1. Introduction

This strategy sets out progress that NHS North Norfolk Clinical Commissioning Group, NHS South Norfolk Clinical Commissioning Group and Norwich Clinical Commission Group (collectively known as the central Norfolk CCGs) will take with partners and services to improve dementia diagnosis rates, services, access to services and outcomes for people living with dementia and their carers. The strategy and action plan have been developed to support progress against national, county and CCG level priorities. It forms a core work stream for each CCG and also the Norfolk and Waveney Sustainability and Transformation Partnership (STP), with the aim of ensuring that actions and developments are taken forward within a wider vision of integrated care and services.

The central Norfolk CCGs believe that implementing this strategy will:

- Improve people’s experience of living with dementia and improve the services they receive.
- Improve the experiences of families and carers of people living with dementia and the services they can access.
- Increase levels of awareness and understanding of dementia amongst the public and service providers, helping to reduce the stigma associated with dementia.
- Ensure a higher proportion of people receive a timely dementia diagnosis and quickly access appropriate post diagnostic support.

2. National Context

In 2009 “Living Well with Dementia - a National Dementia Strategy” was issued. This set out new standards for dementia care focusing on improved awareness, earlier diagnosis and intervention and a higher quality of care. In 2010 the Quality Outcomes for people with dementia were published, these built on the work of the national strategy and dementia NICE guidance.

The Strategy’s ambitions were reinforced in 2012 by the launch of the “The Dementia Challenge: responding to a National Priority” which provided a focus on speeding up the raising of diagnosis rates and improving the skills and awareness needed to support people living with dementia and their carers. Geographical performance in the identification and management of Dementia across England was highlighted in the 2013 “Dementia: A state of the nation report on dementia care and support in England” which also promoted the development of Dementia Friendly communities.

More recently in February 2015 the Department of Health (DoH) issued the Prime Ministers Challenge on Dementia 2020 which includes the Well Pathway:
<table>
<thead>
<tr>
<th>Preventing Well</th>
<th>The risk of people developing dementia is minimised</th>
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</thead>
<tbody>
<tr>
<td>Diagnosing Well</td>
<td>People receive a timely and accurate diagnosis, care plan and review within the first year</td>
</tr>
<tr>
<td>Supporting well</td>
<td>People living with dementia and their carers have access to safe, high quality health and social care</td>
</tr>
<tr>
<td>Living Well</td>
<td>People living with dementia can live normally in safe and accepting communities</td>
</tr>
<tr>
<td>Dying Well</td>
<td>People living with dementia die with dignity in the place of their choosing</td>
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With the key objective that by 2020 England will be the “the best country in the world for dementia care and support for people with dementia, their careers and families to live™". Throughout this the importance of ensuring that people with dementia and their carers are at the heart of everything that is taken forward to realise this vision is critical. The vision’s main objectives include:

- Improved public awareness and understanding of the factors, which increase the risk of developing dementia and how people can reduce their risk by living more healthily.
- People with dementia having equal access to diagnosis, with an expectation that the national average for an initial assessment should be 6 weeks following a referral from a GP (where clinically appropriate).
- Every person diagnosed with dementia having meaningful care following their diagnosis, which supports them and those around them.
- All NHS staff having received training on dementia appropriate to their role.
- An additional 3 million Dementia Friends in England. All hospitals and care homes meeting agreed criteria to becoming a dementia friendly health and care setting. GPs playing a leading role in ensuring coordination and continuity of care for people with dementia. From 1 April 2015 everyone will have access to a named GP with overall responsibility and oversight for their care.
- Over half of people living in areas that have been recognised as Dementia Friendly Communities

In addition, NHS Operational Planning and Contracting Guidance for 2017-19 states that CCGs must:

- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral.
3. Norfolk Picture

Dementia was one of the three priorities within the Norfolk Health and Wellbeing Board 2014 – 2017 strategy. The strategy aimed to make Norfolk a better place for people with dementia and their carers. The objectives contained within this priority were to:

1. Promote awareness of dementia and improve diagnosis rates
2. Build an integrated approach to dementia
3. Understand the components of managed dementia care in Norfolk and identify gaps in provision
4. Promote independent living in the community
5. Improve services for those unable to live independently

The strategy highlighted how:

“The prevalence of dementia is rising both nationally and in Norfolk. Dementia is principally a disease of older people and Norfolk has a higher proportion of people over 65 than the England average. It is estimated that nearly two thirds of people with dementia in Norfolk have not had a formal diagnosis of their condition and that over the next ten years the number of people with dementia will increase by about 5,000”.

