'Challenges and Opportunities for Dementia & Research in WY&H HCP'

CCGs working together

Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

My Declarations of Interest

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GP with a Special Interest in Older People-BTHFT

Clinical Specialty Lead Older People & Stroke Airedale, Bradford District &City CCGs

GP Advisor Yorkshire & Humber Dementia and Older Peoples Mental Health CN

Honorary Visiting Research Fellow Bradford University School of Dementia Studies


Dementia Research

I have dementia and I take part in research. Here's why.

BY WENDY MITCHELL JULY 4, 2017 // 4 COMMENTS TWEET SHARE

So, as you can see, I have dementia, but **I'm still able to contribute to society**.

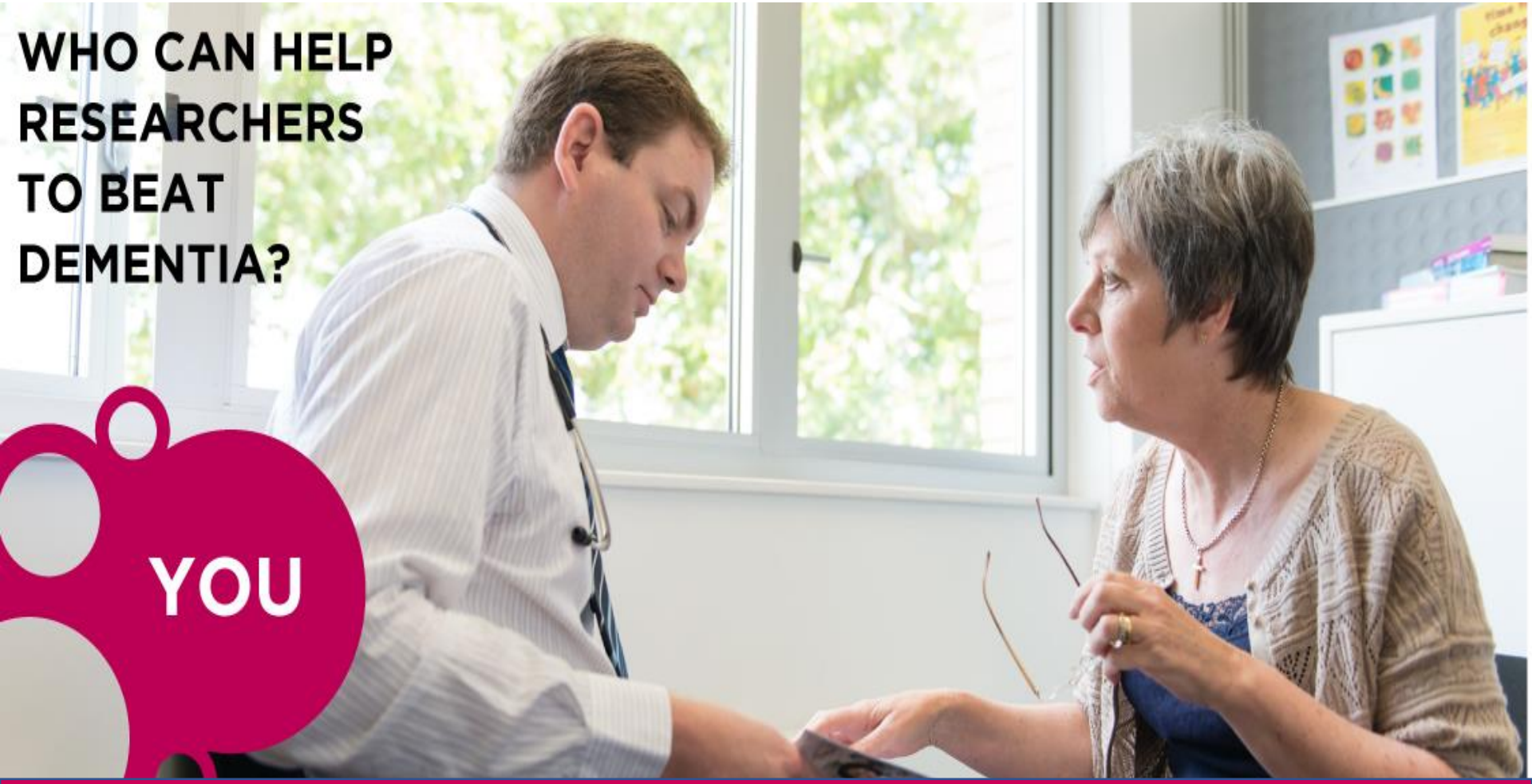
Why am I so willing? Because I like to be involved, because being involved has given me back that sense of purpose that a diagnosis of dementia stripped away from me.

We all had talents before a diagnosis of dementia – we don't suddenly lose all those talents overnight

Being involved makes me feel valued and people listen to what I have to say…….

Join dementia research

NHS
National Institute for Health Research



www.joindementiaresearch.nihr.ac.uk

What are the facts?

The scale of the challenge

850,000 people living with dementia in the UK

By 2025

over **one million** people could have dementia in the UK

By 2050

this figure will exceed **2 million**

1 in 3 people born in the UK this year will develop dementia in their lifetime.

Alzheimer's Research UK

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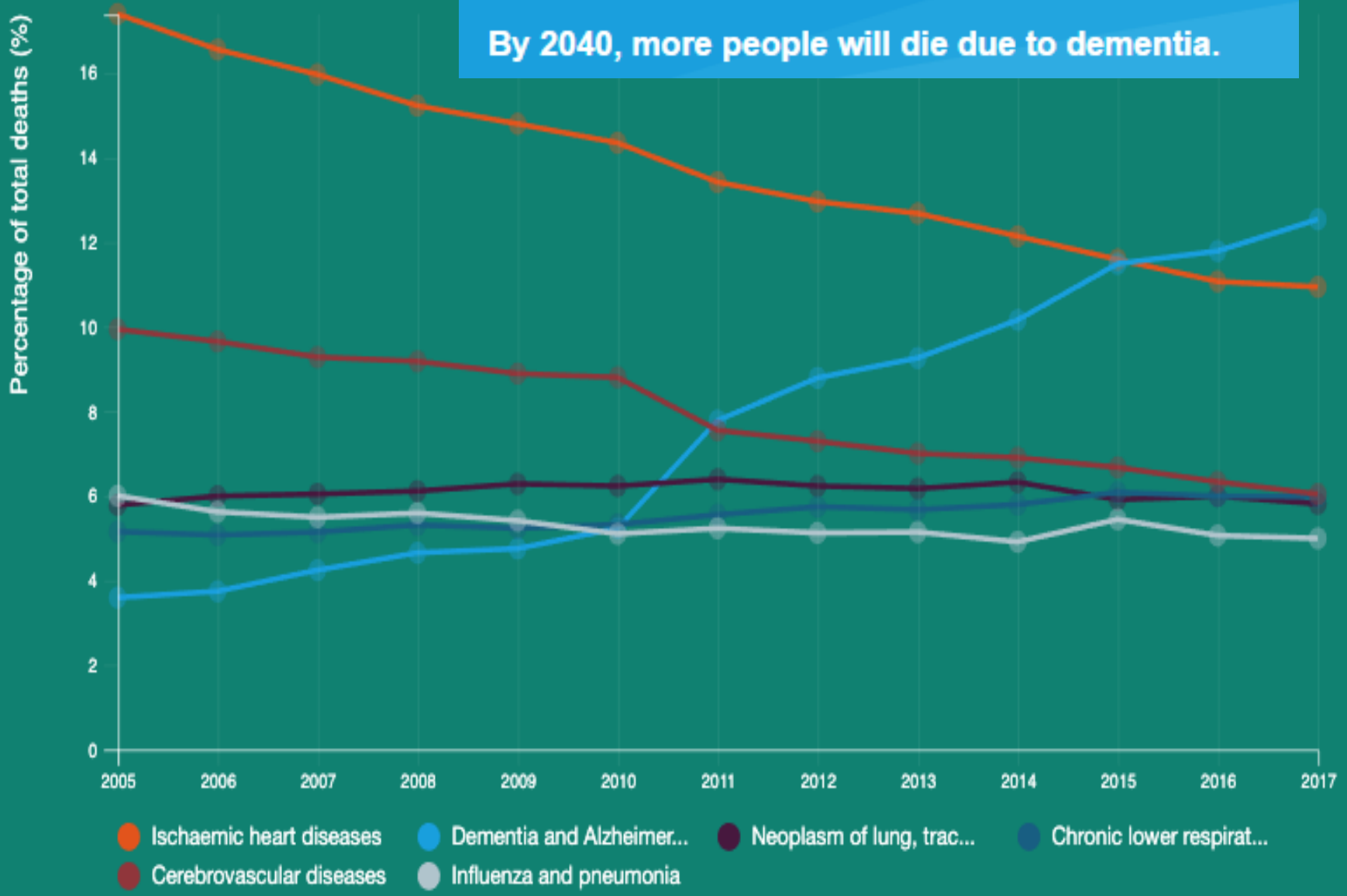
In 2014, there were more than twice the number of deaths due to all cancers than dementia.

