with dementia and their carers.

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

Dementia care is delivered through a range of providers, with diagnosis and medical support provided primarily by health services, and longer-term care delivered by the social care and third sector, as well as private companies providing care homes and domiciliary care. It is the intention that this strategy provides a vehicle for encouraging integration and collaboration across the range of health and social care services.

This strategy sets out the local direction for dementia services from 2010/11 - 2015/16. It is evidence based, built on an analysis of current and predicted future need and has been guided by input from local stakeholders who have contributed to our understanding of the priorities for improving services for people with dementia and their carers in Enfield.

A 3 month period of consultation on the strategy was carried out and revisions to the strategy were made in response to the feedback that we received. A summary of submissions and the response to these submissions is set out in a separate document: *Enfield Joint Dementia Strategy 2011-2016 – A Summary of Submissions Received in Response to the Consultation*. The feedback will also be used to inform the implementation of the strategy, particularly with regard to developing our priorities for the first year of implementation.

The strategy is underpinned by the National Dementia Strategy, which aims to improve dementia services across 3 key areas: improved awareness, early diagnosis, and a higher quality of care; and is set in the context of the vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

The strategy development has been led by the Older People's Mental Health Group, which is a sub-group of the Older People's Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[3]). It has been developed in collaboration with key stakeholders, including carers and service users, who provided advice and expertise on the priorities for developing services in Enfield. A full list of people who have contributed to the development of this strategy through participation in stakeholder workshops or individual discussions is included in Appendix 4.

The strategy will be regularly reviewed and progress on implementation will be monitored by the Older People's Mental Health Group who will have a remit to monitor implementation and make recommendations for further developments.

[3] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

3. National and Local Guidance and Research

National Guidance and Policy Context

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

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

Improving the delivery of services to people affected by dementia is a key national and local priority. *Living Well with Dementia*, the national dementia strategy, was published in February 2009 and aims to improve dementia services across 3 key areas: improved awareness, early diagnosis, and a higher quality of care. The strategy sets out 17 objectives, the majority of which require implementation at a local level.

There are a number of other important national publications containing findings and recommendations regarding the development of dementia services that have directly influenced the development of our local strategy. They are summarised in Appendix 1: National Policy Context.

Local Guidance

In January 2009, Enfield published *A Future for All*, a joint social care and health document which set out the joint commissioning intentions for older people's mental health services (2009 – 2012). This document included a commitment to the development of services for people with dementia and their carers.

This strategy builds on the priority intentions outlined in *A Future for All* and aims to ensure that our strategic objectives and commissioning intentions are underpinned by a robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment and Local Area Agreement. The priorities identified in these documents include:

- Reducing health inequalities

- Early intervention and prevention for people with long term conditions
- Improving outcomes for people with dementia
- Focusing on healthy lifestyles and improved cardiovascular health
- Improving access to health and wellbeing information
- Giving people increased choice and control
- Maximising independence and enabling people to remain in their own homes for as long as possible
- Strengthening the Voluntary and Community Sector and developing their capacity to deliver services.

Enfield is also developing a number of other joint commissioning strategies that will sit alongside the dementia strategy and will contribute to achieving the strategic objectives outlined in Section 6 of this strategy. They include:

- Prevention and Early Intervention
- End of Life Care
- Intermediate Care and Re-ablement
- Carers
- Mental Health; and
- Accommodation

All of the strategies are being developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First*. This is an ambitious work programme to transform local services and will make a significant contribution to achieving the strategic objectives for dementia set out in this strategy. It includes a commitment to:

- Local authority leadership accompanied by authentic partnership working with NHS Enfield, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers
- Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:
    - live independently;
    - stay healthy and recover quickly from illness;
    - exercise maximum control over their own life and, where appropriate, the lives of their family members;
    - sustain a family unit which avoids children being required to take on inappropriate caring roles;
    - participate as active and equal citizens, both economically and socially;
    - have the best possible quality of life, irrespective of illness or disability;
    - retain maximum dignity and respect
- System-wide transformation, developed and owned by local partners covering the following objectives:

- Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users.
- Universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding.
- A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
- Person centred planning and self directed support to become mainstream and define individually tailored support packages.
- Telecare to be viewed as integral not marginal.
- Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision.
- Direct payments utilised by increasing numbers of people, as defined by our Local Area Agreement targets.
- Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
- Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.
- Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors.

The NHS Enfield Operating Plan for 2009/2010 notes the need to work towards implementation of the National Dementia Strategy. NHS Enfield has also adopted a ten year Primary Care Strategy in 2009 which aims to increase the range of services available in the community, and locate these services together. Existing GPs will be grouped together in upgraded premises with the aim of achieving better outcomes and improving patient choice. The establishment of service hubs and the range of services available are currently being worked up[4] within the Coalition Government's outline Programme. Services for people with dementia should be advanced within this model, allowing for greater multi-disciplinary contact, awareness raising and sharing of evidence that will support early diagnosis and support.

Finally, NHS Barnet, Enfield and Haringey have developed a joint commissioning strategy for Adult Mental Health Services (2009 – 2014). This

[4] Current at May 2010

strategy recognises a number of common issues regarding the delivery of dementia services across the 3 boroughs, including:

- The current approach is primarily medically based and there is often a lack of expertise in non-pharmacological approaches
- Social inclusion for people with dementia is not well supported
- The number of referrals back from care homes to acute wards is high

As a result the strategy commits to focusing on:

- Developing person centred care
- Supporting independence through social inclusion and whole systems approaches
- Training for health and social care staff, family members and carers

This strategy builds on the priorities outlined in Barnet, Enfield and Haringey commissioning strategy for Adult Mental Health Services and sets out how we intend to address the issues at a local level. In addition, we have formed a local commissioning forum across the 3 Boroughs to develop collaborative approaches, share best practice and explore the opportunities for joint commissioning. One of the areas that the 3 Borough forum will focus on initially is the commissioning of services for younger people with dementia and the opportunities for developing a joint approach to this.

Research

There is considerable evidence to support good practice in dementia care. Some of the key research findings that have informed the development of this strategy are summarised below:

- Early diagnosis and interventions for dementia is cost-effective and improves the quality of life of people with dementia and their carers (Department of Health 2007)[5]

- Only around 30% of people with dementia have a formal diagnosis made, or contact with specialist service at any time in their illness (National Audit Office 2007)[6]

- Providing people with diagnosis, decreases their level of anxiety and depression. (Carpenter *et al* 2008)[7]

- Early diagnosis and intervention have positive effects on the quality of life of people with dementia (Banerjee *et al.* 2007)[8]

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[5] Department of Health, Transforming the Quality of Dementia Care – Appendix 4, the Clinical and Health Economic Case for Early Diagnosis and Intervention Services in Dementia (2008)

[6] National Audit Office (2007). *Improving services and support for people with dementia*. London: TSO.

[7] Carpenter, BD, Xiong, C, Porensky, EK, Lee, MM, Brown, PJ, Coats, M, Johnson, D and Morris, JC (2008). 'Reaction to a dementia diagnosis in individuals with Alzheimer's disease and mild cognitiveimpairment.' *Journal of the American Geriatrics Society*, 56, 405–12.

- Services that enable early intervention have positive effects on the quality of life of family carers (Mittelman *et al.* 2007)[9]

- People wait up to three years before reporting symptoms of dementia to their doctor. (Alzheimer Society 2002)[10]

- Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer. (Ballard *et al* 2002)[11]

- Early provision of support at home for people with dementia can reduce institutionalisation by 22%. (Gaugler *et al* 2005)[12]

- A brief programme of carer support and counselling at diagnosis alone has been demonstrated to reduce care home placement by 28%. (Mittelman *et al.* 2007)[13]

- People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation but this is not widely appreciated by clinicians, managers or commissioners. (Royal College of Psychiatrists 2005)[14]

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[8] Banerjee, S, Willis, R, Matthews, D, Contell, F, Chan, J and Murray, J (2007). 'Improving the quality of dementia care – an evaluation of the Croydon Memory Service Model.' *International Journal of Geriatric Psychiatry*, 22, 782–8.

[9] Mittelman, MS, Roth, DL, Clay, OJ and Haley, WE (2007). 'Preserving health of Alzheimer caregivers: impact of a spouse caregiver intervention.' *American Journal of Geriatric Psychiatry*, 15, 780–9.

[10] Alzheimer's Society (2002). *Feeling the pulse*. A report for Alzheimer's Awareness Week 2002. London

[11] Ballard, C, Powell, I, James, I, Reichelt, K, Myiut, P et al (2002). 'Can psychiatric liaison reduce
neuroleptic use and reduce health service utilization for dementia patients residing in care facilities.' *International Journal of Geriatric Psychiatry*, 17, 140–45. Turner, S (2005). 'Behavioural symptoms of dementia in residential settings: A selective review of non-pharmacological interventions.' *Aging and Mental Health*, 9 (2), 93–104.

[12] Gaugler, JE, Kane, RL, Kane, RA and Newcomer, R (2005). 'Early Community-Based Service Utilization and Its Effects on Institutionalization in Dementia Caregiving.' *The Gerontologi*st, 45, 177–85.

[13] Mittelman, MS, Roth, DL, Clay, OJ and Haley, WE (2007). 'Preserving health of Alzheimer caregivers: impact of a spouse caregiver intervention.' *American Journal of Geriatric Psychiatry*, 15, 780–9.

[14] Royal College of Psychiatrists (2005). *Who cares wins: Improving the outcome for older people admitted to the general hospital*. London: RCPsych.

A national evidence base on the effectiveness of preventative services is beginning to develop through the Partnership for Older People Projects (POPP). POPP was funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or de
laying their need for higher intensity or institutional care. The evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships. These included pilots focusing on people with dementia.

Consultation

Formal public consultation on the draft dementia strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011.

A total of 37 questionnaires were completed and a further 11 written responses were received; most representing the views of organisations or networks of organisations. In addition, verbal feedback was received at several live consultation meetings.

Over 80% of respondents who completed the questionnaire agreed with the proposed direction that is set out in the strategy.

A number of revisions to the strategy were made as a result of the feedback that was received, including a commitment to allocate additional funding to support the development of increased flexible day opportunities and respite care; and the development of peer support groups for carers. In addition, feedback on the consultation will assist us in setting the priorities for the first year of strategy implementation.

4. Current and Future Demand

Current and future demand for services for people with dementia and their carers has been estimated by undertaking an assessment of the needs of the Enfield population. The assessment of need is based on a balance of national and local data and consists of demography, incidence and prevalence, risk factor data and local and service user data.

What is Dementia?

Dementia is the term used for a range of progressive, terminal organic brain diseases. The symptoms of dementia include:

- Loss of memory – for example, forgetting the way home from the shops, or being unable to remember names and places, or what happened earlier the same day.
- Mood changes – particularly as parts of the brain that control emotion are affected by disease. People with dementia may also feel sad, frightened or angry about what is happening to them.

- Communication problems – a decline in the ability to talk, read and write.

In the later stages of dementia, the person affected will have problems carrying out everyday tasks, and will become increasingly dependent on other people.

There are several diseases and conditions that cause dementia. These include:

- **Alzheimer's disease:** accounts for 62% of dementia in England. It changes the chemistry and structure of the brain, causing the brain cells to die.

- **Vascular dementia**: caused by problems with the supply of oxygen to the brain following stroke or small blood vessel disease and accounts for 30% of dementia. Conditions that blood circulation to the brain, such as hypertension can contribute to vascular dementia.

- **Dementia with Lewy Bodies**: is caused by protein deposits that develop inside nerve cells in the brain and interrupt its normal functioning. It accounts for 4% of dementia.

- **Fronto-temporal dementia:** is a rare form dementia and affects 2% of people with Dementia in England. It often affects the under 65s, affecting their behaviour and personality rather than their memory in the early stages.

Dementia is a terminal condition and people generally live with it for 7–12 years after diagnosis. There are a number of different psychological treatments that can be used to help people cope with the symptoms of dementia and slow down the symptoms. These include cognitive stimulation, behavioural therapy, reality orientation therapy, multi-sensory stimulation and exercise therapy. In addition, medication can be used to treat dementia. The most common medications are acetylcholinesterase inhibitors (AIs) which are widely used to treat Alzheimer's disease. Antipsychotic medication also may also be used in cases where there are severe symptoms of challenging and disruptive behaviour.

Local Needs Assessment

This section highlights key facts from the needs assessment that have informed the development of this strategy (the full needs assessment is included in Appendix 2).

- The number of people aged 65yrs & over living in Enfield is 38,000. This is projected to increase to 40,800 in 5 years and 53,500 in 20 years.
- The number of people aged 85yrs & over living in Enfield is 5,200. This is projected to increase to 5,700 in 5 years and 8,500 in 20 years.

- Enfield has the 8th highest percentage of people aged 65yrs & over in London.
- In 2001, 8.5% of people in Enfield were from Black and Minority Ethnic groups. This is projected to increase to 24% by 2021.
- There are currently 1026 people 65 yrs and over living in a care home. This is projected to increase to 1,113 in 5 years and to 1,537 in 20 years.
- 74% of people with dementia who are receiving social care services are female
- 87.5% of people with dementia who are receiving social care services are over 75 years, and 47% are over 85 years.
- It is estimated that there are approximately 2706 people with late-onset dementia living in Enfield. This is projected to increase to 2978 by 2015; 3446 by 2025; and 3906 by 2030 - an increase of nearly 44% in 20 years.
- Enfield has the 5th highest number of people with late-onset dementia in London (however prevalence rate is the same as the London Average of 7.3%).
- Of the 31 London PCTs, Enfield is ranked amongst the top 12 with the largest number of people with early-onset dementia. It is estimated that there are approximately 64 people with early onset dementia (2007) living in Enfield.
- Early onset dementia is more prevalent among Black and Minority Ethnic groups.[15]
- There is a significantly higher projected increase in late onset dementia among Black and Minority Ethnic groups than in the general population.[16]
- Of the current estimated 2706 people in Enfield with late onset dementia it is estimated that:
    - 1480 have mild dementia
    - 874 have moderate dementia
    - 351 have severe dementia
- Compared to London, Enfield has the:
    - 8th highest prevalence rate for stroke or TIA (mini stroke)
    - 5th highest number of people on the obesity register
    - 7th highest number of smokers
    - 5th highest prevalence rate for hypertension

5. Market Analysis

A market analysis has been undertaken to assist us to build a picture of existing local services and their use, as well as a wider picture of the market and an assessment of current gaps in service availability or performance.