The strategy was built upon the findings of a Norfolk Dementia needs assessment. The assessment highlighted the following:

- There are about 26 new cases of dementia per year per 1000 population of over 65s in Norfolk (diagnosed or undiagnosed).
- Just over half of people with dementia have mild dementia and the remaining have moderate or severe.
- People with dementia find it difficult to feel part of, and participate in, their community in Norfolk. People identified several attributes they wanted from their community which included awareness, support groups, clearer information, and supportive physical environment, activities at the right level, good transport and local amenities.
- Feedback from people with dementia and their carers indicated that people want to know their diagnosis.
- There needs to be a step change in the diagnosis rate if the national NHS England target of 67% is reached.
- People felt that the quality of services provided within Norfolk is good but that there remain capacity issues.
- About 1 in 3 to 1 in 5 people in hospital have dementia.
- There is a reluctance across some GPs to refer for diagnosis, because they see little point diagnosing dementia as they perceive that there are no or limited services to support people with dementia and their carers after diagnosis.

The assessment recommendations included the following:

- CCGs should ensure GPs are aware of available support for people with dementia and their carers.
- Commissioners and providers should work together to help more people with dementia die in their place of choice.
• Health and social care should jointly commission dementia support services.
• Dementia friendly communities should extend to non-geographical communities.
• CCGs should assist GP practices to standardise dementia coding and undertake coding audits.
• Providers, especially acute hospitals, community healthcare, care homes and domiciliary care organisations, should include essential dementia skills and knowledge in their job descriptions when recruiting staff and use dementia coaches for workforce development.
• Commissioners and providers should work together to develop joint referral pathways and where appropriate agree tools.

Learning Disability
Norfolk has an estimated 22,000 people living with a learning disability. For many of these, symptoms will be mild and they will not be receiving care or support from mainstream social care/day services.

The 3 Central Norfolk CCGs have combined responsibility for 68 GP practices, with a combined list size of 637,336. Of this 4321 (2.06%) are recorded as having a moderate to severe learning disability as part of practice QoF returns (NHS Digital 2016/17 Qof Data http://digital.nhs.uk/catalogue/PUB30124).

People living with moderate to severe learning disability are at a higher risk of developing early onset dementia.
• 30% of people 50 or over with a diagnosis of Downs Syndrome will have developed Alzheimer’s
• 50% or more of people with Downs Syndrome will develop Alzheimer’s as they age.
• 1 in every 10 people with a learning disability (not Downs Syndrome) between the ages of 50 and 65 have already developed Alzheimer’s

4. Central Norfolk Dementia Strategy

4.1 Dementia Rates
The Norfolk dementia needs assessment estimated that in 2015 there would be 3792 people with dementia in the South Norfolk CCG area, 4223 in the North Norfolk CCG area and 3942 in the Norwich CCG area. This is set to increase year on year.
NHSE’s national ambition is that two-thirds of people with dementia are identified and given appropriate support.

CCGs have been working with GPs and services to increase dementia diagnosis rates. The latest data available (October 2017) via NHS England QOF reporting showed that diagnosis rates for 65 years plus are:

- 63.7% for SNCCG
- 60.8% for NNCCG
- 60.7% for NCCG (this excludes Bowthorpe Care Village data which increases rate to 63.83%)
4.2 Stratification
The central Norfolk CCGs are taking a stratified approach adding local outcomes to the wider STP objectives.

**Tier 1** level relates to those who require general information and advice and have a low level need that can be met without ongoing intervention by either a wellbeing coordinator/support worker or dementia adviser.

**Tier 2** relates to the provision of ongoing support to families who have a longer term, lower level need that can be met by a wellbeing coordinator/support worker.

**Tier 3** would be provided by Admiral Nurses who are able to offer specialist support and knowledge for cases that have an intensive level of need and complexity that cannot be provided by unqualified members of staff.

Source: NHS Digital Recorded Dementia Diagnoses
4.3 Implementation Plans
The overarching objective within the central Norfolk CCGs' Dementia Strategy is to ensure:

There is good information, advice and support services for people living with dementia and for their carers and families so that people living in central Norfolk are more confident that they can live well and independently with dementia and get access to appropriate services when required.