By 2040, more people will die due to dementia.



Alzheimer's Research UK

3.6 Table 2: leading causes of death by age group for males in England, 2015

Leading causes of death vary by age for males

External | Cancer | Circulatory | Respiratory | Other

Age	1st	2nd	3rd	4th	5th
1-4	Perinatal & congenital	Influenza and pneumonia	Brain cancer	Meningitis and meningococcal infection	Vaccine preventable disease
5-19	Suicide	Transport accidents	Homicide	Leukaemia and lymphomas	Brain cancer
20-34	Suicide	Accidental poisoning	Transport accidents	Homicide	Cirrhosis and other liver disease
35-49	Suicide	Heart disease	Accidental poisoning	Cirrhosis and other liver disease	Stroke
50-64	Heart disease	Lung cancer	Cirrhosis and other liver disease	Colorectal cancer	Chronic lower respiratory diseases
65-79	Heart disease	Lung cancer	Chronic lower respiratory diseases	Stroke	Prostate cancer
80+	Dementia and Alzheimer's disease	Heart disease	Influenza and pneumonia	Stroke	Chronic lower respiratory diseases

3.7 Table 3. Leading causes of death by age group for females in England, 2015

Leading causes of death vary by age for females

External | Cancer | Circulatory | Respiratory | Other

Age	1st	2nd	3rd	4th	5th
1-4	Perinatal & congenital	Homicide	Influenza and pneumonia	Septicaemia	Other acute respiratory diseases
5-19	Suicide	Transport accidents	Perinatal & congenital	Leukaemia and lymphomas	Brain cancer
20-34	Suicide	Accidental poisoning	Transport accidents	Breast cancer	Cirrhosis and other liver disease
35-49	Breast cancer	Cirrhosis and other liver disease	Accidental poisoning	Suicide	Heart disease
50-64	Lung cancer	Breast cancer	Heart disease	Chronic lower respiratory diseases	Cirrhosis and other liver disease
65-79	Lung cancer	Chronic lower respiratory diseases	Heart disease	Dementia and Alzheimer's disease	Stroke
80+	Dementia and Alzheimer's disease	Heart disease	Stroke	Influenza and pneumonia	Chronic lower respiratory diseases

In the UK, dementia is the only condition in the top 10 causes of death without a treatment to prevent, cure or slow its progression.

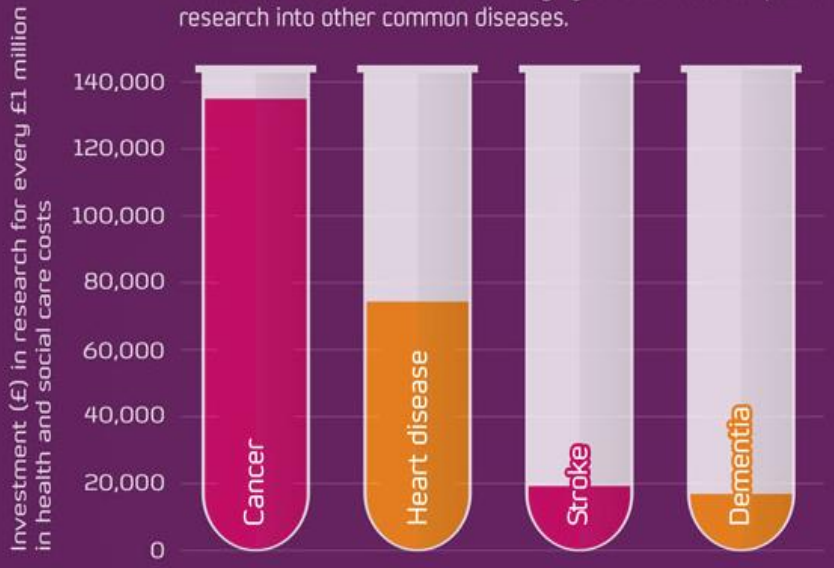
Alzheimer's Research UK

Source: England and Wales; Mortality Statistics: Deaths Registered in England and Wales (Series DR) Scotland: National Records of Scotland Vital Events Reference Tables. Northern Ireland; Northern Ireland Statistic & Research Agency Registrar General Annual Report

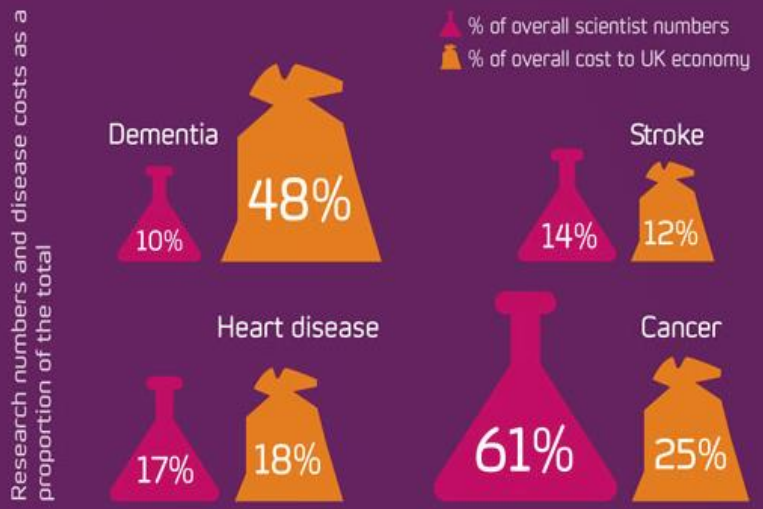
Now the facts about Dementia Research

Dementia research in numbers

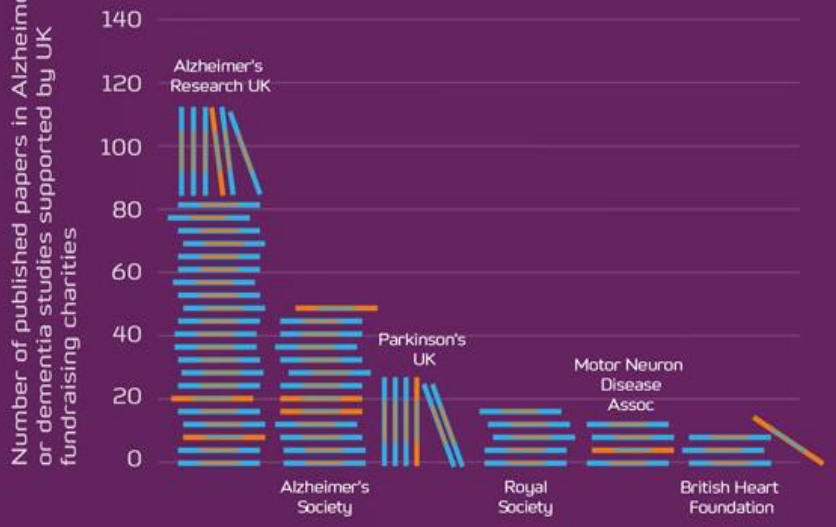
Research into dementia remains hugely underfunded compared to research into other common diseases.