Map of Services

As part of the preparation to inform this strategy a mapping exercise was undertaken to provide a comprehensive understanding of the range of health and social care services that are currently being provided in Enfield for people

[15] Dementia UK 2007 report
[16] London Dementia Needs Assessment

with dementia and their carers. It is an evolving description of services based on our current market intelligence and it is acknowledged that there may be more services that provide support to people with dementia and their carers. As part of the ongoing development of our strategic approach to the commissioning of services we will continue to develop our understanding of the services that people with dementia and their carers are accessing in Enfield. Following is a brief overview of the range of services that are available in Enfield (a detailed map of services is provided in Appendix 3):

Specialist NHS dementia care is primarily provided by Barnet, Enfield and Haringey Mental Health Trust. They provide a memory treatment clinic, in-patient care, day hospital, continuing care, mental health liaison and community mental health teams. Community Psychiatric Nurses support an Alzheimer's Society weekly drop-in session. In patient beds for assessment and long stay, along with day hospital/treatment service is provided at Chase Farm Hospital.

Specialist care is also provided by general practitioners who provide diagnosis and ongoing management. As peoples dementia progresses they may need help at home, for example, domiciliary care and, in the later stages, residential or nursing home care. These services are commissioned by Enfield Council and are provided by both the council and the independent sector. A number of older people are also supported with care packages at home or in Nursing Homes through NHS Continuing Healthcare funding.

People with dementia and their carers also access a wide range of services provided by the third sector, including respite care, day opportunities and information and advice.

General Hospital services are primarily provided by Chase Farm and North Middlesex Hospitals.

New Initiatives:

1. Dementia Demonstrator Pilot

In 2009, Enfield Council, in partnership with the Alzheimer's Society, NHS Enfield and the Barnet , Enfield and Haringey Mental Health Trust were successful in securing funding of £165,000 (over 2 years) from the Department of Health to pilot a new dementia service – the Dementia Demonstrator Pilot.

The new service is being managed by the Alzheimer's Society and provides the following services:

- An introduction call to all people and their carers who have received a diagnosis of dementia
- Sign posting offered for immediate needs and assistance to access services if required.
- The development of a local information pack and fact sheets
- A dedicated helpline

- Adviser 'surgery' appointments offered for face to face meetings if requested.
- Facilitate local connections and access to peer support networks.

The service is run by a dementia advisor, supported by a team of voluntary staff. Funding from the Department of Health is for 2 years only however NHS Enfield and Enfield Council have made a commitment to continue to commission the service if, after evaluation of the pilot, it is shown to be effective and valued.

2. Unique Care Pilot

A pilot based on Practices in Enfield North West is starting in autumn 2010 to better support people with long term conditions in their own homes. People on GPs' Dementia Registers will be included in this pilot which aims to:

- Deliver patient centred coordinated care, a single assessment point and improved quality care
- Reduce unnecessary hospital admissions and excess bed days in the over 65s through extra case management resource
- Identify high risk patients and initiate packages of care by additional Community Matrons and Social Workers to avoid hospital admission, carrying out in-reach services to acute trusts where admissions do occur.

NHS Enfield adopted a ten year Primary Care Strategy[17] in 2009 with the aim of increasing the range of services available in the community, and locating those services together. It is planned that existing GPs will be grouped together in upgraded premises with the aim of achieving better outcomes and improving patient choice. The establishment of service hubs and the range of services available are currently being worked up within the Coalition Government's outline Programme[18]. Services for people with dementia should be advanced within this model, allowing for greater multi-disciplinary contact, awareness raising and sharing of evidence that will support early diagnosis and support.

A review of medicines management in care homes for older people has recently been carried out for the Department of Health. A review by the Care Quality Commission of health services into all care homes is currently in progress[19]. The outcome of these reviews will be taken into account in planning to meet dementia needs and will be used to inform the development of the strategy implementation plan. A Pharmacy Needs Review to be completed by February 2011 is also underway and will assist in our understanding of dementia needs.

[17] Making Enfield Better - NHS Enfield Primary Care Strategy (2009)

[18] Current as at May 2010

[19] Current as at May 2010

Service Quantity

This part of our market analysis aims to identify any known under or over supply of services and comment on current service utilisation, including waiting times.

Acute Trust: Chase Farm & North Middlesex Hospitals

A considerable number of patients are admitted to hospital with a diagnosis of dementia. In 2008/09, Chase Farm and North Middlesex Hospitals admitted 71 people with a primary diagnosis of dementia, of which over 78% were emergency admissions. These admissions utilised 860 bed days. Based on a bed day cost of £223, this equates to over £191,780.

Expanding this analysis to the first three diagnostic positions, there were 420 admissions which utilised 4,856 bed days. Based on a bed day cost of £223, this equates to over £7.8 million.

With the correct model of diagnosis and treatment, it should be possible to reduce the number of costly admissions to hospital thereby freeing up resources to be used more cost effectively.

Primary Care

NHS Enfield has 922 patients on general practice dementia registers. This equates to approximately only 1/3 of the expected numbers based on the estimated current prevalence. Issues impacting upon this may include GPs' caution where screening or diagnosis is difficult at early stages, lack of confidence in outcomes of any intervention, coupled with the perception that responses should be social rather than medically driven.

Of the 922 patients on the dementia register, 850 were eligible for review, and 677 of these patients had their care reviewed in the previous 15 months. The register is largely dependent upon correspondence with secondary care where a primary or additional diagnosis may have been made; GPs' attention is also drawn to those cases where referral may not be appropriate and diagnosis may be based on their clinical judgement and knowledge of the patient. Reviews should involve communication and co-ordination from secondary care and be a face to face review of physical and mental health needs, and include carers' support needs.

Memory Treatment Clinic

The memory treatment clinic in Enfield was set up to provide prescribing and monitoring of anti-dementia medications, working to the current NICE guidelines for monitoring and prescription.

It has never been a diagnostic service; a diagnosis is made in other parts of the mental health services in Enfield, or by other mental health services or neurology services, but all referrals to the memory treatment clinic come from the psychiatric staff within the Enfield Older People's Mental Health Service who are, in effect, monitoring the referrals. This is different to other areas

where memory assessment and treatment services are combined and can therefore lead to some confusion and duplication.

When referrals are accepted, patients are seen four times during the first 6 months, and thereafter every 6 months. For the first 6 months, the medication is prescribed by Mental Health Trust staff; after that, general practitioners take over prescribing. If patients live alone, it is a requirement of their treatment that a care package is instituted to ensure they take the medication. Carers are also seen, inline with NICE guidelines.

New referrals to the Enfield memory treatment clinic:

- Between Jan 2006- Dec 2006 -119
- Between Jan 2007- Dec 2007 - 138
- Between Jan 2008 - Dec 2008 – 160
- Between Jan 2009-Dec 2009-182

The rise in numbers of new referrals is particularly significant as up until October 1st 2007, patients from the Cheshunt/Waltham Cross area of Hertfordshire were seen in the clinic but were transferred out through 2007.

In 2006, using the NICE costing template, Barnet, Enfield and Haringey Mental Health Trust projected that 80 new patients with moderate dementia would be referred to the clinic in 2008. In reality, double these numbers were referred.

In January 2010 there were 455 patients in the memory treatment clinic and 18 on the waiting list. There has been an increase in the waiting time for access to the clinic from 36 days in 2008 to the current waiting time of 12 weeks.

Hospital Mental Health Liaison Service

Specialist Mental Health liaison is provided to general acute hospital wards at Chase Farm by one full time nurse with consultant input.

Continuing Care

Continuing healthcare is fully NHS funded care for patients who are

- physically frail
- have a long term mental illness as a result of a physical change in the brain, for example dementia, or
- need end-of-life (palliative) care

Continuing healthcare is provided in independent sector nursing homes that are part of a London Framework agreement. The framework agreement is intended to improve and standardise the prices paid for care, while maintaining the quality of care.

- Continuing care is also provided in The Oaks and Silver Birches inpatient wards. These wards provide an assessment and continuing care service for older people who are suffering from the effects of a chronic degenerative mental health condition (dementia/cognitive impairment). The wards provide specialist inpatient mental health care where there are significant psychological and behavioural symptoms of dementia.

Social Care

Enfield Council commission and provide a range of social care services for people with dementia and their carers. These include assessment and review, residential and nursing care, support in the home, extra care housing, respite care, support for carers, assistive technology and information and advice.

Key facts on social care activity:

- 125 Mental Health assessments were recorded as dementia (2006/07)
- The number of service users receiving a review increased from 240 in 2005/06 to 480 in 2008/09
- The number of people receiving a service package increased from 260 in 2005/06 to 600 in 2008/09
- Approximately 50% of people who received a service were in a residential or nursing placement.
- Support was provided to 680 carers aged 65+ (2008/09), of these, 137 were caring for people with dementia.
- The number of people with dementia who are receiving social care funded residential or nursing care has increased from 209 in 2005/06 to 343 in 2009/10. This can be broken down as follows:
    - The number of people with dementia living in general nursing care homes has increased from 24 in 2005/06 to 51 in 2009/10.
    - The number of people with dementia living in dementia registered nursing care homes has increased from 7 in 2005/06 to 16 in 2009/10.
    - The number of people with dementia living in general residential care homes has increased from 140 in 2005/06 to 174 in 2009/10.
    - The number of people with dementia living in dementia registered residential care homes has increased from 38 in 2005/06 to 102 in 2009/10.

There are 6 dementia nursing care homes in Enfield with a total capacity of 335 places. A spot check of vacancies as at May 2010 indicated that there were 22 vacancies available, only 1 of these vacancies was with a block contracted provider.

There are 33 residential care providers in Enfield who are registered to provide dementia care. They have a total capacity of 1138 places. A spot check of vacancies as at May 2010 indicated that there were 23 vacancies, of these only 4 were under a block contract.

This would suggest that there is currently an adequate supply of nursing and residential care services for people with dementia in the short term however with the significant predicted increase in the number of people with dementia over the next 20 years this is unlikely to be sufficient in the medium to long term.

Stakeholders have identified an undersupply of services for carers and poor access to good information and support following diagnosis as well as a gap in the provision of respite within nursing care homes.

Service Quality

Care Homes

This section provides information on what we know about the quality of current services.

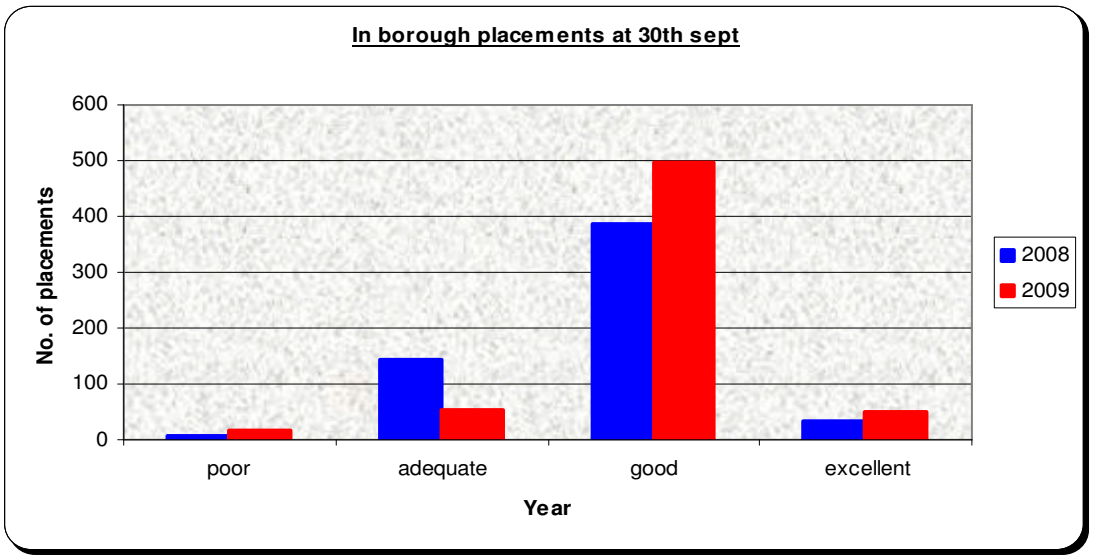
Enfield has 33 residential care homes registered to provide dementia care. Of these 3 are rated as excellent (3 star); 28 are rated as good; and 2 are rated as adequate (1 star).

The Care Quality Commission (CQC) created the 'CRILL' tool (Capturing Regulatory Information at Local Level) to link Councils purchasing data (residential, nursing & domiciliary care) with performance on Key National Minimum Standards (KNMS) by provider establishment. Details of Enfield commissioned services are sent to CQC for analysis. The Commission check the information provided and populate it with information from their database which illustrates a percentage of placements/places in services that meet or exceed 80% of KNMS.

