Appendix 1: Hammersmith and Fulham

In the JSNA, services were RAG rated against National Strategy Objectives, NICE Guidance, views expressed by people with dementia and their carers, qualitative research with clinicians, and supporting evidence. From this RAG rating, gaps were identified and recommendations developed. The table below highlights the recommendations which were developed from the areas highlighted as Red or Amber in the JSNA and those that align with the service aims from the North West London Service Framework Specification (NWL Strategic Review of Dementia May 2015)

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Memory Service Care	*A. Memory service care varies between provider: in some cases the patient may not have access to timely diagnostic or adequate community support.* *B. Peer support is now being commissioned as part of Living Well service in Westminster and Kensington and Chelsea, however there appears to be a lack of resource in Hammersmith and Fulham.*	1. Develop a single point of access to diagnostic assessment and ensure all patients across all three Boroughs have equitable access 2. Introduce a peer support programme across three boroughs taking into account evaluation findings of Kensington and Chelsea/Westminster programme	Aim 6: To promote a positive experience of services to people with dementia and family/carers
	C. Diagnosis rates still do not meet estimated prevalence and can be further improved *D. Training is needed for GPs, staff in care and support roles and families to recognise the signs and symptoms of dementia and know what to do next*	3. Improve screening and diagnosis in care home and Extra Care residents 4. Consider training to increase referral from or support diagnosis in primary care, in line with NWL strategy 5. Audit completion of diagnostic assessment for those first identified in hospital and address accordingly 6. Establish a good standard of training to achieve a level of expertise across all partner agencies including social care, residential care, extra care, clinicians, GPs	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix

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Community Care	*E. It is not clearly understood whether voluntary sector resources and support available to carers is adequate to need, distributed equitably and accessible to all. There is variation between boroughs in the extent of such services available* *F. There appears to be insufficient community support for people with dementia and their carers to learn to manage distressing signs of dementia, e.g. through purposeful activity.* *G. There are Dementia Advisers and Dementia Guides but there appears to be insufficient resources to meet need. There is a lack of dementia advice/care coordination to support timely access to advice. Resources are needed across 3 boroughs to ensure care staff have support to recognise and signpost people for diagnosis and to provide the right interventions and level of support.*	7. Ensure adequate provision, through 3rd sector and health and social care services, of activities and support around living well with dementia and managing distressing behaviours 8. Provide adequate infrastructure and training for care staff. 9. Ensure people are supported to access the care appropriate to them through the use of personal budgets 10. Ensure that there are sufficient Dementia Advisers to coordinate access to services.	Aim 4: To promote support and inclusion for people with dementia and family/carers using the Service Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix Aim 6: To promote a positive experience of services to people with dementia and family/carers
	H. There is insufficient support for work of the Dementia Action Alliances across the three boroughs (can eventually join up across 3 boroughs and the Pan-London Alliance)	11. Ensure adequate resource to support the work of the Dementia Action Alliance and other opportunities to raise public awareness of dementia across the three boroughs	Aim 4: To promote support and inclusion for people with dementia and family/carers using the Service

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Residential Care	*I. The provision of care home beds locally (particularly dementia specific beds) tends to be lower than many other areas, meaning a significant proportion of residents are placed out of borough, in some cases away from family and friends.*	12. Address supply of local care home beds in future local authority and CCG commissioning intentions, including those specifically for dementia care.	
	J. Little is known about the quality of dementia care in care homes locally	13. Address findings from Care Quality Commission (CQC) national report on dementia care in care homes; audit to provide assurance of quality of care in care homes. 14. Ensure there are opportunities for coordinated training and support for care homes to enable recognition of patients with dementia and to improve confidence in care for complex needs and difficult behaviours. 15. Ensure either all staff in intermediate care have appropriate training for looking after people with dementia or a specialist service is provided.	Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix Also links to Aim 3

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
General Medical Care	*K. Little is known about adequate use of antipsychotics – an audit is due to take place in Chelsea and Westminster Hospital.*	16. Audit and address accordingly use of antipsychotics in hospitals and community prescriptions	Aim 3: To prevent or minimise the inappropriate use of anti-psychotic medication, including advice on alternative strategies for people with dementia living at home, in care homes or in other residential settings
	L. A need has been speculated for increased liaison psychiatry provision in Hammersmith and Fulham, dementia specialist nursing in the community and in hospital, and care navigators. *M. Opportunities for reducing escalation of problems and care need have been identified through early targeted hospital care.*	17. Ensure adequate monitoring, assessment and provision of care for other physical and mental health needs for people with dementia. 18. Ensure timely identification and targeted care of those with dementia in hospital 19. Provide dementia friendly environment within hospitals 20. Ensure adequate provision of liaison psychiatry and dementia nurses, consider expanding remit	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 6: To promote a positive experience of services to people with dementia and family/carers

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Whole Systems Care	*N. There are few easy channels of communication between different providers of dementia care*	21. All patients, carers and clinicians should have consistent and comprehensive information with clear signposting of care pathways 22. The current fragmentation in care provision would be addressed through centralised coordination and improved communication/collaboration between services	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 6: To promote a positive experience of services to people with dementia and family/carers
	O. Numbers of people with dementia are likely to increase by 55% in the next 15 years, all relevant providers and services must be equipped with adequate resource to meet this need.	23. Ensure adequate training and support across all services for staff and carers looking after people with dementia 24. Current practice and resources must be scaled to meet increasing need or consider adapting models of care with innovation across health and social care to reduce the scale of care required. Ensure that any changes to services are evidence based. 25. Explore joint working with police and other community safety partners to support appropriate and effective use of assistive technology/telecare for patients with dementia.	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix
	P. The Dementia Strategy in Kensington and Chelsea will end in 2016. The Westminster and	26. There should be a joint health and social care dementia programme board for the three	Aim 1: To provide commissioners with confidence that service specifications

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
	Hammersmith and Fulham strategies have both expired. The North West London Mental Health Programme Board has recently produced a dementia strategy for diagnosis and treatment support	boroughs to facilitate implementation of the North West London dementia strategy in alignment with findings and recommendations from this JSNA. 27. Local services are active stakeholders with wider initiatives to ensure strategy is sensitive to local needs	and operational standards are consistently met
	Q. Housing, environment and planning strategies do not specifically mention dementia or carers of people with dementia	28. The increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing and environment	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Patient and Carer's Rights	*R. Lack of sufficient resource to support with end of life care across the three boroughs.* *S. Lack of defined carer support pathway.* *T. Support is needed for advocating peoples' best interests and awareness of the Mental Capacity Act 2005* *U. There is little supporting infrastructure available to provide help to self-funders to "micro-commission" care as mandated by the Care Act 2014.*	29. Ensure that there is a clear end of life care pathway for people with dementia with appropriate advanced care planning and powers of attorney and clinicians are responsive to these wishes. 30. Provide a clear and comprehensive pathway, including respite care, for carers with equality of access across three boroughs, taking into account the unique needs of carers of people with dementia. 31. Patients and carers should be aware of advance directives and power of attorney and how to initiate them. 32. Ensure there is adequate infrastructure to support self-funders to access care	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 6: To promote a positive experience of services to people with dementia and family/carers