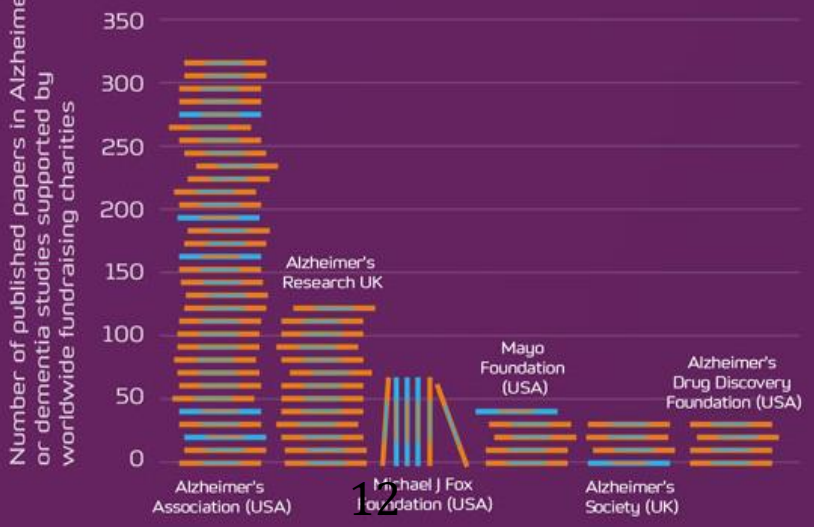
There are an estimated 4,061 dementia researchers in the UK (28,062 for cancer, 6,433 for heart disease, 4,784 for stroke).

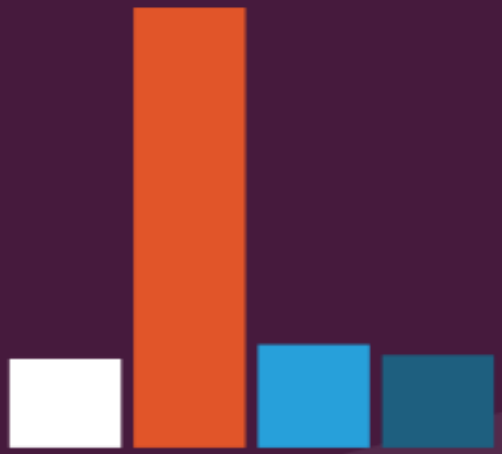


Leading dementia research charities, UK, 2012



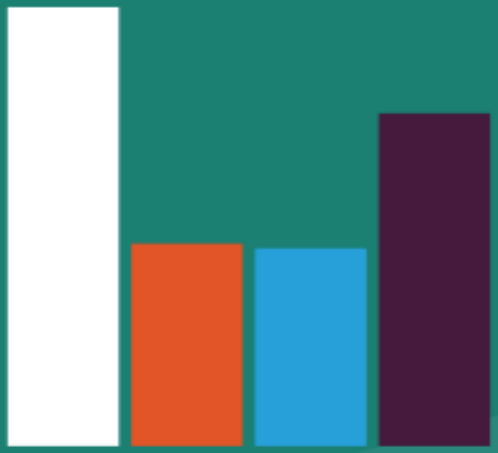
Leading dementia research charities, worldwide, 2012





In 2014/15 there were 3,169 dementia papers published, 15,697 in cancer, 3,678 in coronary heart disease and 3,304 in stroke.

Alzheimer's Research UK



The number of UK researchers has risen by 91% in dementia, by 42% in cancer, 41% in coronary heart disease and by 69% in stroke between 2008/09 and 2014/15.

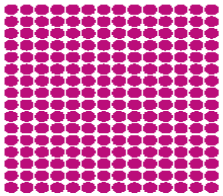
Alzheimer's Research UK

Join dementia research

NHS National Institute for Health Research

Join Dementia Research in numbers

30,145
total volunteers



56,956
screenings

7,888
participants that have enrolled in studies to date

26%
of volunteers have participated in a study

165
Studies have recruited

108
Studies currently open to recruitment

852
trained researchers using the service

176
NHS, University & commercial sites have used the system

Join dementia research

These statistics are accurate as of 1 September 2017

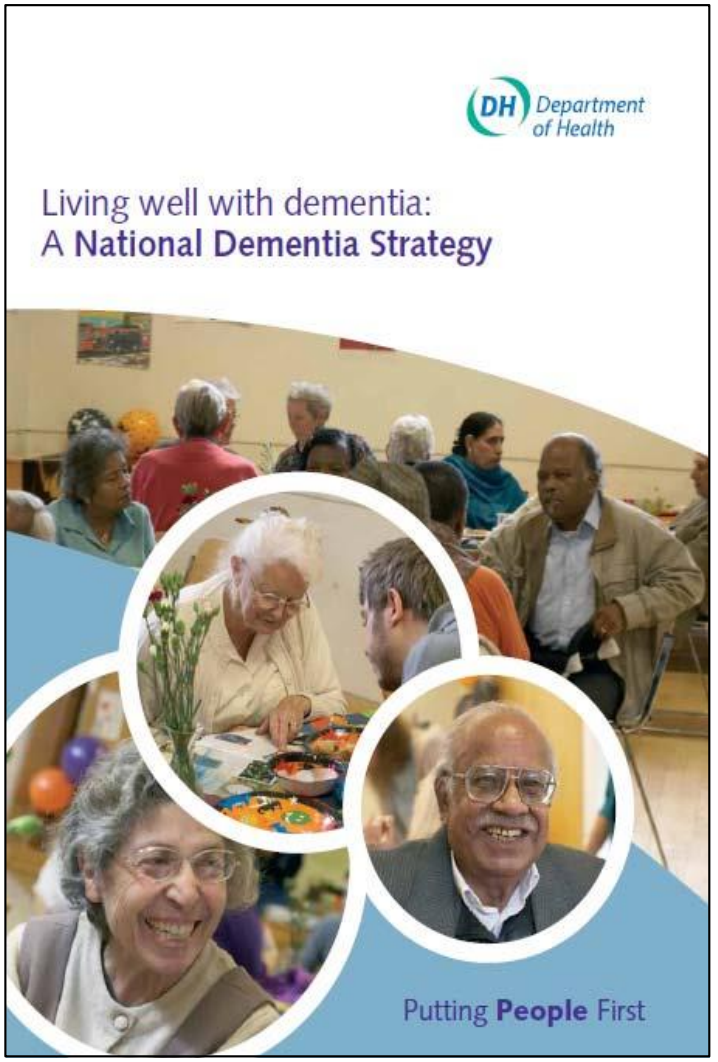
What are the National drivers in Dementia Care ?