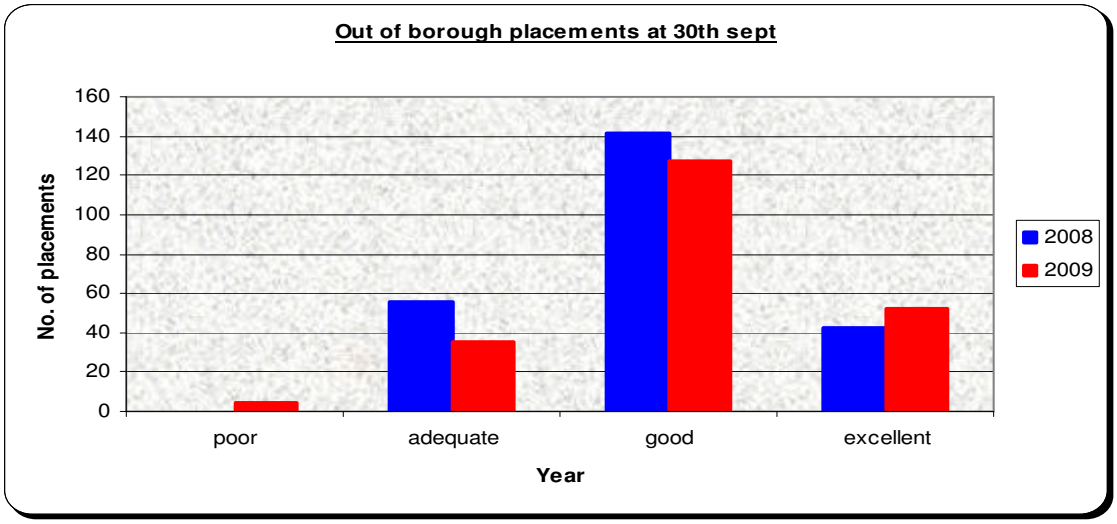
Overall there has been a positive improvement in the quality of residential placements and domiciliary care service provision both available and commissioned in Enfield when comparing 2009/10 with 2008/09. In order to continue to improve quality, Enfield has:

- Introduced quality payments to providers achieving a 3 star rating
- Reduced admissions to poor/adequate providers
- Supported the domiciliary care market through routine monitoring and engagement

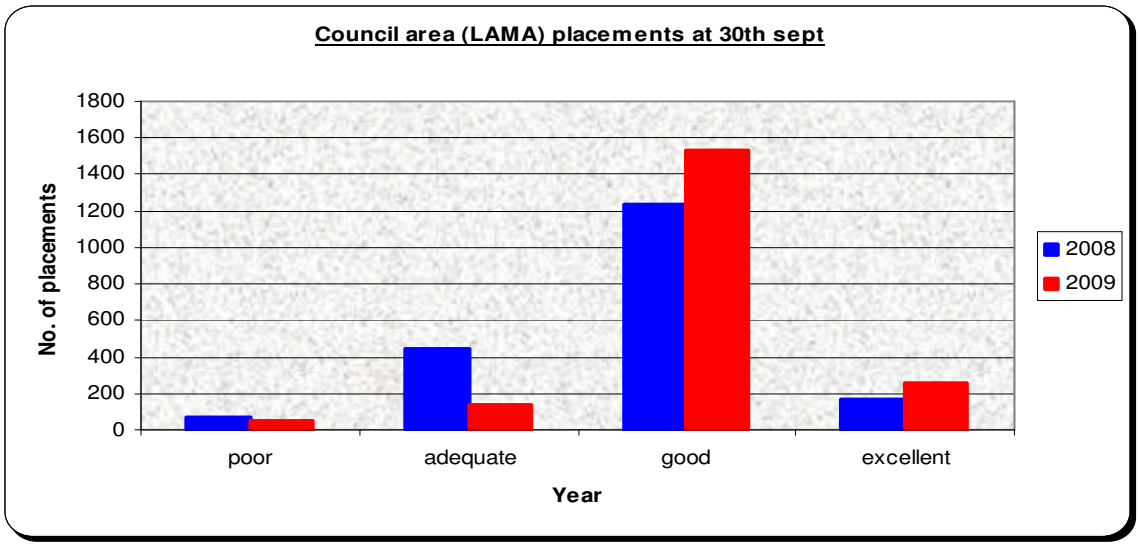
The following 3 graphs show the change in CQC ratings between 2008 and 2009.



The number of in borough placements made by the LA as at 30th September 2009 shows a decrease in the number ranked as adequate, from 25% of all placements in 2008 to 9% in 2009. There has been an increase in the number recorded as Good, from 68% of placements in 2008 to 81% in 2009. Excellent ranked placements in 2008 were 6% of the total; in 2009 they increased to 8%.



For out of borough placements made by the LA the percentage of placements in adequate providers has decreased from 23% in 2008 to 15% in 2009, whilst numbers in good providers have also decreased from 59% in 2008 to 53% in 2009. This is due to the increase in the numbers placed with providers ranked as excellent which have risen from 42 to 52, or 18% in 2008 to 22% in 2009 of all placements.



There has been a large increase in good placements in Enfield, rising from 64% in 2008 to 78% in 2009, similarly numbers in excellent placements have risen from 168 in 2008 to 258 in 2009, an increase from 9% to 13%. Placements in providers ranked as adequate decreased, from 23% in 2008 to 7% in 2009.

All of the 6 nursing care homes in Enfield that are registered to provide dementia care are rated as good (2 star).

Primary Care

Of an estimated prevalence of 2706 people in Enfield with dementia, only 922 are recorded on G.P dementia registers. Issues impacting upon this may include GPs' caution where screening or diagnosis is difficult at early stages, lack of confidence in outcomes of any intervention, coupled with the perception that responses should be social rather than medically driven.

Carers Views

In a recent carers survey, carers of people with dementia said the following regarding their satisfaction with social care services received in the past year:

- 2 were extremely satisfied
- 6 were very satisfied
- 10 said they were fairly satisfied
- 1 was very dissatisfied

(a further 5 either didn't respond or were neither satisfied or dissatisfied)

When asked about the care and support that the person that they cared for received in the past year:

- 17 said it had made things easier for them
- 1 said it had made things more difficult
- 1 said it had made little difference
- 1 said the person they care for received no support but it would have helped if they did

(a further 3 did not respond to this question)

Contracting Arrangements

This section describes the contractual arrangements that are currently in place and any strengths or weaknesses in the arrangements.

Service	Contract type	Strengths	Weaknesses
Domiciliary care	Providers agree to provide services for a fixed fee regardless of volume and agree provision on a stand-by basis.	No waste, services are purchased as and when they are needed.	Unpredictability of placing numbers may discourage providers from investing in services
Residential, nursing and extra care	Block contracts	Simplifies administration – an agreed price for an agreed service Provides value for money due to the volume they are purchased in Stable types of contract that run for an agreed time – this allows provider to invest in their service Can help to manage unpredictability in service demand Costs are guaranteed & known in advance	Inflexible – contract is for a fixed time & service level Not realistic for the future with the increase forecast in the take up of Direct Payments and Individual Budgets. Can create a perverse incentive to fill places in order to secure cheaper rates
Respite, day opportunities and other services provided by the 3rd sector	Grant Funded	Innovation and links to local community	Not market tested for quality or price

Specialist dementia services are commissioned from Barnet, Enfield and Haringey Mental Health Trust within a block contract.

Continuing health care is funded by NHS Enfield through a framework agreement which is designed to improve and standardise the prices paid for care, while maintaining the quality of care.

Finance and Funding

This section is intended to give a picture of the financial resources available now and potentially over the period of the strategy.

The strategy includes a number of commissioning intentions which will require various levels of financial investment. In order to be successful, commitment to implementing this Strategy will require some level of direct and in-direct investments in both people and services by the NHS and Council and other providers of care. The approach that has been taken is an 'invest to save' approach that is premised on the view that if we don't make significant changes to the way services are currently delivered, we will find it increasingly difficult to meet the growing demand for services. As set out earlier in the strategy, the number of people with late onset dementia in Enfield is set to increase by 44% in the next 20 years. It is clear that without changes to the way services are developed, costs will continue to rise significantly putting huge pressure on health and social care budgets.

Through implementation of this strategy we aim to improve the quality of services for people with dementia and their carers, whilst at the same time using resources efficiently and effectively to ensure continued affordability.

Current Funding

There is no comprehensive local data on the current combined health and social care costs of dementia services. People with dementia commonly access a wide range of services provided by the NHS, Enfield Council and a multitude of private and not-for-profit providers. Psychiatric services for dementia are commissioned from Barnet, Enfield and Haringey Mental Health Trust within a block contract, and there is no national "payment-by-results" tariff for costing mental health activities. In addition, as people often do not have a diagnosis of dementia, they may be recorded as accessing services for other reasons.

The Alzheimer Society (2007)[20] found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). The cost varied according to the level of progression of dementia, with further progressed cases requiring more intensive and complex care and thus costing more. The figure provided is an average of people at various stages of their illness.

[20] Alzheimer's Society (2007). *Dementia UK.*

Applying these figures to Enfield would mean that the current cost of late-onset dementia in Enfield is an estimated £68.9 million per year, and by 2030 the annual cost of dementia in Enfield will have increased to over £99.5 million. Whilst these estimates give us an indication of the increasing financial impact of dementia, they should also be treated with caution as they are indicative of service provision, the cost of which differs from borough to borough. In addition, we should not interpret this to mean that the cost of £25,472 per person is optimal – the optimal figure may be more or less than this.

Whilst we acknowledge the need to improve our understanding of current dementia resources, we do know a number of things and these are summarised in the table below:

Service	**Funding 2009/10**
Mental Health services (including dementia) commissioned from Barnet, Enfield and Haringey Mental Health Trust.	£10.5m
Enfield Councils gross spend on older peoples health and social care services.	£56.7m
Adult Social Care spend on services for people with dementia.	£14.1m
Approximately spend on residential care services for people with dementia.	£10.65m
Approximately spend on home care for services for people with dementia.	£2.07m
The cost of day opportunities for people with dementia.	£536k
Direct payments for people with dementia.	£539k
2 years pilot dementia adviser programme.	£165,000

Future funding to support the implementation of the strategy

The Department of Health estimates that it will cost £1.9 billion to implement National Dementia Strategy over 10 years. To support the implementation, £60m of notional additional baseline funding was made available to PCTs nationally for 2009/10 within the overall baseline. No ring fencing has been applied in respect of Dementia, and no actual funds allocated. The NHS Enfield Board holds responsibility for allocation of funds locally, and needs to balance local and national priorities. An additional £90m of notional additional baseline funding will made available to PCTs nationally in 2010/11 within the overall baseline.

The Department of Health expects implementation to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention.

In their report, the National Audit Office[21] concluded that services are not currently delivering value for money. Spending was late with diagnosis, and early intervention was not widely available. Also services in the community are not delivering consistently or cost-effectively to support people to live as independently as possible.

Enfield, like the rest of the UK, is facing a significant rise in its older population. There is a choice to continue with the same modes of treatment, but prepare for an increased volume, or to radically adjust how services are delivered. This latter 'spend to save' option is the preference put forward in the National Dementia Strategy and supported by the NAO and Public Accounts Committee.

[21] Improving Dementia Services in England, National Audit Office (2010)

6. Gap Analysis and Design of Future Provision

The following table sets out our key strategic objectives for the development of local dementia services and our associated commissioning intentions. This is the nub of the strategy and describes what we intend to do to improve services over the next 5 years for people with dementia and their carers.

The strategic objectives and associated commissioning intentions were developed in partnership with key stakeholders. They are aligned with the aims and objectives of the National Dementia Strategy and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA.	Objective 1: Improving public and professional awareness and understanding of dementia.	Advice from local stakeholders that raising awareness and understanding of dementia will encourage people to engage with services earlier; increase early diagnosis and intervention thereby reducing cost by delaying admission to hospital and long term care; reduce prevalence of vascular dementia; and improve quality of life. 3rd sector providers report low referrals from primary care. People currently wait up to 3 years before reporting symptoms of dementia to their doctor.[22] 70% of carers report being unaware of the symptoms of Dementia before diagnosis.[23]	Develop a local awareness and social marketing campaign that supports the planned national awareness campaign by targeting the following groups: • People aged 50 + • Carers of people with dementia • Black and minority ethnic groups • People with learning disabilities and their carers • Major employers whose workforce has significant interaction with the public e.g Police, transport, post office workers etc.

[22] Alzheimer's Society (2002). *Feeling the Pulse*. London: Alzheimer's Society.
[23] Easai Inc/Pfizer (2004). *Facing Dementia Survey*. London: Easai Inc and Pfizer.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		In Enfield the estimated number of people with dementia is approximately 2770 (64 with early onset dementia)[24] however only 922 people are recorded on G.P registers as having a formal diagnosis. A pilot awareness campaign carried out by the Alzheimer's Society in 2007 achieved positive results with 78% of G.Ps believing that such a campaign would lead to people reporting symptoms earlier.[25] The current evidence base suggests that up to 50% of dementia cases may have a vascular component (ie vascular dementia or mixed dementia).[26] We can therefore postulate that improving the cerebrovascular health of our population will lead to a decrease in the prevalence of dementia. The number of people over 65 yrs in Enfield with a BMI of 30 or more is approximately 9,900.[27] This is predicted to increase to 13,707 by 2030. Enfield has the 5th highest number of people (aged 16+) on the obesity register in London and the 7th highest number of smokers in London. These figures give reason to assume that the proportion of people with vascular dementia in Enfield may be even higher	• People living in the more deprived wards of the Borough • People at risk of poor cerebrovascular health • Schools Explore potential to link with existing campaigns and services, for example: • Existing health promotion campaigns • Carers health checks • Health trainers programme • Learning Disability services Address the promotion of healthier lifestyles through exercise and diet through the Prevention strategy. Consult with local employers of public-facing staff to gain advice on how best to develop staff awareness including access to local resources for staff. Include dementia awareness in all

[24] Data source: Healthcare for London Dementia Needs Assessment (2007)
[25] Alzheimer's Society (2008). Worried about your memory. London: Alzheimer's Society.
[26] Living Well: The National Dementia Strategy (DH, 2009)
[27] Data source: POPPI
[28] Improving Dementia Services in England (NAO)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		than regional averages. A May 2009 survey found 28 per cent of people still thought (wrongly) that dementia was a 'natural part of ageing'; and 22 per cent thought (again wrongly) there was no way to reduce the risk of dementia.[28]	induction training for employees within the NHS, Council and partner organisations working with adults and older people. Ensure awareness raising is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to. Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life, and ensure that people with dementia, carers and health and social care professionals are aware of this pathway

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF DEMENTIA	Objective 2: Good-quality early diagnosis and intervention for all.	Research suggests that early identification and treatment of dementia is effective in terms of quality of life and overall cost-effectiveness.[29] The benefits of early diagnosis are recognised by the National Service Framework (NSF): 'If dementia is not diagnosed early, carers can become demoralised due to lack of recognition and support and having to cope with apparently unexplained behavioural changes[30]. Currently only about one-third of people with dementia receive a formal diagnosis at any time in their illness.[31] When diagnoses are made, it is often too late for those suffering from the illness to make choices. Further, diagnoses are often made at a time of crisis; a crisis that could potentially have been avoided if diagnosis had been made earlier. In Enfield only 1/3 of the estimated number of people with dementia are recorded on G.P registers which suggests significant under diagnosis.	Reconfigure the current Memory Treatment Clinic model to enable it to better manage existing and future demand, including the capacity to meet the needs of the growing population of older people with dementia from BME groups. Explore the option of direct referral to the clinic from primary care; and consider the benefits of developing the service to provide assessment and treatment. Cross Borough options for development and remodelling will be explored through the Haringey, Barnet and Enfield Dementia Commissioning Forum. Model the impact of increasing early diagnosis on other services. People diagnosed early are likely to receive pharmaceutical and therapeutic interventions that will help them live active lives for longer therefore reducing hospital admissions and delaying the need for long

[29] Banerjee, Sube and Wittenberg, Raphael (2009) Clinical and cost effectiveness of services for early diagnosis and intervention in dementia. *International journal of geriatric psychiatry*, 24 (7). pp. 748-754. ISSN 0885-6230

[30] National Service Framework, Department of Health (2001)

[31] *Improving services and support for people with dementia.* National Audit Office (2007). London: TSO.

[32] *Transforming the quality of dementia care: consultation on a National Dementia Strategy*, Department of Health (2008)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		The 2007 National Audit Office report *Improving services and support for people with dementia* estimated that re-engineering systems for dementia could yield £6.5 million of acute trust savings per year. The National Dementia Strategy consultation document *Transforming the quality of dementia care*[32] includes an appendix on the clinical and health economic case for early diagnosis and intervention services for people with dementia. The economic case demonstrates how, over 10 years, reductions can be made in admissions to long-term institutional care thus releasing revenue to invest in prevention and early intervention. NICE has published a commissioning guide on memory assessment services which describes the potential benefits of commissioning effective memory assessment services, which include: • Providing a cost effective way of increasing the number of people seen for early diagnosis and intervention; • reducing total care expenditure by delaying the time to nursing home admissions and other costly outcomes; • reducing the stigma of dementia and barriers to recognition and diagnosis; • improving the quality of life of people with dementia and their carers by promoting and maintaining their independence; • reducing inequalities and improving access to appropriate treatment and support;	admissions and delaying the need for long term residential care. However it is likely that pressures will be felt by other parts of the health and social care economy as more people are referred for diagnosis, treatment and support. Establish formal processes to ensure that people who are admitted to hospital with a diagnosis of dementia are notified to the appropriate GP practice to ensure that the patient is placed on the dementia register. Shift resources from the point of crisis to prevention and early intervention services that help people to maintain their independence and prevent or delay the need for high cost care (this will be implemented through the Enfield Prevention Strategy).

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		• increasing patient choice, improving partnership working, patient experience and engagement; and • Achieving better value for money. The local Memory Treatment Clinic is provided by Barnet, Enfield and Haringey Mental Health Trusts. It receives referrals from Older People's Mental Health Services (who provide assessment and diagnosis) and provides prescribing and monitoring of anti dementia medications. This is different to most memory clinic models where assessment and treatment services are combined and referrals are accepted directly from GPs. There is increasing demand for services with new referrals increasing each year and waiting times growing (refer to Section 5: Market Analysis for further details).	
3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE	Objective 6: Improved community personal support services. Objective 7:	Approximately 2/3 of people with dementia are cared for in the community. According to the 2001 census, 4298 people in Enfield aged 65+ were providing informal support. In 2008/09 support was provided to 680 carers aged 65+ (unfortunately we are unable at this stage to identify how many of these were	Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers. Implement *Putting People First*

[33] Dementia UK report
[34] Living well with Demenit: The National Dementia Strategy (2009). Department of Health
[35] Banerjee et al 2003, *Predictors of institutionalisation in people with dementia,* Journal of Neurology, Neurosurgery and Psychiatry 74, 9 1315-1316

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
RESPITE OPTIONS.	Implementing the Carers' Strategy for people with dementia.	caring for people with dementia) The development of more flexible, person centred respite options was identified as a key priority by local stakeholders during workshops to develop this strategy. It is estimated that 53% of people aged over 65 years with 'dependency problems' were supported by unpaid carers only, 34% received both informal and formal care, 9% formal care only and 3% were unsupported.[33] Support for carers can play an important role in reducing admissions to residential care and enabling people with dementia to remain in the community for as long as possible.[34] Co-residence of a carer is a strong predictor of a person with dementia remaining living in the community and avoiding entry to institutional care.[35] The White Paper "Our health, Our care, Our say", the NICE/SCIE guideline and the New Deal for Carers all emphasise the importance of short breaks as part of a spectrum of care to enable people to remain in the community.	personalisation changes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers. Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs. Ensure that the need for respite is an integral part of people's assessment and care package; and that if respite is include in the care package they are able to access flexible respite using Direct Payments. Where the person is entitled to it, they should also be able to access the Independent Living Fund to add to the resources available to fund respite. Ensure that the rights of carers to an assessment of needs are upheld. Engage in discussions with the market regarding their ability to respond to the personalisation agenda in the provision of

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			flexible and responsive respite services. Ensure that the needs of carers of people with dementia are addressed through the Enfield Carers Strategy. Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.
4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.	Objective 6: Improved community personal support services. Objective 10: Considering the potential for	Approximately 2/3 of people with dementia live in their own homes.[36] During workshops to develop this strategy, local stakeholders identified the development of more person centred home care services as a key priority that will significantly contribute to improving outcomes for people with dementia and their carers.	Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible home care services to better meet people's needs. This will include the development of self-directed care and individual budgets to increase individual choice and control over the services that they receive.

[36] Living Well: National Dementia Strategy (DH, 2009)
[37] 35 CSCI (2006). *Time to Care?* London: TSO.
[38] *Evaluation of the Individual Budgets pilot programme* Personal Social Services Research Unit 2008

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
	potential for housing support, housing-related services and telecare to support people with dementia and their carers.	The Commission for Social Care Inspection (CSCI) has found that good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.[37] The evidence so far shows that older people are least likely to make use of the opportunities afforded by personal budgets.[38] The number of people in Enfield aged 45+ who have a learning disability is 2345. This is projected to increase by 26% by 2030. People who have learning difficulties have a higher prevalence of dementia compared with the general population. 20% of people with a learning disability aged 65 years and over will develop dementia. About 20 per cent of people with learning difficulties have Down's syndrome, and people with Down's syndrome are at particular risk of developing early onset dementia.	Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams. Invest in assistive technology to support people to remain in their own homes. Ensure that Enfield's Supporting People Programme offers appropriate housing related support to people with dementia. Commission a range of housing options that better meet the specialist needs of people with learning difficulties and dementia. Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their well being. These services will be appropriate for people at different stages of the disease.

http://www.pssru.ac.uk/pdf/IBSEN.pdf

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			Commission training for carers on caring for someone with dementia.
5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Objective 13: An informed and effective workforce for people with dementia.	Among those aged 65+ living in Nursing Homes, the estimated prevalence of dementia is 66% & 50% in residential care homes.[39] A third of care homes specialising in dementia do not adequately train staff according to a Laing Buisson's market survey of UK care homes[40]. 30 Enfield providers of residential care are registered to provide dementia (EMI) care. Of these, CQC rate 10 as adequate,18 as good, and 2 as excellent. Research carried out by MacDonald et al (2003)[41] suggests that most cognitive impairment in non-specialist nursing homes appeared to be unrecognised.	The Department of Health has commissioned Skills for Care and Skills for Health to map the training needs of the workforce and the training currently available across all sectors, identifying the gaps. The mapping exercise will conclude in March 2010 and make recommendations to inform the Department's workforce action plan. Following development of the national action plan, we will develop a local dementia workforce plan that links to, and complements, the identified national workforce development initiatives.

[39] Dementia UK report
[40] Care of Elderly People UK Market Survey 2009. Laing Buisson.

[41] The recognition of dementia in 'non EMI' nursing home residents in South East England. MacDonald, A.J.D. and Carpenter, G.I. (2003) *The recognition of dementia in 'non EMI' nursing home residents in South East England.* International Journal of Geriatric Psychiatry, 18 (2). pp. 105-108. ISSN 0885-6230 .

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		Only 31% of GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia, a decrease since the same question was asked in for the Forget Me Not report11 eight years ago.[42] Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer. (Ballard et al 2002)[43] The need for improved training is a priority that runs across all themes in the National Strategy and was highlighted by local stakeholders as a priority area for development.	We will ensure that all commissioned services include service specifications that specify dementia training and core competencies that include, but are not limited to, the national minimum standards. We will ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams. All community based health and social care staff will receive core training in dementia.

[42] Living Well with Dementia: A national Dementia Strategy (DH 2009)

[43] Ballard, C, Powell, I, James, I, Reichelt, K, Myiut, P et al (2002). 'Can psychiatric liaison reduce neuroleptic use and reduce health service utilization for dementia patients residing in care facilities.' *International Journal of Geriatric Psychiatry*, 17, 140–45. Turner, S (2005). 'Behavioural symptoms of dementia in residential settings: A selective review of non-pharmacological interventions.' *Aging and Mental Health*, 9 (2), 93–104.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS	Objective 3: Good-quality information for those with diagnosed dementia and their carers. Objective 4: Enabling easy access to care, support and advice following diagnosis. Objective 5: Development of structured peer support and learning networks.	Better access to information is a key component that has been identified in local stakeholder events. Approximately half of the carers of people with dementia who responded to the recent carers survey said that they would like more information. The need for a key contact who can provide ongoing advice and support for people who are stable and have been therefore been discharged from health and social care services has been identified as a key priority in discussions with local stakeholders.	Undertake an evaluation of the Enfield Dementia Demonstrator Pilot programme for dementia advice in order to inform future commissioning decisions regarding this service. Ensure that dementia information materials and resources are available for all people with dementia and their carers. Ensure that the needs of carers of people with dementia for support and advice are included in the Enfield Carers Strategy.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY	Objective 8: Improved quality of care for people with dementia in general hospitals. Objective 9: Improved intermediate care for people with dementia.	Of 202 new residential & nursing home admissions In Enfield in 09/10, 126 (or 62%) came directly from hospital. There is currently no specialist dementia assessment ward therefore people with dementia are assessed in general medical wards which may not be conducive to conducting accurate assessment due to the chaotic and challenging environment. A considerable number of patients are admitted to hospital with a diagnosis of dementia. In Enfield in 2008/09, there were 420 admissions with a diagnosis of dementia. These admissions utilised 4856 bed days which equates to a cost of over £7.8m. Up to 70% of acute hospital beds are currently occupied by older people and up to a half of these may be people with cognitive impairment, including those with dementia and delirium. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation[44]. There is minimal mental health input to Enfields current Intermediate Care Service (1 specialist mental health nurse in hospital discharge team). Updated DH guidance for Intermediate Care recommends	Hospital Mental Health Liaison Service: Collate and analyse current data and review existing model of service provision in order to develop an 'invest to save' business case for expanding the role of the current liaison service. This would include exploring the benefits of expanding the service to include responsibility for general hospital staff dementia training and education. Ensure that people with dementia are able to access Intermediate care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff. In addition we will increase the capacity of Intermediate Care to provide in reach to care homes in order to reduce hospital admissions. (To be implemented as part of the Intermediate Care Strategy). Review the appropriateness of current arrangements for assessing people with dementia in general hospitals, including appropriateness of current assessment

[44] Living Well with Dementia: A national Dementia Strategy (DH 2009)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		that: - All older people at risk of entering care homes should be able to access Intermediate Care - No one should be directly transferred from an acute ward to long term residential care (unless exceptional circumstances) - Intermediate care should be able to meet the needs of people with dementia or mental health needs.	environment. Implement and evaluate the Unique Care Pilot described in Section 5. Agree local targets for a reduction in inpatient admissions and length of stay and increase in the number of patients on dementia registers. Review the quality, range and provision of services for people who require continuing healthcare.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED		Early-onset dementia (dementia that affects people aged under 65) affects approximately 1 in 40 people in England. Enfield had between 46.2 and 47.7 people per 100,000 with early-onset dementia in 2007. Of the 31 London PCTs, this ranks Enfield amongst the top 12 with the largest number of people with early-onset dementia. The actual number of people with early-onset dementia in 2007 was 64. This is a prevalence rate of 1.6% of the population of people aged 30 years and over in Enfield which is higher than the London average of 1.4%. The number of people in Enfield aged 45+ who have a learning disability is 2345. This is projected to increase by 26% by 2030. About 20 per cent of people with a learning disability have Down's syndrome, and people with Down's syndrome are at particular risk of developing early onset dementia.	Ensure that health and social care staff working with people with learning disabilities and other younger people at risk of dementia receive training in dementia awareness. Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia. Explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey. This will be taken forward by the newly formed 3 Borough Dementia Commissioning Group.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS	Objective 11: Living well with dementia in care homes. Objective 8: Improved quality of care for people with dementia in general hospitals.	An independent review which had been commissioned by the Department of Health reported in November 2009 that up to 150,000 people with dementia are inappropriately prescribed anti-psychotic drugs, contrary to clinical guidelines. This may contribute to 1,800 additional deaths each year. The Department set out an action plan to reduce the use of these drugs, including an audit to establish definitive prescribing figures for each PCT. The key recommendation for PCTs is to commission from local specialist older people's mental health services an in-reach service that supports primary care in its work in care homes. This extension of service needs the capacity to work routinely in all care homes where there may be people with dementia and may be aided by regular pharmacist input into homes. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.[45] The NAO has estimated the excess cost to be more than £6 million per year in an average general hospital.[46] Stays in acute general hospital affect people with dementia badly – increasing their confusion and speeding up deterioration.	We will commission our specialist older peoples mental health team to provide in-reach service to support primary care in its work in care homes. We will commission primary care and pharmacy in reach services to ensure more appropriate use of anti-psychotic medication. We will ensure distribution, promotion and implementation of the 'good practice resource pack' that is being developed by the National Dementia Strategy Implementation Team. We will enter into collaborative partnerships with care home providers to encourage the development of local leaders who can demonstrate excellence in provision of services. Identify a senior clinician within Chase Farm Acute Trust to take the lead for quality improvement and training in dementia care in hospital.