National Dementia Strategy 2009

- 5 year plan
- 17 interlinked objectives
- £150million extra funding

Key themes

- Improving awareness
- Early and better diagnosis
- Improved quality of care
- Delivering the Strategy



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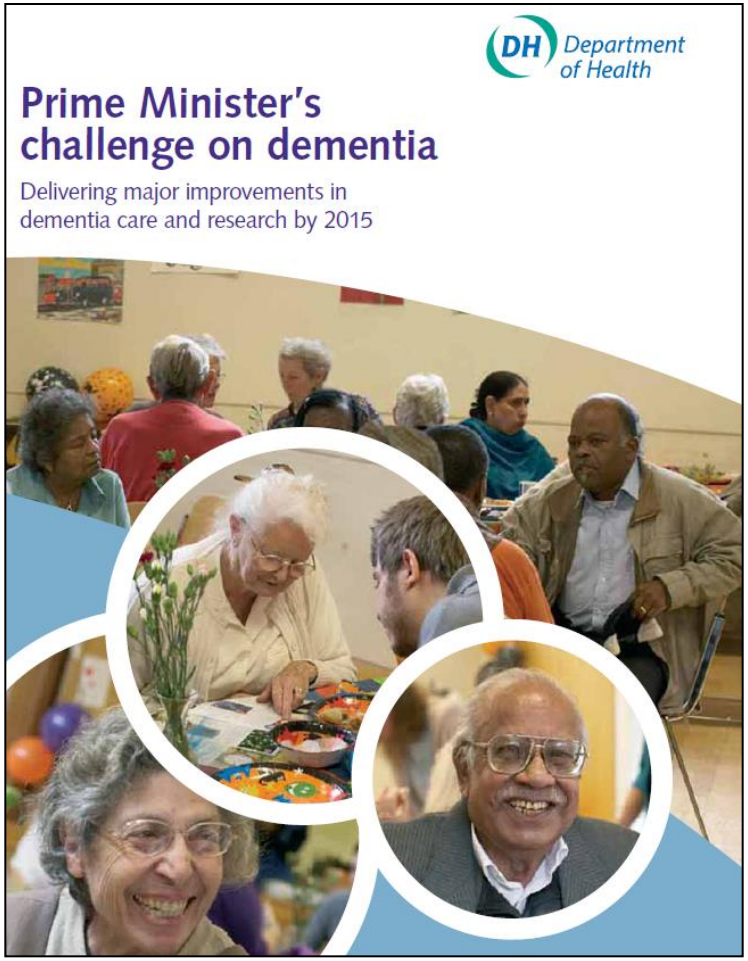
Prime Minister's challenge on dementia 2012



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Department of Health

I million dementia friends
Highest diagnosis rate

Awareness
Key role of GPs
Post diagnostic support
    Information, advice, carers
Access to diagnosis
Staff training
Dementia Institute
Dementia Friends/ businesses
Advance Care Planning
Research

Appendix 1 – Adult Social Care Outcomes Framework 2017/18 – at a glance

1: Enhancing quality of life for people with care and support needs	2: Delaying and reducing the need for care and support	3: Ensuring people have a positive experience of care and support	4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm
Overarching measures 1A. Social care-related quality of life 1J – Adjusted Social care-related quality of life – impact of Adult Social Care Services	**Overarching measure** 2A. Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	**Overarching measures** ***People who use social care and their carers are satisfied with their experience of care and support services*** 3A. Overall satisfaction of people who use services with their care and support	**Overarching measure** 4A. Proportion of people who use services who feel safe
Outcome measures ***People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match t… needs*** 1B. Proportion of people who use services have control over their daily life 1C. Proportion of people using social care receive self-directed support, and those receiving direct payments ***Carers can balance their caring roles and maintain their desired quality of life*** 1D. Carer-reported quality of life ***People are able to find employment whe… they want, maintain a family and social l… and contribute to community life, and av… loneliness or isolation*** 1E. Proportion of adults with a learning disability in paid employment 1F. Proportion of adults in contact with secondary mental health services in paid employment 1G. Proportion of adults with a learning disability who live in their own home or w… their family 1H. Proportion of adults in contact with secondary mental health services living independently, with or without support 1I. Proportion of people who use services carers, who reported that they had as mu… social contact as they would like	**Outcome measures** ***Everybody has the opportunity to have the best health and wellbeing throughout their life, and***	3B. Overall satisfaction of carers with social	**Outcome measures** ***Everyone enjoys physical activity and feels secure*** ***People are free from physical and emotional abuse, harassment, neglect and self-harm*** ***People are protected as far as possible from***

Appendix 3 – The Public Health Outcomes Framework 2016-19 at a glance

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification

Public Health Outcomes Framework 2016–2019
At a glance

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in low income families
1.2 School readiness
1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training
1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*
1.7 Proportion of people in prison aged 18 or over who have a mental illness
1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) ††(ii-NHSOF 2.5) †† (iii-ASCOF 1F)*
1.9 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Levels of offending and re-offending
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation † *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Appendix 2 – NHS Outcomes Framework 2017/18 – at a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential years of life lost (PYLL) from causes considered amenable to healthcare
i Adults * ii Children and young people
1b Life expectancy at 75
i Males * ii Females *
1c Neonatal mortality and stillbirths

Improvement areas

Reducing premature mortality from the major causes of death
i.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.1†) *
1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7†)
1.3 Under 75 mortality rate from liver disease (PHOF 4.8†)
1.4 Under 75 mortality rate from cancer (PHOF 4.5†) *
i One- and ii Five-year survival from all cancers
iii One- and iv Five-year survival from breast, lung and colorectal cancer
v One- and vi Five-year survival from cancers diagnosed at stage 1&2 (PHOF 2.19††)

Reducing premature mortality in people with mental illness
1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9†)
ii *Excess under 75 mortality rate in adults with common mental illness*
iii *Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services* (PHOF 4.10††)

Reducing mortality in children
1.6 i Infant mortality (PHOF 4.1†) *
ii Five year survival from all cancers in children

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

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

Overarching indicators

2 Health-related quality of life for people with long-term conditions (ASCOF 1A††) *

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions (ASCOF 1E††, PHOF 1.8†)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions *
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (ASCOF 1D††)

Enhancing quality of life for people with mental illness
2.5 i Employment of people with mental illness (ASCOF 1F†† & PHOF 1.6††)
ii *Health-related quality of life for people with mental illness* (ASCOF 1A†† & PHOF 1.6††)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia (PHOF 4.18†)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life* (ASCOF 3F††)

Improving quality of life for people with multiple long-term conditions
2.7 Health-related quality of life for people with three or more long-term conditions (ASCOF 1A††)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission *
3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11†)

Improvement Areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i *Physical health-related procedures*
ii *Psychological therapies*
iii *Recovery in quality of life for patients with mental illness*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *Survival from major trauma*

Improving recovery from stroke
3.4 *Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B††*)
ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B††*)

Improving Dental Health
3.7 i *Decaying teeth* (PHOF 4.02**)
ii Tooth extractions in secondary care for children under 10

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services *
ii GP Out-of-hours services
iii NHS dental services
4b Patient experience of hospital care
4c *Friends and family test*
4d *Patient experience characterised as poor or worse*
i *Primary care*
ii *Hospital care*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services * and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 *Patient experience of community mental health services*

Improving children and young people's experience of healthcare
4.8 *Children and young people's experience of inpatient services*

Improving people's experience of integrated care
4.9 *People's experience of integrated care* (ASCOF 3E**)

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a *Deaths attributable to problems in healthcare*
5b *Severe harm attributable to problems in healthcare*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Deaths from venous thromboembolism (VTE)-related events
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 *Proportion of patients with category 2, 3 and 4 pressure ulcers*
5.4 *Hip fractures from falls during hospital care*

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Improving the culture of safety reporting
5.6 Patient safety incidents reported

NHS Outcomes Framework 2017/18
at a glance

Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)

* Indicator is shared
** Indicator is complementary

≠ Indicator is for health inequalities assessment
Indicators in italics are in development

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NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL

Risk of people developing dementia is minimised

"I was given information about reducing my personal risk of getting dementia"

STANDARDS:

- Prevention[1]
- Risk Reduction[5]
- Health Information[4]
- Supporting research[5]

DIAGNOSING WELL

Timely accurate diagnosis, care plan, and review within first year

"I was diagnosed in a timely way"

"I am able to make decisions and know what to do to help myself and who else can help"

STANDARDS:

- Diagnosis[1][5]
- Memory Assessment[1][2]
- Concerns Discussed[3]
- Investigation[4]
- Provide Information[4]
- Integrated & Advanced Care Planning[1][2][3][5]