[45] 38 Royal College of Psychiatrists (2005). *Who Cares Wins: Improving the outcome for older people admitted to the general hospital*. London: RCPsych.
[46] NAO (2007). *Improving services and support for people with dementia*. London: TSO.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			Review the current care pathway for the management and care of people with dementia in hospital, led by that senior clinician. Explore the potential use of the commissioning for quality and innovation (CQUIN) payment framework, to incentivise general hospital providers to improve quality and innovation.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA	Objective 12: Improved end of life care for people with dementia.	For a given disorder, people with dementia have 4–6 times the mortality than the cognitively intact. There is strong evidence to suggest that people with dementia receive poorer end of life care than those who are cognitively intact in terms of provision of palliative care. For example, few people with dementia have access to hospice care.[47] End of life planning needs to take place whilst the person still has the capacity to make decisions about their end of life care and where these decisions can be recorded.	Ensure people with dementia have the same access to palliative care services as others. Ensure that end of life care is included in the local pathway for dementia and is consistent with the Gold Standard Framework as identified by the National End of Life Care Strategy. Continue quality payments to care homes that achieve the Gold Standard for End of Life Care. Commission a Gold Standard Framework Facilitator to work with care homes to assist them to implement the Gold Standard Framework. Continue to raise awareness of the Mental Capacity Act among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so. Enable people with dementia and their

[47] Living Well with Dementia: A national Dementia Strategy (DH 2009)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			carers the opportunity and support to discuss and document advance care plans. Ensure that care home staff are trained and supported so that they feel more confident in adhering to advance care plans.
11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS	Objective 14: A joint commissioning strategy for dementia.	Early-onset dementia is more common amongst black and minority ethnic groups with 6.1% of all people with early-onset dementia being from black and minority ethnic groups compared with 2.2% of all groups.[48] This may be due to some groups that are more prone to hypertension and cardiovascular disease. Number of people with dementia in black and minority ethnic groups is set to rise sharply. In Enfield it is projected that 642 people from black and minority ethnic groups will have late-onset dementia by 2021 compared to an estimate of 231 people in 2001. This is a 178% increase which is higher than the London average of 123%.[49] These significant projected	Review current service provision to assess whether it is meeting the needs of Black and Minority Ethnic groups. Engage with the Black and Minority Ethnic community to gain a better understanding of their needs and current gaps in service provision. Ensure that the needs of Black and Minority Ethnic groups are taken into account during the implementation of all strategic objectives.

[48] *Dementia UK 2007 report*

[49] *London Dementia needs assessment*

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		increases are due to first generation migrants from the 1950's to the 1970's reaching the age groups most at risk of dementia.	

7. Implementation and Monitoring Arrangements

The implementation and monitoring of the strategy will be overseen by the Older Peoples Mental Health Group, which is a sub-group of the Older Peoples Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[50]).

A detailed 5 year implementation plan will be developed in partnership with NHS Enfield; the Local Borough of Enfield; Barnet, Enfield and Haringey Mental Health Trust and key local stakeholders. This will be agreed by the Older Peoples Mental Health Group who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Local Borough of Enfield will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older Peoples Mental Health group.

The Older Peoples Mental Health Group will also have a lead role in the development of a communication and engagement plan that will set out:

- how implementation of the strategy will be communicated to key stakeholders and members of the public; and
- how stakeholders will be engaged throughout the implementation.

[50] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

Appendix 1: National Policy Context

Forget Me Not: In 2000 the Audit Commission published its *Forget Me Not* report; key findings included:

- Only one half of general practitioners (GPs) believed it important to look actively for signs of dementia and to make an early diagnosis.
- Less than one half of GPs felt that they had received sufficient training.
- There was a lack of clear information, counselling, advocacy and support for people with dementia and their family carers.
- There was insufficient supply of specialist home care.
- Poor assessments and treatment with little joint health and social care planning and working.

They found little improvement when reviewing change two years later.

National Service Framework for Older People(2001) (NSF): Describes eight standards for improvement in services to older people including a specific standard on mental health in older people which aims to promote good mental health and to treat and support those older people with dementia and depression. The NSF advocates early diagnosis and intervention and recommends that the NHS and local councils should review arrangements for health promotion, early detection and diagnosis, assessment, care and treatment planning, and access to specialist services.

Who Cares Wins (2005): This report was published by the Royal College of Psychiatrists and highlights the neglected clinical problem of mental disorder affecting older people admitted to general hospitals. Based on evidence from pilots and the success of liaison psychiatry for adults under 65 years old, it calls for the development of specialist mental health liaison services for older people.

Everybody's Business – Integrated mental health services for older adults: a service development guide (2005): This guide sets out the essentials for a service that works for older people's mental health in general, including memory assessment services to enable the early diagnosis of dementia for all and integrated community mental teams whose role includes the management of people with dementia with complex behavioural and psychological symptoms.

NICE/SCIE Clinical Guideline (2006)**:** This guideline recommends several key areas that should be developed in order to improve services for people with dementia and their carers. Recommendations include:

- integrated working across all agencies;
- provision of memory assessment services as a point of referral for diagnosis of dementia;
- assessment, support and treatment (where needed) for carers;
- assessment and treatment of non-cognitive symptoms and behaviour that challenges;
- dementia-care training for all staff working with older people; and

- improvement of care for people with dementia in general hospitals.

Dementia UK Report (2007): Published by the Alzheimer's Society, recommends making dementia an explicit national health and social care priority, and improving the quality of services provided for people with dementia and their carers.

The National Audit Office value for money study (2007): This report was critical about the quality of care received by people with dementia and their families. It found that the size and availability of specialist community mental health teams was extremely variable, and that confidence of GPs in spotting the symptoms of dementia was poor and lower than it had been in 2000. They also commented on deficiencies in carer support. The report concluded that overall services are not currently delivering value for money to taxpayers or people with dementia and their families; that spending is late – too few people are being diagnosed or being diagnosed early enough; and that early intervention is needed to improve quality of life. Finally it concluded that services in the community, care homes and at the end of life are not delivering consistently or cost effectively against the objective of supporting people to live independently as long as possible in the place of their choosing. The NAO advocated a 'spend to save' approach, with upfront investment in services for early diagnosis and intervention, and improved specialist services, community services and care in general hospitals resulting in long-term cost savings from prevention of transition into care homes and decreased hospital stay length.

Public Accounts Committee report (2007):
The National Audit Office report was submitted for consideration by the House of Commons Public Accounts Committee (PAC), and at the committee's public hearing on 15 October 2007 the NHS Chief Executive and others from the Department of Health were questioned on the NAO's criticisms and recommendations. As is normal practice, following the hearing the PAC subsequently published its own report on dementia services in January 2008. The Committee's comments and recommendations (available at www.publications.parliament.uk/pa/cm200708/cmselect/cmpubacc/228/22802.htm) were consistent with those of the NAO report and with earlier reports on the changes that were needed.

The Government's response to the PAC report is available at www.official-documents.gov. uk/document/cm73/7323/7323.pdf. The response accepted virtually all the conclusions and recommendations of the Committee, emphasising that their findings would be fully addressed in the National Dementia Strategy

The Carers' Strategy (2008):
Half a million family members who care for people with dementia provide over £6 billion a year of unpaid care. A far-reaching consultation of carers contributed to the development of the Carers' Strategy and its implementation will ensure a 10-year plan that builds on the support for carers and enables them to have a life outside caring.

The End of Life Strategy (2008):
This strategy highlights the fact that end of life care for people with dementia is an under-developed area and recommends it be given specific attention.

Updated Intermediate Care Guidance (2009):
This guidance builds on the 2001 guidance on intermediate care and recommends renewed emphasis on those at risk of admission to residential care and inclusion of people with dementia.

Appendix 2: Dementia: Joint Needs Assessment

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Population Projections

Table 1:Population aged 65 and over, in five year age bands, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69	10,300	12,100	11,500	13,700	16,100
People aged 70-74	9,400	9,000	10,700	10,200	12,200
People aged 75-79	7,600	8,100	7,800	9,300	9,000
People aged 80-84	5,500	5,900	6,500	6,400	7,700
Total population 65 and over	**38,000**	**40,800**	**43,000**	**47,200**	**53,500**

Data Source:POPPI

There is a projected 41% population increase by 2030. The largest increase will be in the 65-69 bracket (56% increase).

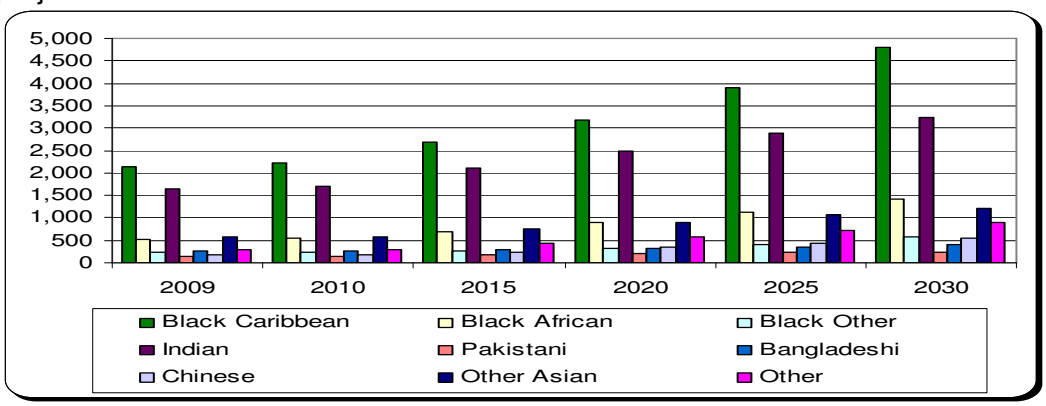
Table 2:Population aged 65 and over, in five year age bands, by gender, projected to 2030

	2009	2015	2020	2025	2030
Males aged 65-69	4,900	5,700	5,500	6,800	8,100
Males aged 70-74	4,500	4,200	5,000	4,800	6,000
Males aged 75-79	3,400	3,700	3,600	4,300	4,200
Males aged 80-84	2,200	2,600	2,900	2,800	3,400
Males aged 85 and over	1,700	2,200	2,700	3,300	3,800
Total males 65 and over	**16,700**	**18,400**	**19,700**	**22,000**	**25,500**
Females aged 65-69	5,400	6,400	6,000	6,900	8,000
Females aged 70-74	5,000	4,800	5,700	5,400	6,200
Females aged 75-79	4,200	4,300	4,200	5,100	4,800
Females aged 80-84	3,300	3,300	3,600	3,600	4,300
Females aged 85 and over	3,500	3,500	3,700	4,300	4,700
Total females 65 and over	**21,400**	**22,300**	**23,200**	**25,300**	**28,000**

Data Source:POPPI

In 2009 the male/female split is 44% male 56% female. It is projected that there will be a slightly higher proportion of males by 2030 (48%).

Figure 1: BME Population projections aged 65 and over, in five year age bands, projected to 2030



Data Source:GLA

The highest population increases are Black Caribbean (6% in 2009 to 11% in 2030) and Indian (4% in 2009 to 7% in 2030). The White population is projected to decrease from 84% to 71%.
8.5% of the 2001 Enfield PCT population of people aged 65+ was BME. It is projected that this will increase to 23.7% by 2021[1].

1 *This is from the Healthcare for London Dementia Needs Assessment*

Table 4: Population aged 45 and over, in five year age bands to 2030, projected to have a learning disability

	2009	2015	2020	2025	2030
People aged 45-54 predicted to have a learning disability	924	1,048	1,012	956	972
People aged 55-64 predicted to have a learning disability	635	689	813	883	858
People aged 65-74 predicted to have a learning disability	427	454	482	515	610
People aged 75-84 predicted to have a learning disability	261	280	287	318	339
People aged 85 and over predicted to have a learning disability	98	109	125	148	167
Total population aged 45 and over predicted to have a learning disability	**2345**	**2580**	**2719**	**2820**	**2946**

Data Source:POPPI & PANSI

The Enfield population of people aged 45+ is projected to increase by 25.6% by 2030.
The age bracket with the largest percentage increase in population is the 85+ group. This is projected to increase by 70%. In actual numbers the 55-64 age group will increase the most (223 increase in people).

Accommodation Status Projections

Table 5: Numbers of population aged 65 and over, in five year age bands, by gender and living alone, projected to 2030

	2009	2015	2020	2025	2030
Males aged 65-74 predicted to live alone	1,880	1,980	2,100	2,320	2,820
Males aged 75 and over predicted to live alone	2,482	2,890	3,128	3,536	3,876
Females aged 65-74 predicted to live alone	3,120	3,360	3,510	3,690	4,260
Females aged 75 and over predicted to live alone	6,710	6,771	7,015	7,930	8,418
Total population aged 65-74 predicted to live alone	**5,000**	**5,340**	**5,610**	**6,010**	**7,080**
Total population aged 75 and over predicted to live alone	**9,192**	**9,661**	**10,143**	**11,466**	**12,294**

Data Source:POPPI

In 2030 19,374 people are predicted to be living alone compared to 14,192 in 2009. Though this is a 36.5% increase in the number of people predicted to be living alone, as a percentage of the projected population this is actually a slight decrease in the proportion of the projected population living alone. In 2009 it is predicted that 37% of

the total 65+ population lives alone compared to 36% of the total 65+ population in 2030.

Table 6: Percentage of population aged 65 and over, in five year age bands, by gender and living alone, projected to 2030

	2009	2015	2020	2025	2030
%age of Males aged 65 and over predicted to live alone of total 65+ population	30.7%	32.5%	33.2%	33.5%	34.6%
%age of Females aged 65 and over predicted to live alone of total 65+ population	69.3%	67.5%	66.8%	66.5%	65.4%

Table 6 indicates that a higher proportion of the 65+ population will be male by 2030. Life expectancy in Enfield is 77.9 for males and 81.9 for females[2.] This is higher than the England average (77.3).

[2] *This is from the JSNA Dec 2008*

Table 7: Numbers of population aged 65 and over, in five year age bands, living in a care home, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 living in a LA care home with or without nursing	7	8	8	9	10
People aged 75-84 living in a LA care home with or without nursing	35	37	38	42	45
People aged 85 and over living in a LA care home with or without nursing	56	61	70	81	91
People aged 65-74 living in a non LA care home with or without nursing	100	107	113	122	144
People aged 75-84 living in a non LA care home with or without nursing	295	315	322	354	376
People aged 85 and over living in a non LA care home with or without nursing	533	584	666	778	871
Total population aged 65 and over living in a care home with or without nursing	**1,026**	**1,113**	**1,217**	**1,386**	**1,537**

Data Source:POPPI

It is projected that 511 more people aged 65+ will be in a care home in Enfield by 2030. The 2009 population projection of people living in a care home is 2.7% of the total population. By 2030 it is projected that 2.9% of the total 65+ Enfield population will be living in a care home.

Health Projections

Table 8: Numbers of population aged 65 and over, in five year age bands, predicted to have a longstanding health condition caused by a stroke, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 predicted to have a longstanding health condition caused by a stroke	388	412	434	472	565
People aged 75 and over predicted to have a longstanding health condition caused by a stroke	486	534	568	642	695
Total population aged 65 and over	**874**	**946**	**1,003**	**1,115**	**1,261**

predicted to have a longstanding health condition caused by a stroke					

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 387 people with a longstanding health condition caused by stroke.

In 2008/09 3351 people within Enfield PCT were on the Stroke or TIA (Transient Ischaemic Attack) register which is a 1.1% prevalence of these conditions[3]. Enfield has the 8th highest prevalence rate for stroke or TIA in London.

[3] *This information is taken from the 2008/09 QoF and is all ages. The prevalence rate is calculated by the number of people on the register divided by the number of people registered with a GP.*

Table 9: Numbers of population aged 65 and over, in five year age bands, predicted to have a longstanding health condition caused by a heart attack, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 predicted to have a longstanding health condition caused by a heart attack	881	935	987	1,074	1,286
People aged 75 and over predicted to have a longstanding health condition caused by a heart attack	977	1,051	1,111	1,256	1,354
Total population aged 65 and over predicted to have a longstanding health condition caused by a heart attack	**1,859**	**1,985**	**2,098**	**2,330**	**2,639**

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 780 people with a longstanding health condition caused by a heart attack.

In 2008/09 1615 people within Enfield PCT were on the Heart Failure register which is a 0.5% prevalence of these conditions[2] and 37952 people (all ages) were on the GP's hypertension register which is a prevalence of 12.7%. Enfield has the 5th highest prevalence rate for hypertension in London - the London average is 10.8%.

Table 10: Numbers of population aged 65 and over, in five year age bands, predicted to have a BMI of 30 and more, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69 with a BMI of 30 or more	3,252	3,822	3,630	4,317	5,070
People aged 70-74 with a BMI of 30 or more	2,715	2,574	3,060	2,916	3,480
People aged 75-79 with a BMI of 30 or more	1,932	2,024	1,974	2,382	2,274

People aged 80-84 with a BMI of 30 or more	1,166	1,234	1,357	1,340	1,610
People aged 85 and over with a BMI of 30 or more	835	885	973	1,147	1,273
Total people aged 65 and over with a BMI of 30 or more	**9,900**	**10,539**	**10,994**	**12,102**	**13,707**

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 3807 people with a BMI of 30 or more. Though this is a 38.5% increase in the number of people predicted to be obese by 2030, as a percentage of the projected population this is actually a slight decrease in the proportion of the projected population with a BMI of 30 or more. In 2009 it is predicted that 26% of the total 65+population has a BMI of 30 or more compared to 25.6% of the total 65+ population in 2030.

The highest proportion of the 65+ population with a BMI of 30+ is the 65-69 age band (approx 35%). The 85+ age band has the lowest numbers of people predicted to have a BMI of 30+ (approx 9%).
Enfield has the 5th highest number of people (aged 16+) on the obesity register in London.

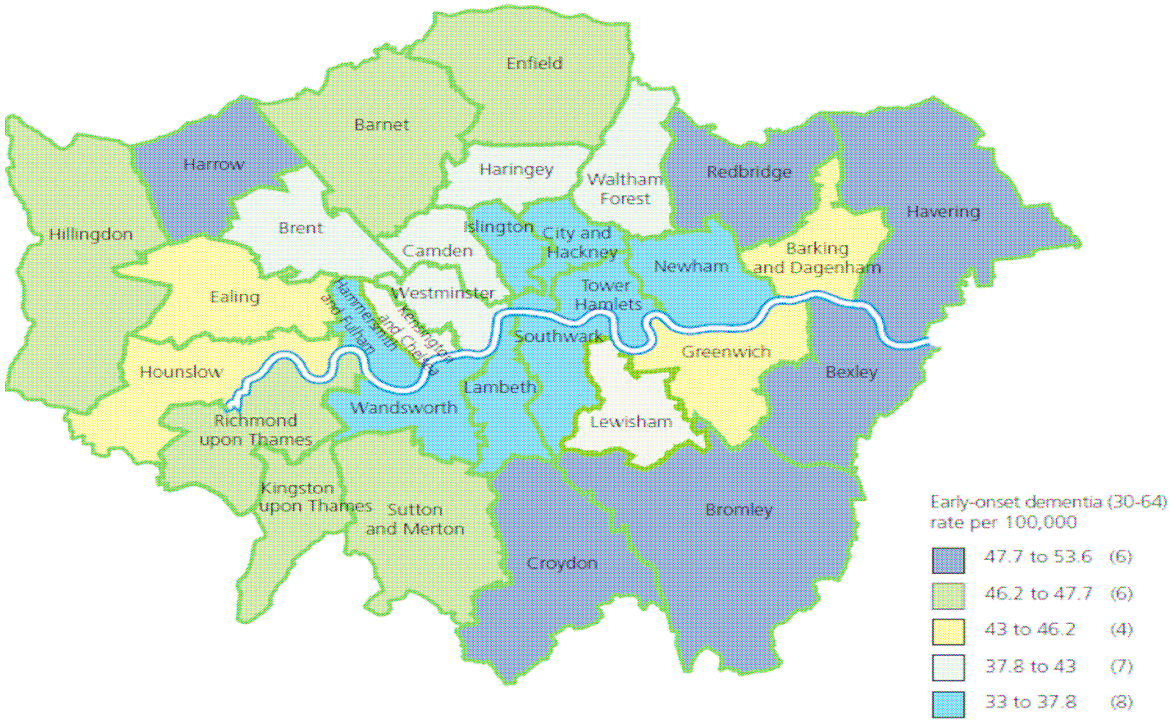
Enfield has the 7th highest number of smokers (who are registered with a GP) in London.

Current Early-Onset Dementia Prevalence Rates

Early-onset dementia (dementia that affects people aged under 65) affects approximately 1 in 40 people in England. Enfield had between 46.2 and 47.7 people per 100,000 with early-onset dementia in 2007. Of the 31 London PCT's, this ranks Enfield amongst the top 12 with the largest amount of people with early-onset dementia.

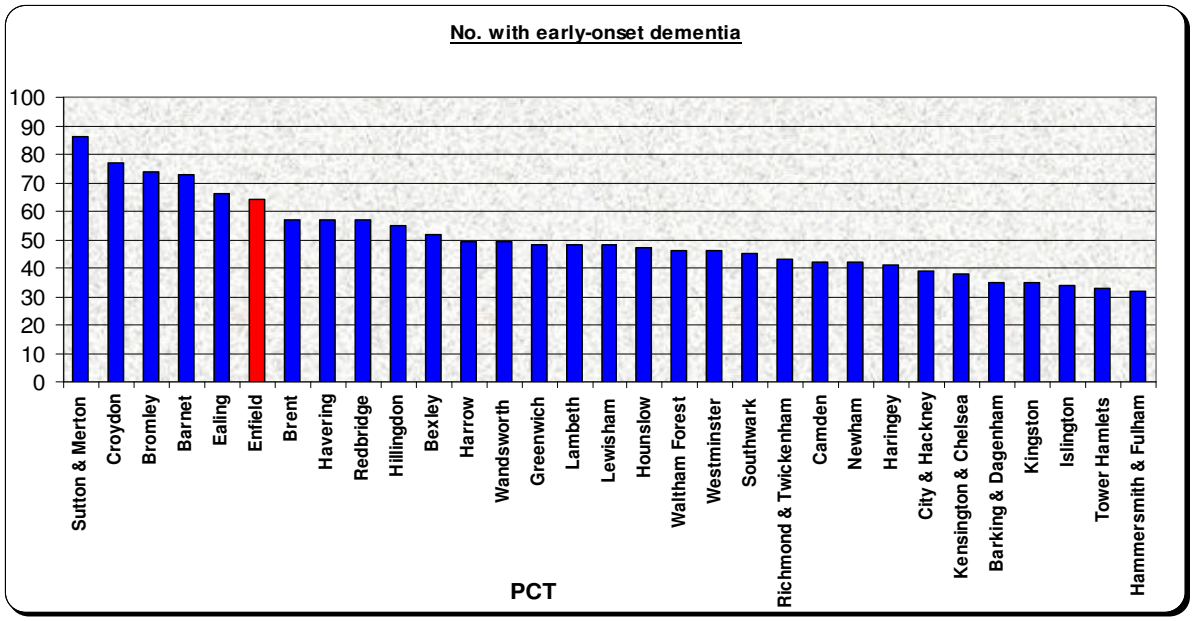
The actual number of people with early-onset dementia in 2007 was 64.

Figure 2: Estimated prevalence of early-onset dementia by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 3: Number of people aged 30-64 with early-onset dementia by PCT, 2007



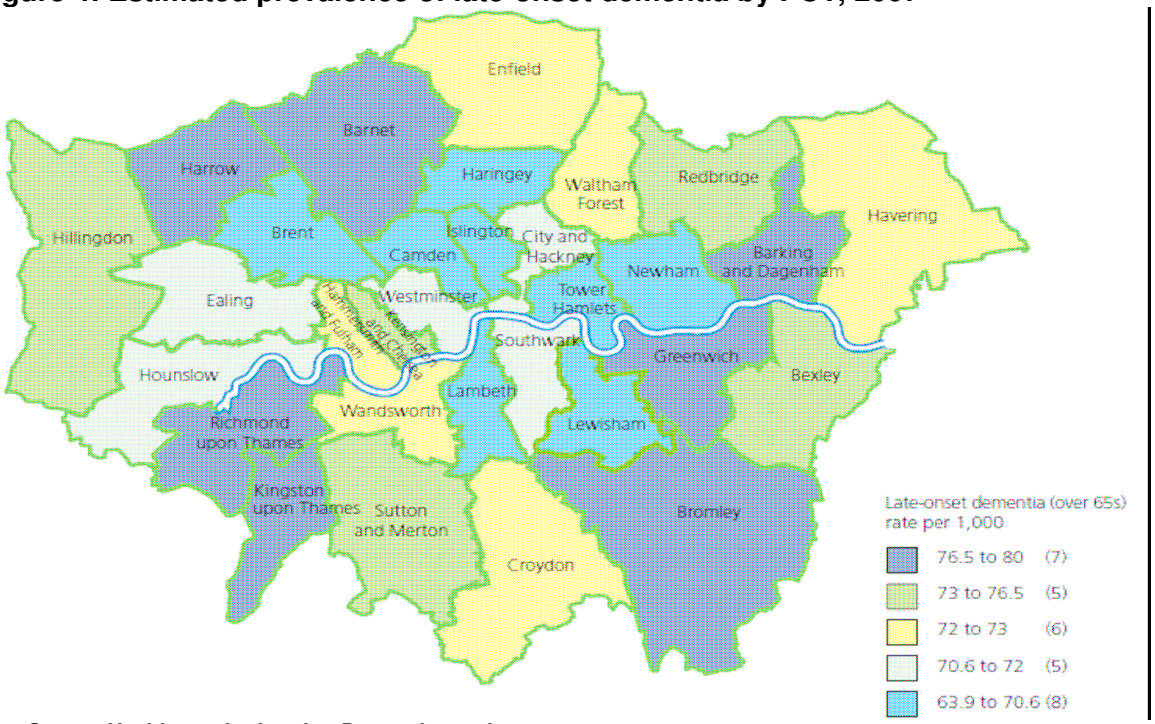
Data Source:Healthcare for London Dementia needs assessment

Current Late-Onset Dementia Prevalence Rates

Late-onset dementia (dementia that affects people aged 65 plus) affects 7.3% of London's population. Enfield had between 72 and 73 people per 1000 with late-onset dementia in 2007.