SUPPORTING WELL

Access to safe high quality health & social care for people with dementia and carers

"I am treated with dignity & respect"

"I get treatment and support, which are best for my dementia and my life"

STANDARDS:

- Choice[2][3][4], BPSD[6][2]
- Liaison[2], Advocates[3]
- Housing[3]
- Hospital Treatments[4]
- Technology[5]
- Health & Social Services[5]
- Hard to Reach Groups[3][5]

LIVING WELL

People with dementia can live normally in safe and accepting communities

"I know that those around me and looking after me are supported"

"I feel included as part of society"

STANDARDS:

- Integrated Services[1][3][5]
- Supporting Carers[2][4][5]
- Carers Respite[2],
- Co-ordinated Care[1][5]
- Promote independence[1][4]
- Relationships[3], Leisure[3]
- Safe Communities[3][5]

DYING WELL

People living with dementia die with dignity in the place of their choosing

"I am confident my end of life wishes will be respected"

"I can expect a good death"

STANDARDS:

- Palliative care and pain[1][2]
- End of Life[4]
- Preferred Place of Death[5]

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

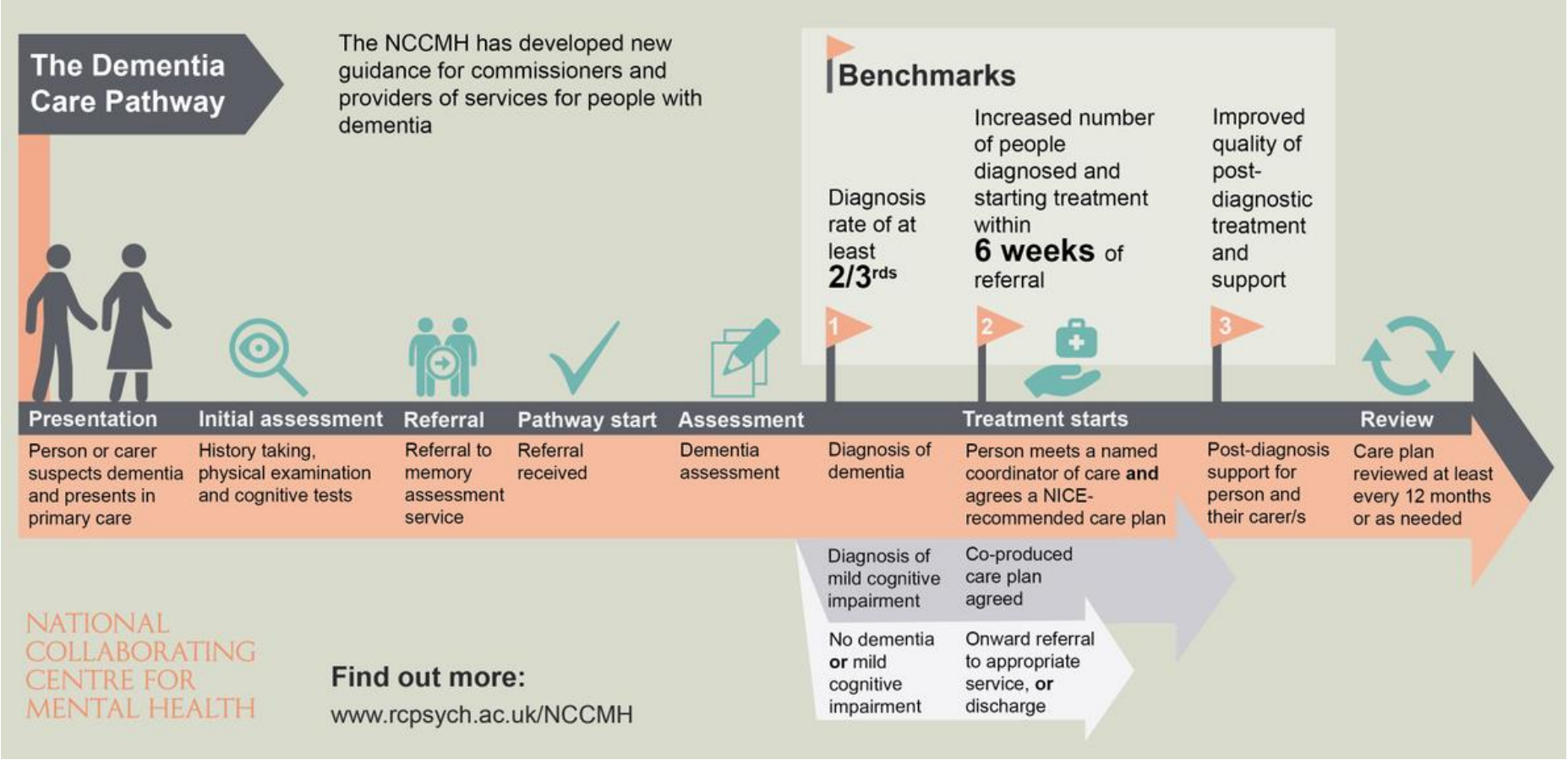
TRAINING WELL

- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

MONITORING WELL

- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

What does the journey look like?



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What does good dementia care look like?

	Key statements
"I was diagnosed in a timely way"	We know that if I am referred for an assessment for dementia, I will receive a timely diagnosis and agree on an initial care plan.
"I am able to make decisions, and I know what to do to help myself and who else can help"	We know that I will have a personal choice in decisions affecting my care and support. We know that I will be able to jointly develop my care plan. We know that if I need help, I will be supported to make a decision, for example through the use of independent advocacy services.
"I am treated with dignity and respect"	We know that services are designed around us and our needs, and that they will be appropriately staffed and staff will have the right levels of training. We know that services will provide the best possible care, and will be regularly reviewed by other agencies.
"I get treatment and support which are best for my dementia and my life"	Once I am diagnosed, we know that we will have a named coordinator of care who will jointly review my care plan with us as our needs change. This will happen at least once a year.
"Those around me and looking after me are supported"	We know that my care plan will cover my own needs as well as those of the people who support me. This will include our emotional, psychological and social needs. We know that a carer's assessment will be offered.
"I feel included as part of society"	We know that my care plan will give us the support we need to live well. This may include helping me build relationships, be involved in my community or engage in activities that I enjoy.
"I am confident my end-of-life wishes will be respected and I can expect a good death"	We know that my care plan will help us to plan for the future, including my end-of-life wishes.