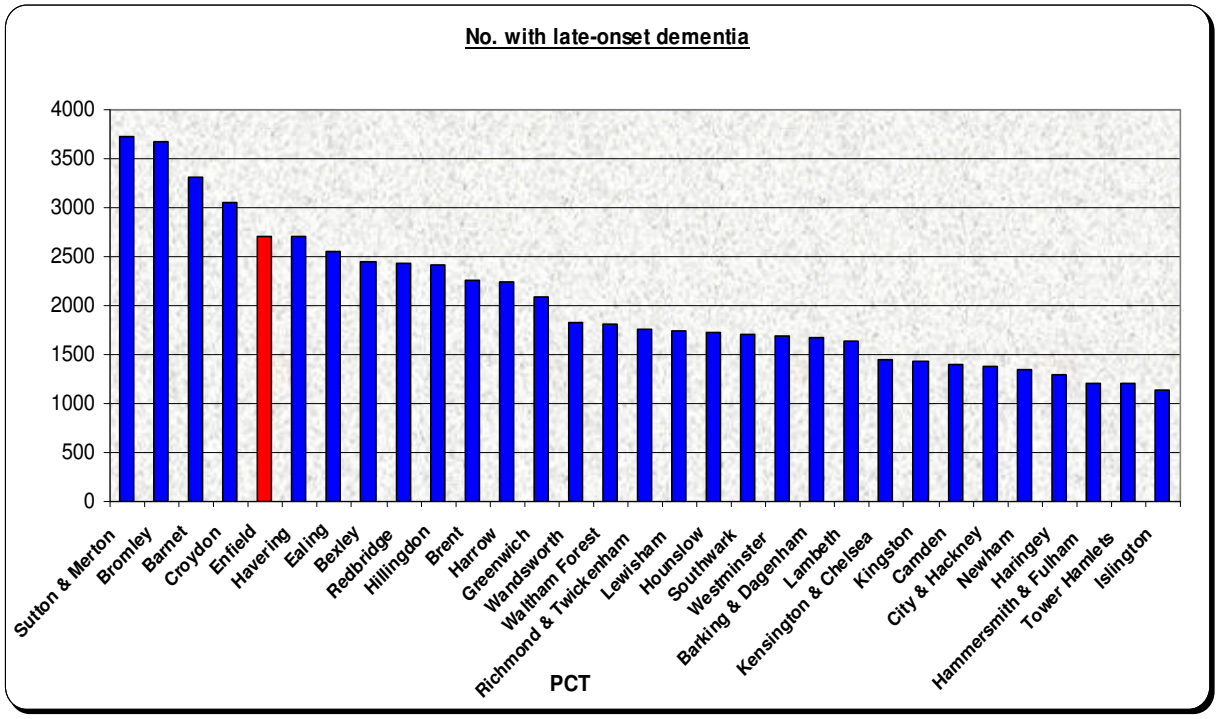
The number of people with late-onset dementia in 2007 was 2706. This is a prevalence rate of 7.3% for Enfield which is the same as the London average.

Figure 4: Estimated prevalence of late-onset dementia by PCT, 2007



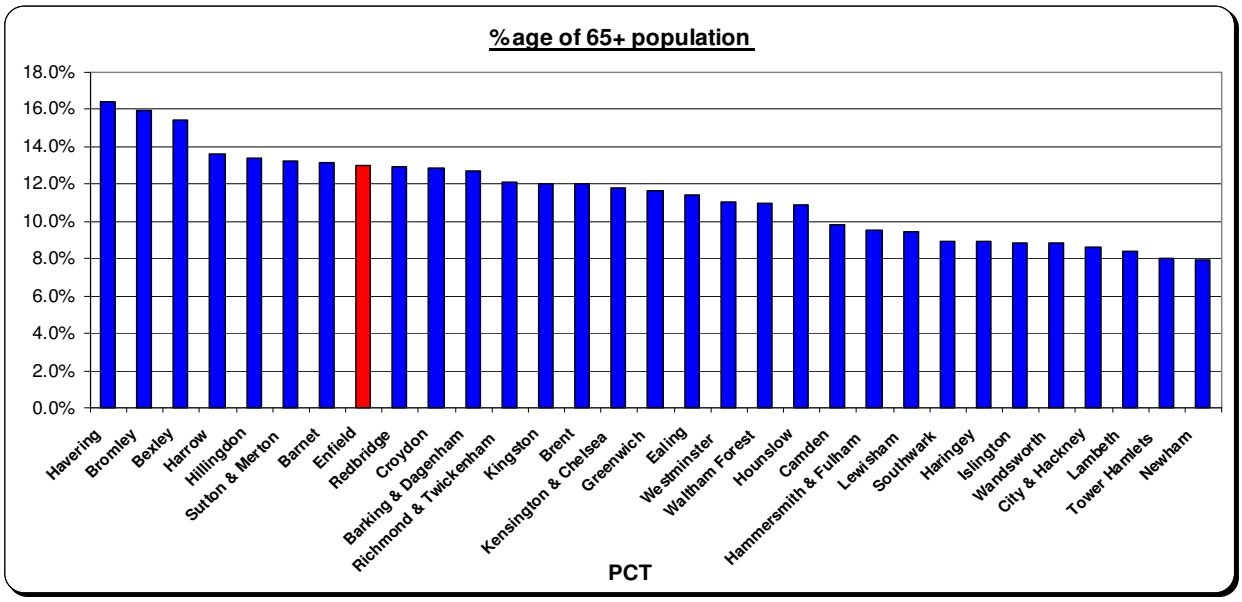
Data Source:Healthcare for London Dementia needs assessment

Figure 5: Number of people aged 65+ with late-onset dementia by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 6: Percentage of population aged 65+ by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 6 shows the percentage of each PCT's population that is aged 65+. 13% of Enfields population is 65+ compared to a London average of 11.4%.
Figure 6 shows that the reason there are fewer people in inner London boroughs with dementia is due to there being a lower proportion of the population being aged 65+. Enfield PCT has the 8th highest percentage of people aged 65+ and the 5th highest number of people with late-onset dementia in London.

Applying the current prevalence rates for late-onset dementia in Enfield with the projected population figures for older people would indicate that Enfield will have the following amount of people diagnosed with dementia in future years.

Table 11: Numbers of population aged 65 and over, in five year age bands, predicted to have late-onset dementia, projected to 2030

	2009	2015	2020	2025	2030
Projected number of people with late-onset dementia	2774	2978	3139	3446	3906

Data Source:Healthcare for London Dementia needs assessment

Though it is estimated that 2769 people have dementia in 2007 only 905 were registered with a GP as having dementia. This means that approximately two thirds of people in Enfield with dementia have not been registered as such with their GP. It is likely that the majority of these people have mild dementia. This number of people in Enfield on the GP dementia register in 2008 has risen slightly to 922. Of the 922 patients on the dementia register, 850 were eligible for review. 677 of these patients had their care reviewed in the previous 15 months[4]. This gives Enfield a performance of 79.6% which is similar to the London average of 79.7%.

Of the 2706 estimated prevalence of people with late-onset dementia in 2007 it is estimated that 1480 have mild dementia, 874 with moderate dementia and 351 with severe dementia [5]. This is a split of 54.7% mild, 32.3% moderate and 13% severe.

The prevalence rate of early and late onset dementia is 1.6% for Enfield which is higher than the London average of 1.4%.

[4] *This is from the 2008/09 QoF*
[5] *This is from the Healthcare for London Dementia Needs Assessment*

Prevalence by Age Band and Sex

The prevalence of dementia varies between age groups and gender. The prevalence rate of dementia is higher amongst the female population from 30 until 45 when the male population then shows a higher prevalence rate. This trend continues until the 75 age group when the shift changes back to females.

Figure 7: Prevalence of early-onset dementia in the UK by age and sex

Age	Female rate per 100,000 population	Male rate per 100,000 population
30-34 years	9.5	8.9
35-39	9.3	6.3
40-44	19.6	8.1
45-49	27.3	31.8
50-54	55.1	62.7
55-59	97.1	179.5
60-64	118.0	198.9

Data Source:Healthcare for London Dementia needs assessment

Figure 8: Prevalence of late-onset dementia in the UK by age and sex

Age	Female (%)	Male (%)
65-69 years	1.0	1.5
70-74	2.4	3.1
75-79	6.5	5.1
80-84	13.3	10.2
85-89	22.2	16.7
90-94	29.6	27.7
95+	34.4	30.0

Data Source:Healthcare for London Dementia needs assessment

Dementia Type

The most common form of dementia is Alzheimer's which affects nearly two-thirds of all people with dementia in the UK. Figure 9 shows the estimated breakdown of the London population by dementia type.

Figure 9: Breakdown of the population of London with dementia by type, 2007

Type of dementia	Proportion of people with dementia	Estimated number in London
Alzheimer's disease	62%	40,150
Vascular dementia	17%	11,009
Mixed (AD and VD)	10%	6,476
Dementia with Lewy bodies	4%	2,590
Frontotemporal dementia	2%	1,295
Parkinsons' dementia	2%	1,295
Other	3%	1,943
Total	100%	64,759

Data Source:Healthcare for London Dementia needs assessment

The distribution of dementia type varies between male and female. Women are more prevalent to Alzheimer's (67%) than men (55%) and men are more likely to have a vascular dementia/mixed dementia (31% men compared to 25% in women).

Prevalence by Ethnic Groups

Early-onset dementia is more common amongst BME groups with 6.1% of all people with early-onset dementia being from BME groups compared with 2.2% of all groups[6]. This could be due to some groups that are more prone to hypertension and cardio vascular disease.

It is projected that 642 people from BME groups will have late-onset dementia by 2021 compared to an estimate of 231 people in 2001. This is a 178% increase which is higher than the London average of 123%[7]. These significant increases are due to first generation migrants from the 1950's to the 1970's reaching the age groups most at risk of dementia.

[6] *From the Dementia UK 2007 report*
[7] *From the London Dementia needs assessment*

Social Care Assessments, Reviews, Services

In Enfield 4.5% of MH assessments were recorded as a percentage of dementia prevalence in 2006/07 which is higher than the London average of 2.4%. This equates to 125 mental health assessments recorded as dementia.

Table 12: Numbers of service users with dementia receiving a review from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Number of Services Users reviewed in the year	240	420	490	480
London Average	166	177	281	223

Data Source:RAP A1

Table 12 shows the number of clients who have received a social care service and a review in the year. Enfield has performed above the London average each year.

Table 13: Numbers of service users with dementia, ages 18+, receiving a service package from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Number of Services Users with dementia receiving services in the year	260	380	485	600
London Average (excluding Bromley as anomaly with figures)	183	182	189	180

Data Source:RAP P1

The number of service packages provided to clients has continued to increase each year. On average 95% of the clients receiving services are age 65+. The number of clients that Enfield social services provides support to is significantly above the London average.

Table 14: Numbers of service users with dementia, ages 18+, receiving a service package from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Received a community based service in the year	135	240	275	400
Received a residential service in the year	140	180	235	295
Percentage of clients who have received a residential service in year of total clients receiving services	53.8%	47.4%	48.5%	49.2%
London Average of dementia clients	44.9%	45.6%	45.1%	50.8%

receiving a residential service					

Data Source:RAP P1

Please note that in table 14 the sum figures for community based clients and clients in a residential placement will differ from table 13 as some clients would have received both types of service in the year.

Approximately 50% of Enfield clients who received services were in a residential/nursing placement. The London average shows that there is a steady increase in the proportion of clients with dementia being placed in a residential setting rather than being supported in the community. As the number of people projected to have dementia increases there will be a greater demand for dementia registered homes in Enfield. In 2005/06 in Enfield there were 1.8 places (per 100 people) in homes registered to older people [8].

[8] *Information from Healthcare for London Dementia needs assessment*

Length of Stay in a Care Home

Table 15: Length of stay of residential with dementia and nursing with dementia placements, from 2005/06 to 2008/09

Financial Year	2005/06			2006/07			2007/08			2008/09		
Service Type	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths
Nursing Older with Dementia	10	13	108	25	28	78	11	15	69	14	14	81
Residential Older with Dementia	36	12	88	36	23	90	41	38	81	53	29	113
Grand Total	**46**	**25**	**105**	**61**	**51**	**105**	**52**	**53**	**92**	**67**	**43**	**90**

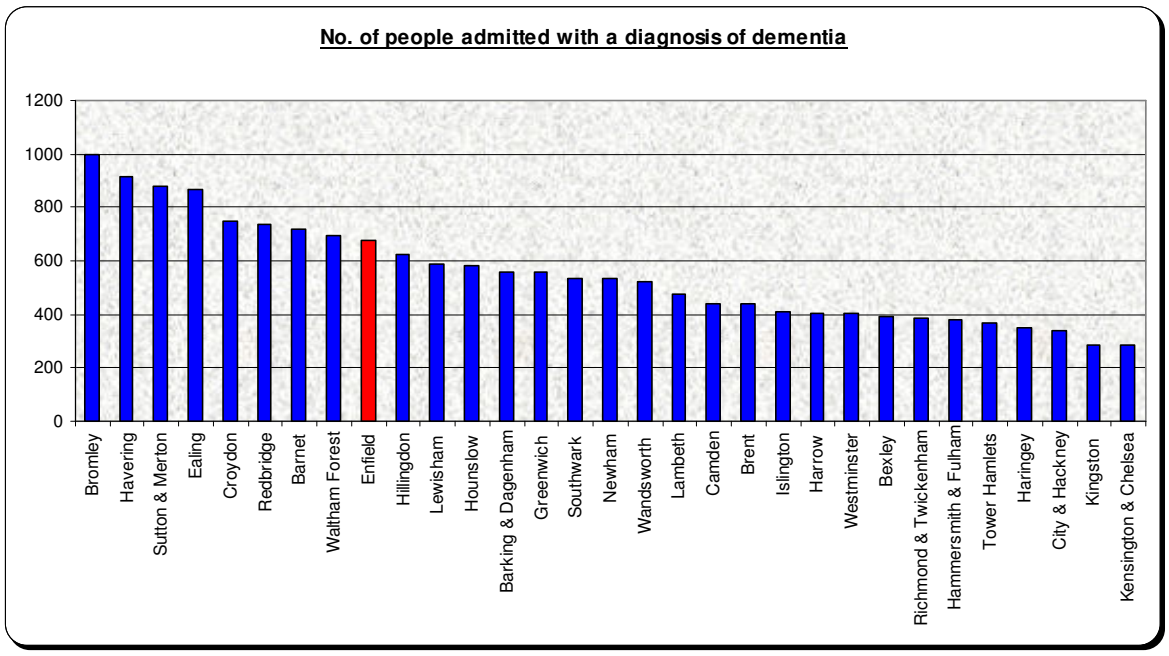
Data Source: HASC Performance Team

Table 15 shows the length of stay for clients who have died whilst in a residential/nursing placement with dementia placed by Health & Adult Social Care. Over the last 4 years the average length of weeks for a client in a nursing home with dementia is 84 weeks and 93 weeks for a residential placement.

Admissions to Hospital

In 2007/08 680 people with any diagnosis of dementia were admitted into hospital. This is above the London average of 552.

Figure 10: Number of people admitted to hospital with any diagnosis of dementia, by PCT, 2007

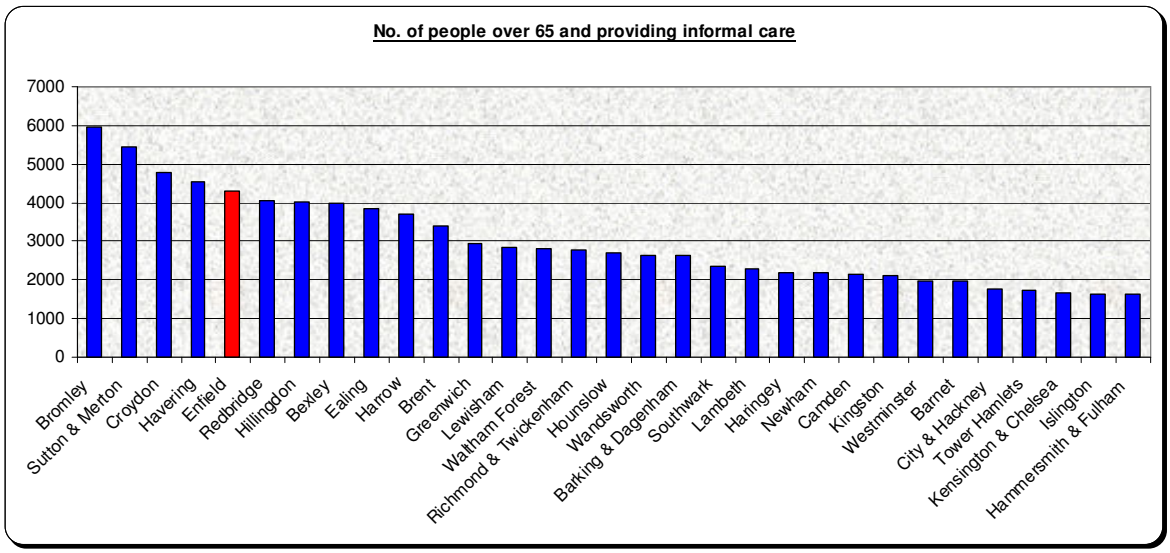


Data Source:Healthcare for London Dementia needs assessment

Figure 10 shows that Enfield had the 9th highest number of people with dementia admitted to hospital in London.
The number of people admitted into hospital with a primary diagnosis of dementia was significantly lower, only 47 people. This is much lower than the London average of 75 people admitted. Enfield was the 5th lowest performing PCT in London in this area.

Carers

Figure 11: Number of people 65+ providing informal support

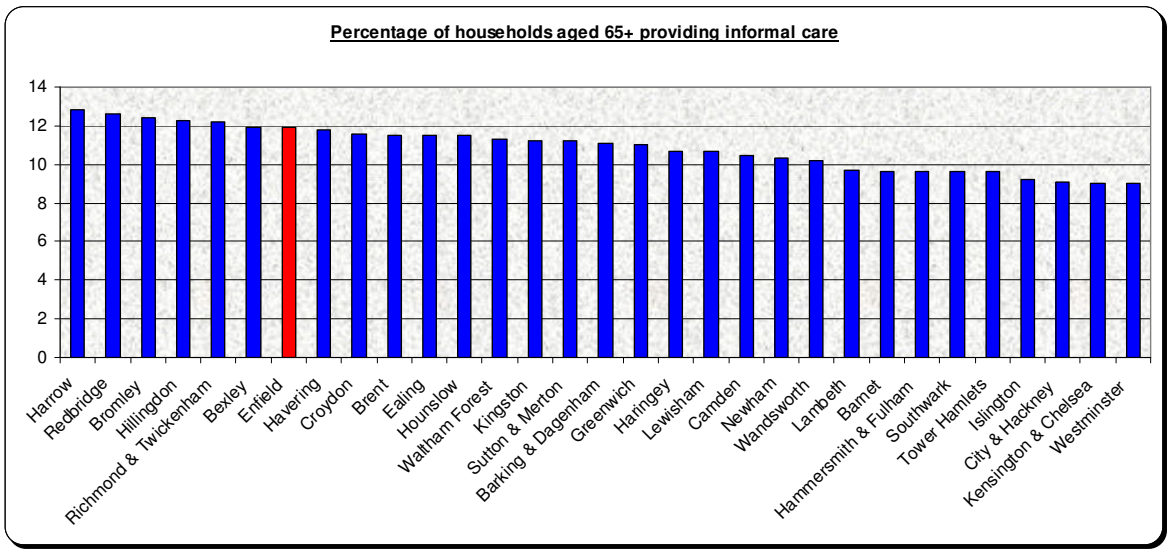


Data Source:Healthcare for London Dementia needs assessment

The 2001 census stated that 4298 people aged 65+ provided informal support. This is higher than the London average of 2998 clients.

In relation to the number of households aged 65+, 11.9% of these households provide informal care. This is above the average of 10.85%.
Please note that this information is now 9 years out of date therefore could have significantly changed.

Figure 12: Number of people 65+ providing informal support



Data Source:Healthcare for London Dementia needs assessment

Enfield LA provided support to 680 carers aged 65+ in 2008/09[9]. This was above the London average of 446. Enfield was the 7th highest performing LA in London in this area.

[9] *RAP 2008/09*

Appendix 3: Map of Local Services

Service	Provider	Description
Cornwall Villa - acute admission ward for older people with mental health needs	BEHMHT	Provides in-patient care for older people, usually 65+, who are suffering acute mental illness and need to be in hospital care for a period of observation and assessment to help the care team decide on the best course of treatment.
Continuing Care In-Patient Wards o The Oaks o Silver Birches o Bay Tree House	BEHMHT	The Oaks and Silver Birches provide an assessment and continuing care service for older people who are suffering from the effects of a chronic degenerative mental health condition (dementia/cognitive impairment). The wards provide specialist inpatient mental health care where there are significant psychological and behavioural symptoms of dementia, which may include: • Persistent threatening behaviour, aggression or violence • Recent history of self harm • Persistent unwillingness to accept services which are necessary to maintain independent living • Persistent wandering Bay Tree House provides a similar service for older people with a functional illness
Older Peoples Community Mental Health Team (Refuge House)	BEHMHT	The OPCMHT offers community-based services for older people with severe and enduring mental health needs and dementia. Teams offer a person-centred approach, based on individual assessment, in order to support service users in achieving their personal goals, and where possible retaining their place in the community. CMHTs are multi-disciplinary teams of nurses, social workers, psychiatrists, clinical psychologists and occupational therapists. In most cases teams offer a multi-disciplinary assessment and management plan and in some cases they also provide follow-up and a review of treatment plans.
Memory Treatment Clinic	BEHMHT	The memory treatment clinic in Enfield provides prescribing and monitoring of anti

Service	Provider	Description
(Refuge House)		dementia medications, working to the current NICE guidelines for monitoring and prescription.
Clinical Psychology	BEHMHT	Provides specialist dementia assessment & support to memory clinic.
Day Hospital ○ The Elms (dementia and cognitive impairment ○ The Hawthorns (functional illness) Both delivered from the Warwick Centre, Chase Farm site	BEHMHT	Provide multi-disciplinary specialist day services for people aged 65 and over with organic and long-standing functional mental health problems, sometimes with substance misuse problems. The service provides: • Assessment, including a memory assessment service • Diagnosis • Management plans Support is provided to support people in their own home through step-up/step-down services, psychological support, developing social skills and new coping strategies and additional services are offered such as occupational therapy, advocacy, bereavement counselling, outreach services, sign-posting
MH liaison	BEHMHT	Specialist MH liaison to general acute hospital wards provided by a full time nurse with consultant input. (Note: This is not a commissioned service)
Day opportunities	Age Concern	The Parker Centre in Edmonton provides a caring and safe environment for people with dementia, which allows their carer to have more time for themselves. The Centre offers activities such as reminiscence work, arts and crafts, singing, indoor bowling, board games, quizzes, group work, cookery, poetry, gentle exercise and day outings. Also offers support for carers about dementia, how to care for their loved ones and how to adapt to changing needs.
	LBE	Rose Taylor is a 15 place day centre for older people with dementia which is based in a residential care home offering a range of social activities. It is open 7 days per week and also offer home made meals that are prepared on site.

Service	Provider	Description
	Enfield Asian Welfare Association	EAWA provides a preventative and high need day opportunities centre for Asian Elders, including those with dementia. EAWA are also starting a new service which is designed to help new carers of Older People on discharge from hospital; to engage with a Carers Assessment; and to be sign posted to access the services they need to support them in their caring role.
Nursing & Residential Homes	There are a large number of nursing and residential care providers in Enfield. A complete list can be found in the Enfield Older Peoples Care Directory.	The majority of residential homes for older people provide service for people with dementia and 30 care homes are registered specifically to provide dementia care. There are 5 nursing homes in the Borough contracted to provide specialist nursing dementia care. Nursing homes also provide continuing healthcare which is funded by the NHS.
Extracare Schemes	Alcazar Court Skinners Court	Extracare schemes provide domiciliary care and housing related support. These are not specifically for people with dementia however people with dementia use these services.
Respite & Carers Services	LBE	Respite care provided from a residential setting, day opportunities setting, or personal care and assistance at home to give a carer a break. There are dedicated respite units for people with Dementia at Coppice Wood Lodge (5 places) and Bridge House (8 places).
	Crossroads Care Enfield	Provides care at home, including for people with dementia, to enable carers to have a break.

Service	Provider	Description
	Alzheimer's Society	Two Carers support groups – information, education and support. Information drop-ins where you can call in without appointment for advice and information, or just for a chat. A community psychiatric nurse is available to all carers for a one-to-one consultation. Purchases respite care from Age Concern and Crossroads
	Age Concern Enfield	'Time-out' home based respite for carers of people aged 50 years and over with dementia. Day opportunities service in Edmonton provides a range of therapeutic and cognitively stimulating activities 6 days per week.
	Nursing homes	Respite is purchased from nursing care providers through spot purchasing arrangements.
	Carers UK	Campaigns to raise awareness of the needs of carers, provides information and advice and helps them become more aware of their own role and status in the community. They also run Carers Line, a free phone helpline offering information and support to carers.
	Enfield Carers UK	The Enfield branch of Carers UK supports, informs and represents carers in the borough of Enfield. A monthly meeting is held in Edmonton. They also hold a monthly drop-in where taster sessions of complimentary therapies are offered.
	Enfield Mental Health Carers	Provides information, advice, training, advocacy, respite, emergency respite, befriending and group support to carers of people with mental health difficulties.
	Asian Carers Consortium	This organisation aims to provide a culturally and linguistically appropriate home based sitting and home care service to Asian carers (including carers of those with dementia) living in Enfield.
	Dazu Young Carers	Dazu supports children and young people who are under 18 years of age and who have caring responsibilities within their families (including caring for family members with dementia).

Service	Provider	Description
Information & advice	Age Concern	Information/Signposting Service provides a one-stop shop providing independent information on a wide range of subjects affecting older people.
	Greek & Cypriot Association	Provides information and advice to people with dementia and their carers.
	G.Ps	922 people on G.P registers.
Home Care	LBE	Provides help with personal care, eating and drinking, and supervising medication.
Home Care	External Providers	Approximately 8-9 external providers regularly provide homecare to people with dementia.
	Enfield Mental Health User Group	Monthly drop-in for older people who receive mental health services.

Appendix 4: Stakeholder Participation

The London Borough of Enfield and NHS Enfield would like to thank those that gave up their time to contribute to the development of the strategy, including:

- Dr. Janet Carrick, Consultant Psychiatrist, Barnet, Enfield and Haringey Mental Health Trust
- Jacqui Wood, Alzheimer's Society
- Anne Taylor, Age Concern
- Kate Holmes, Enfield Mental Health Users
- Julia Brownlie, Barnet, Enfield and Haringey Mental Health Trust
- Jack Williams, Carer
- Steve Tall, Barnet, Enfield and Haringey Mental Health Trust
- John Hancock, Private Sector Housing
- Elaine Yeo, Clinical Director, NHS Enfield
- Gwennie Oakley, Manager Older Peoples Mental Health Team, Barnet, Enfield and Haringey Mental Health Trust
- Pauline Waldron, Anchor Trust Housing Association
- Lisa Doherty, Alzheimer's Society
- Jenny Murtagh, Homecare, London Borough of Enfield
- Needyanand Raya, Care Home Manager
- Glynis Vaughn, Older Peoples Mental Health Team Manager, Barnet, Enfield and Haringey Mental Health Trust
- Cathy McMahon, Age Concern, Enfield
- Shetna Shah, Enfield Asian Welfare Association
- Tosque Dnovo, Alcazar Court
- Hinnah Gill, Enfield Mental Health Carers