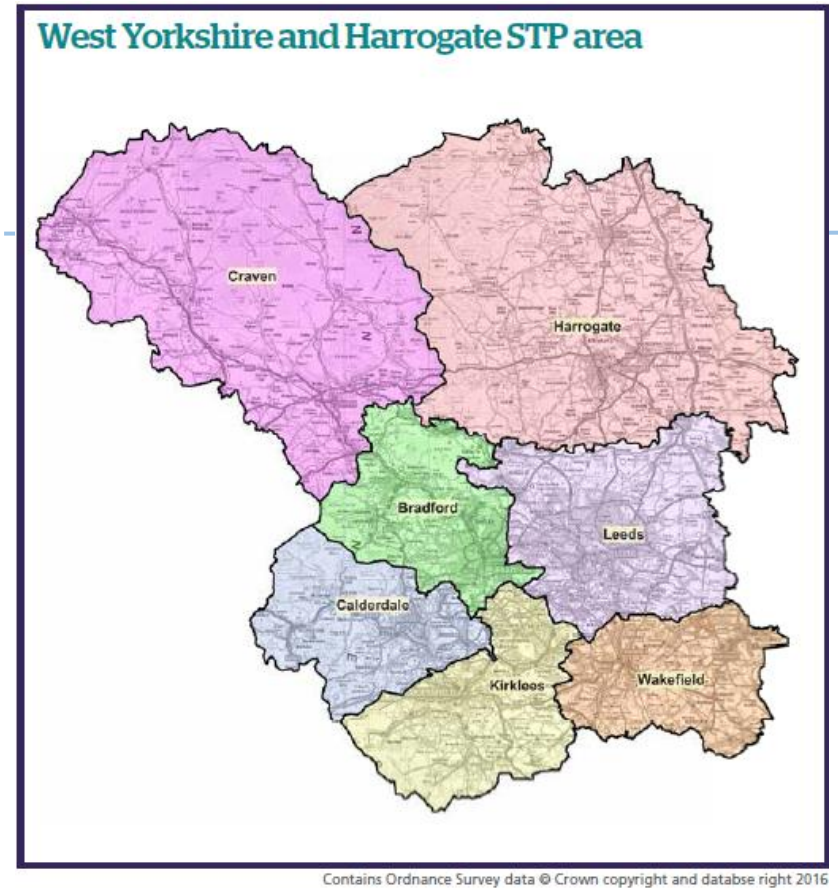
‘’i ‘’statements

- I have personal choice and control over the decisions that affect me.
- I know that services are designed around me, my needs and my carer’s needs.
- I have support that helps me live my life.
- I have the knowledge to get what I need.
- I live in an enabling and supportive environment where I feel valued and understood.
- I have a sense of belonging and of being a valued part of family, community and civic life.
- I am confident my end of life wishes will be respected. I can expect a good death.
- ***I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to it.***

http://www.dementiaaction.org.uk/

What are the more local drivers ?

West Yorkshire and Harrogate Health & Care Partnership
Six local area plans……



- Bradford District & Craven
- Calderdale
- Harrogate & Rural District
- Kirklees
- Leeds
- Wakefield

Covering prevention, primary care, and joined up health and social care services.

Based around the relationships of the Health and Wellbeing Boards and Health and Wellbeing Strategies.

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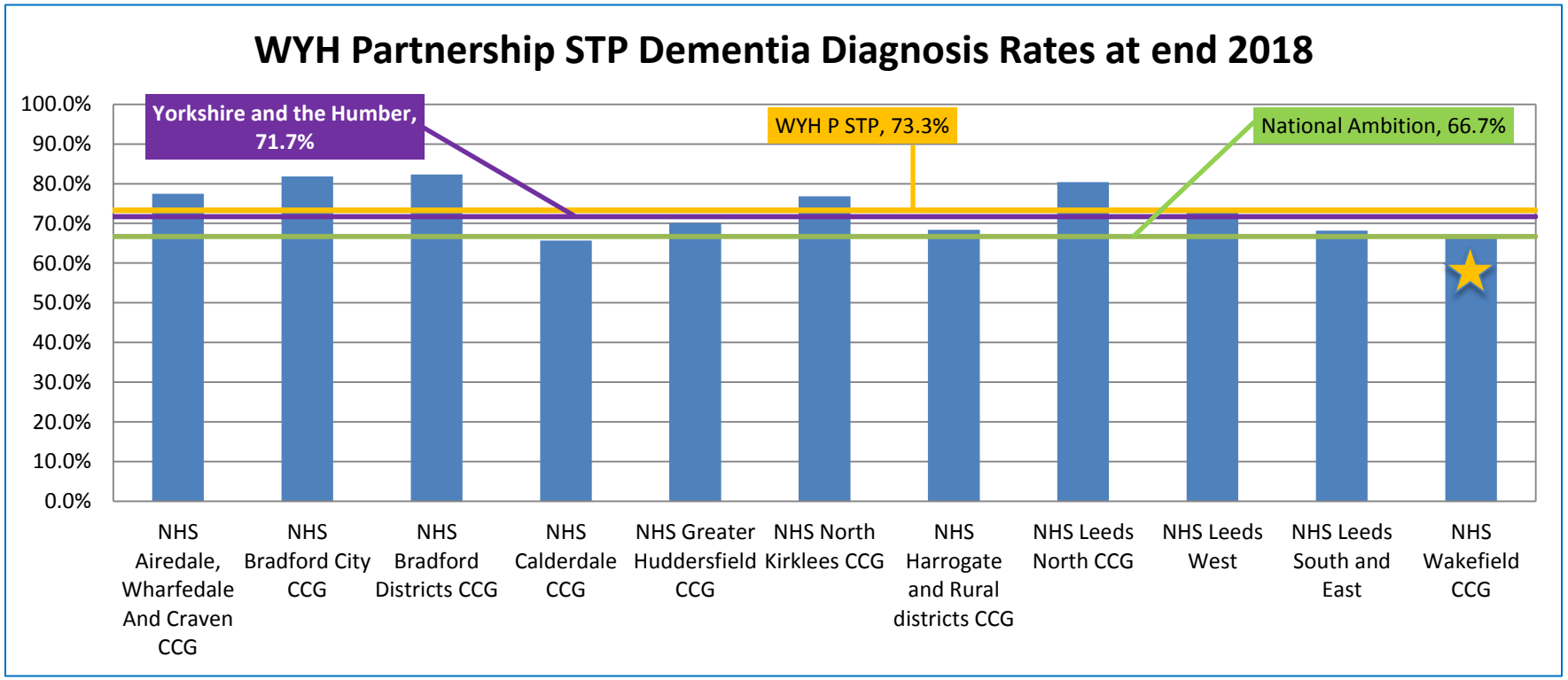
Made up of….

- **It starts with people….2.6 million**

- 11 Clinical Commissioning Groups (6 management teams)
- 8 councils (including 1 county, 5 metropolitan councils, 2 districts)
- 6 hospital trusts, 4 community & mental health trusts
- A number of large independent sector providers,
- Yorkshire Ambulance Service
- 333 GP practices
- 601 community pharmacies
- Over 665 care homes
- 319 domiciliary care providers
- 10 hospices
- Thousands of voluntary and community organisations.

What are Successes!

Dementia Diagnosis Rates (DDR) end 2018



Diagnosing Well

• a note is attached to the value, hover over to

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Display Values | Trends | Values & Trends

Export table as image

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Indicator	Period	England	West Yorkshire	NHS Airedale, Wharfdale And Crave...	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Greater Huddersfield CCG	NHS Harrogate And Rural District...	NHS Leeds CCG	NHS North Kirklees CCG	NHS Wakefield CCG
Dementia: Blood tests recorded at diagnosis	2017/18	68.0	76.3	83.9	82.7	83.3	75.3	69.9	73.9	73.9	66.7	80.6
Estimated dementia diagnosis rate (aged 65 and over) ≥ 66.7% (significantly) similar to 66.7% < 66.7% (significantly)	2018	67.5	72.8	76.9	83.7	81.3	65.5	69.6	76.5	73.6	68.1	67.1

CCGs working together

Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

Living Well

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Compared with benchmark: Lower | Similar | Higher | Not compared

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Indicator	Period	England	West Yorkshire	NHS Airedale, Wharfdale And Crave...	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Greater Huddersfield CCG	NHS Harrogate And Rural District...	NHS Leeds CCG	NHS North Kirklees CCG	NHS Wakefield CCG
Dementia care review documented in the last 12 months	2017/18	77.5	78.9	79.9	76.4	79.5	74.8	81.4	79.2	79.3	78.2	77.8

CCGs working together

Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

But we have our Challenges !

Supporting Well

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

* a note is attached to the value, hover over to see m

Display: Values | Trends | Values & Trends

Export table as image | Export table as CSV file

Indicator	Period	England	West Yorkshire	NHS Airedale, Wharfdale And Crave...	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Greater Huddersfield CCG	NHS Harrogate And Rural District...	NHS Leeds CCG	NHS North Kirklees CCG	NHS Wakefield CCG
Dementia: Quality rating of residential care and nursing home beds (aged 65 years and over)	2018	68.6	54.8	82.9	55.8	53.4	54.3	48.3	56.8	48.7	54.2	49.9
Dementia: Residential care and nursing home bed capacity (aged 65 years and over)	2018	68.2	66.6	80.9	102.4	72.7	58.2	54.3	79.0	57.6	54.9	76.1
Dementia: Percentage of assessed residential care and nursing home beds (aged 65 years and over)	2018	94.1	91.3	92.1	100	95.0	84.1	90.6	87.5	92.8	100	86.0
Dementia: Ratio of inpatient service use to recorded diagnoses - CCG responsibility	2017/18	56.5	55.3	43.1	43.4	54.5	69.1	56.3	43.3	57.2	55.5	61.1
Dementia: Direct standardised rate of emergency admissions (aged 65 years and over) - CCG responsibility	2017/18	3609	3898	2869	4183	4173	4893	3934	2940	4041	3550	4075
Dementia: Short stay emergency admissions (aged 65 years and over) - CCG responsibility	2017/18	28.9	30.4	25.3	47.8	43.7	37.1	39.7	27.8	24.0	29.2	23.1
Alzheimer's disease: Direct standardised rate of inpatient admissions (aged 65 years and over) - CCG responsibility	2017/18	702	850	460	303*	674	737	666	810	1042	868	1097
Vascular dementia: Direct standardised rate of inpatient admissions (aged 65 years and over) - CCG responsibility	2017/18	527	559	809	595	568	771	650	415	539	387	436
Unspecified dementia: Direct standardised rate of inpatient admissions (aged 65 years and over) - CCG responsibility	2017/18	1279	1359	832	1649	1651	1761	1528	914	1213	1507	1552

Dementia: Direct standardised rate of emergency admissions (aged 65 years and over) - CCG responsibility 2017/18

Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	368,044	3,609	3,598	3,621
West Yorkshire	–	16,600	3,898	3,838	3,958
NHS Airedale, Wharfdale …	–	1,004	2,869	2,694	3,053
NHS Bradford City CCG	–	320	4,183	3,731	4,673
NHS Bradford Districts CCG	–	2,147	4,173	3,998	4,354
NHS Calderdale CCG	–	1,761	4,893	4,667	5,128
NHS Greater Huddersfield…	–	1,574	3,934	3,741	4,134
NHS Harrogate And Rural …	–	1,099	2,940	2,768	3,120
NHS Leeds CCG	–	5,216	4,041	3,931	4,153
NHS North Kirklees CCG	–	999	3,550	3,332	3,778
NHS Wakefield CCG	–	2,480	4,075	3,915	4,239

Dementia: Short stay emergency admissions (aged 65 years and over) - CCG responsibility 2017/18

Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	115,125	28.9	28.8	29.1
West Yorkshire	–	5,352	30.4	29.7	31.1
NHS Airedale, Wharfdale …	–	296	25.3	22.9	27.9
NHS Bradford City CCG	–	166	47.8	42.6	53.1
NHS Bradford Districts CCG	–	1,018	43.7	41.7	45.8
NHS Calderdale CCG	–	667	37.1	34.9	39.4
NHS Greater Huddersfield…	–	652	39.7	37.4	42.1
NHS Harrogate And Rural …	–	313	27.8	25.2	30.5
NHS Leeds CCG	–	1,275	24.0	22.9	25.2
NHS North Kirklees CCG	–	323	29.2	26.6	32.0
NHS Wakefield CCG	–	642	23.1	21.6	24.7

Source: Health and Social Care Information Centre (HSCIC)

Dying Well

* a note is attached to the value, hover over to see more

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Display Values | Trends | Values & Trends

Export table as image | Export table as CSV file

Indicator	Period	England	West Yorkshire	NHS Airedale, Wharfdale And Crave...	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Greater Huddersfield CCG	NHS Harrogate And Rural District...	NHS Leeds CCG	NHS North Kirklees CCG	NHS Wakefield CCG
Direct standardised rate of mortality: People with dementia (aged 65 years and over)	2017/18	903	959	1084	1307	944	978	908	861	947	865	1011
Deaths in Usual Place of Residence: People with dementia (aged 65 years and over)	2017/18	68.5	66.5	78.9	72.9	75.9	60.4	69.0	71.1	59.7	67.6	61.6
Place of death - care home: People with dementia (aged 65 years and over)	2017/18	58.0	56.5	71.6	57.1	65.2	49.7	58.0	64.2	49.6	55.5	51.2
Place of death - hospital: People with dementia (aged 65 years and over)	2017/18	30.5	32.0	20.0	24.3	23.4	37.9	28.6	28.0	38.9	30.5	36.5
Place of death - home: People with dementia (aged 65 years and over)	2017/18	9.9	9.5	7.0	15.7	10.3	10.2	10.4	6.4	9.2	12.1	10.2

Bradford Districts CCG

Why do we have the challenges?

NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL

Risk of people developing dementia is minimised

"I was given information about reducing my personal risk of getting dementia"

STANDARDS:

- Prevention[1]
- Risk Reduction[5]
- Health Information[4]
- Supporting research[5]

DIAGNOSING WELL

Timely accurate diagnosis, care plan, and review within first year

"I was diagnosed in a timely way"

"I am able to make decisions and know what to do to help myself and who else can help"

STANDARDS:

- Diagnosis[1][5]
- Memory Assessment[1][2]
- Concerns Discussed[3]
- Investigation[4]
- Provide Information[4]
- Integrated & Advanced Care Planning[1][2][3][5]

SUPPORTING WELL

Access to safe high quality health & social care for people with dementia and carers

"I am treated with dignity & respect"

"I get treatment and support, which are best for my dementia and my life"

STANDARDS:

- Choice[2][3][4], BPSD[6][2]
- Liaison[2], Advocates[3]
- Housing[3]
- Hospital Treatments[4]
- Technology[5]
- Health & Social Services[5]
- Hard to Reach Groups[3][5]

LIVING WELL

People with dementia can live normally in safe and accepting communities

"I know that those around me and looking after me are supported"

"I feel included as part of society"

STANDARDS:

- Integrated Services[1][3][5]
- Supporting Carers[2][4][5]
- Carers Respite[2],
- Co-ordinated Care[1][5]
- Promote independence[1][4]
- Relationships[3], Leisure[3]
- Safe Communities[3][5]

DYING WELL

People living with dementia die with dignity in the place of their choosing

"I am confident my end of life wishes will be respected"

"I can expect a good death"

STANDARDS:

- Palliative care and pain[1][2]
- End of Life[4]
- Preferred Place of Death[5]

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

TRAINING WELL

- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

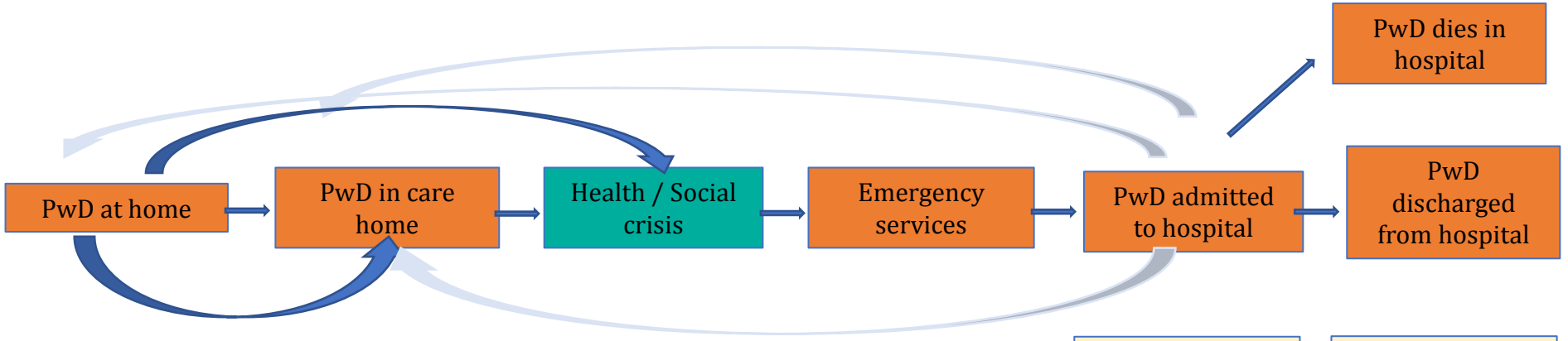
MONITORING WELL

- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

Poor transitions of care

- **Transitional care** refers to the coordination and continuity of health **care** during a movement from one healthcare setting to either another or to home, called **care transition**, between health **care** practitioners and settings as their condition and **care** needs change during the course of a chronic or acute illness.

Typical life journey for People with Dementia (PwD) showing multiple transitions of care



Supported by
- Family carers
- Social carers
- Falls team
- District nurses
- GPs
- Admiral nurses
- Mental health services for older people

Supported by
- Family carers
- Social carers
- Community matron
- District nurses
- Falls team
- GPs
- Mental health services for older people

Examples
- Carer respite
- Carer breakdown
- Illness of carer
- UTIs
- Falls
- Dehydration
- Confusion

Supported by
- Out of hours service
- NHS Direct
- Ambulance service
- GPs

Supported by
- Rapid response team
- A&E staff
- Medical admissions staff
- Care of the elderly multi-disciplinary team

Supported by
- Care of the elderly multi-disciplinary team
- Hospital matron
- Discharge team
- Social care assessors
- Community matron

Adapted from: https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/past-initiatives/end-of-life-care-and-dementia/end-of-life-project-report.pdf

NHS

OUTCOME

- Examples
- Carer respite
- Carer breakdown
- Illness of carer

- UTIs
- Falls
- Dehydration
- Confusion

Hospital

A&E

Care Home

New Care Providers

Costs

Increased length of stay

Increased re-admission rates

Care Home Admissions

Mortality/Morbidity

Increased adverse events

Increased emotional and physical pain

Relationship Breakdowns

Experience

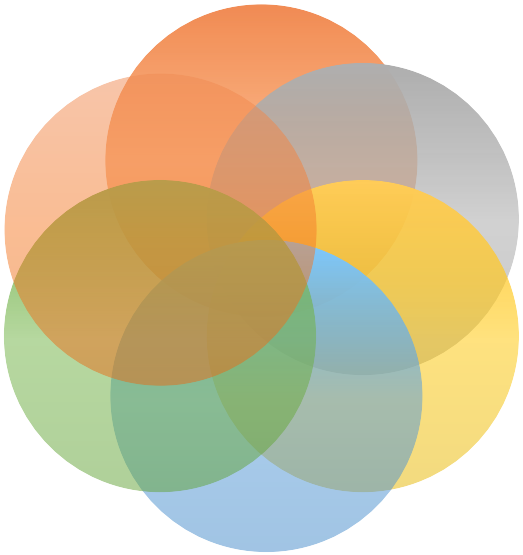
CCGs working together

Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

How might a crisis present?

'Unable to cope due to unrecognised physical or mental health needs

Behaviours that challenge /psychotic symptoms



Unplanned admissions due to acute illness

(falls/sepsis/ etc)

Informal and formal Carer strain or Carer emergency

Poor palliative care/End of life care in an acute hospital

Delirium

Burdensome Transitions for People with Dementia near the End of Life

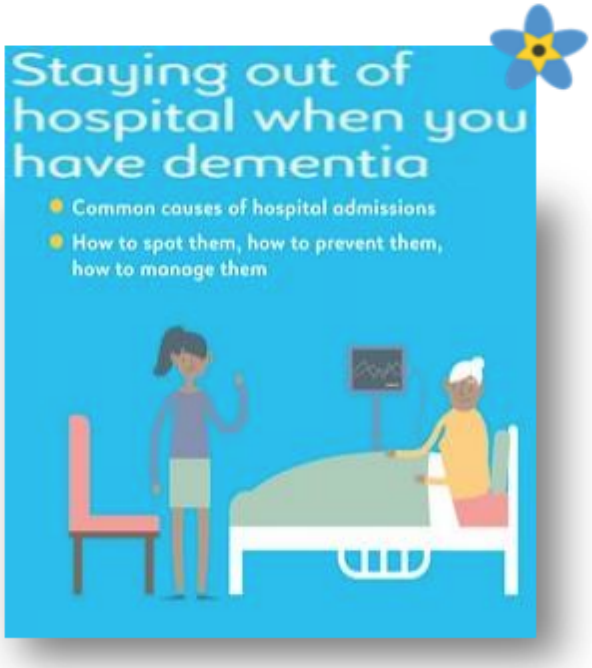
- Transitions between care settings at the end of life can result in adverse consequences, particularly for individuals with dementia.
- 'Burdensome' transitions have been defined as transitions in the last 3 days of life, or multiple transitions (⩾2 from infection or ⩾3 from any cause) in the last 90 days of life.
- Individuals with multiple transitions in the last 90 days were more likely to be male, have physical illness problems and problems with depressed mood and less likely to be living in a care home

- Burdensome Transitions for People with Dementia near the End of Life: Retrospective Cohort Study Using Linked Clinical and Administrative Data **Katherine SleemanKCL**

What are we trying to do to reduce the challenges?

STP initiative

- Working with 3 STPs to take part in project
- Bring together a range of measures with potential to reduce:
    - unnecessary admissions
    - length of stay
- Person centred meaningful care
- Targeting care homes and individual residents within those homes for bespoke support



Progressing the initiative

- Work on reducing Delirium in Hospitals/Care Homes and in a primary care setting
- Increased uptake of advance and emergency care planning
- An inpatient matrix to understand behaviours prior to discharge


Dementia Research

Coming back to research-Why is there not more Dementia Research in primary care?

The Challenges for Primary Care?

Challenges!

- Disempowerment
- Low Diagnosis rates
- Populations in 1'care v studies in 2'care
- Primary care lead by doctors v studies coming from schools of nursing/therapy etc
- Difficulty engaging Care Home
- Mental Capacity
- Lack of popularity
- Who gets the accruals!
- Exclusion of BAME populations

The Opportunities for Primary Care?

Opportunities!

- The Dementia Well Pathway /national direction
- Rising diagnosis rates
- JDR
- Collaboration with Universities-PhD studies
- GP Champions
- GPwSI
- Collaborations between 1' and 2 'care
- Dementia Friendly Surgeries
- Annual care Planning reviews
- PPGs and Patient ambassadors

Join dementia research

NHS National Institute for Health Research

To see if you can help a dementia research study visit:

www.joindementiaresearch.nihr.ac.uk

Or call our one of our helplines:

Alzheimer's Research UK
The Power to Defeat Dementia

Leading the fight against dementia
Alzheimer's Society

Alzheimer's Research UK (0300 111 5 111)
Alzheimer's Society (0300 222 1122)

CCGs working together
Airedale, Wharfedale and Craven CCG
Bradford City CCG

Finally why does research not lead to better care?

Some Gaps!

- Lack of collaboration between the 'Dementia real World' and the 'Research World
- A Gap between how topics for studies are developed and the actual needs of front line staff
- A Gap in the commissioning of research into some strands of the Dementia Well Pathway
- Not using the the research published to commission care .
- A mismatch in moving small scale research to real world settings.

How do we change this?


COMMISIONERS
CLINICAL NETWORKS
Teamwork
Trust
Inspiration
PLWD
Share
Universities
COLLABORATION
Exchange
CRN
NIHR
Success
Support
Assist
CCG
GPs
Acute and Mental Health Providers

Conclusions?

Dementia is a growing issue for society but Dementia awareness and care is improving and Dementia research is on the way up-so we just need to now ensure we collaborate to ensure that the best evidence leads to better care

Thank You!

- sara.humphrey@bradford.nhs.uk