Each improvement plan addresses the questions posed by the NHS England Checklist - Key Lines of Enquiry for Dementia.

The central Norfolk CCGs all have improvement Plans based around the 5 Pillars Model which provides a framework for people living with dementia, their families and carers with the tools, connections, resources and plans to allow them to live as well as possible with dementia and prepare for the future.
Supporting Community Connections - Support to maintain and develop social networks.

Peer Support - From other people with dementia, their families and carers to help come to terms with ill and maintain wellbeing and resilience.

Planning for Future Care - Support, when they are ready, to plan the shape of their future care from their own perspective together with those around them, developing a personal plan with their choices, hopes and aspirations which can guide professionals.

Understanding the Illness and Managing the Symptoms - Support to come to terms with dementia and learn about self-management of the condition.

Planning for Future Decision Making - Support to set up powers of attorney and other legal issues.

The central Norfolk CCGs plans contain the detailed delivery proposals and milestones and will provide the focus for delivery of this strategy becoming the focal document for discussion at the central dementia programme board meetings.

4.4 Priorities

NHSE’s national ambition is that two-thirds of people with dementia are identified and given appropriate support.

Further, it is a national priority to increase numbers accessing treatment, following diagnosis, within 6 weeks by 5%.

In addition there is a national drive to offer diagnosis and subsequent support in primary and community care settings. This eases access for patients, their families and carers, bringing their care closer to home, offering a holistic approach to care.

The central Norfolk CCGs are fully cognisant of these ambitions which inform the key priorities going forward.

The key priorities across all three 3 CCG plans are as follows:
Priority 1 | Improving Access to diagnosis

- Focus on working with primary care professionals to enable improved and increased screening and diagnosis of dementia within primary care. Some of the ways this will be enabled are as follows:
  - Learning sessions for GPs, Nurses and HCAs
  - Promotion of screening and diagnosis tools for use by all within the GP surgery
  - Promotion of correct coding for patients diagnosed with dementia
  - Support from clinicians with an interest in dementia to desktop review GP systems for un-coded or incorrectly coded patients with dementia
  - Support from clinicians with an interest in dementia to review GP systems for patients who may benefit from an assessment for diagnosis of dementia

- Focus on working with care homes to enable improved and increased screening and diagnosis of dementia within primary care. Some of the ways this will be enabled are as follows:
  - Awareness raising and training for care home staff
  - Implementing the Diagnosis of Advanced Dementia in Care Homes tool (DiADEM) for use by practices with registered patients whose place of usual residence is a care home
  - Support from clinicians with an interest in dementia to review care home data for patients who may benefit from an assessment for diagnosis of dementia

Memory Assessment Services

In partnership with CCGs across the wider STP footprint of Norfolk and Waveney, the central Norfolk CCGs are keen to explore opportunities to move memory assessment services as fully as possible into primary and community care.

It is expected that in the future only complex diagnosis should be undertaken by secondary services.

Central Norfolk CCGs will work alongside local CCG colleagues, the local mental health services and primary care to identify appropriate models of care to allow the shift of assessment services out of secondary care.

This work will likely involve the piloting of some memory assessment models in primary care, to test options with a view to a wider roll out across the STP footprint whilst allowing for local variation in each CCG area. This work will take place over 2018/19 and into 2019/20.

Learning Disability

In line with the NICE Guidance (under review and currently out for consultation), https://www.nice.org.uk/guidance/indevelopment/gid-scwave0776/consultation/html-content it is the aim of the central Norfolk Dementia Programme Board to:-

- Work with providers to ensure equity of access to screening for people with LD
- Work with GP Practices to ensure that people with learning disabilities have access to an annual health check
- Increase access to assessment / diagnosis and treatment for dementia by people with learning disabilities
- Work with providers to ensure that reasonable adjustments are made to referral and assessment pathways for people with learning disabilities
- Work with colleagues in Adult Social Care to ensure that people with learning disabilities have a regular assessment of their care needs

Priority 2 | Access to Information and Support
To ensure the provision of, and easy access to, good information and a range of services for people living with dementia and their carers and families post-diagnosis. This includes:
  - Information and advice services
  - Signposting services
  - Access to dementia support workers
  - Access to admiral nurses
  - Integrated provision of services with social care such as dementia day care centres

Admiral Nurses

Admiral nurses work with families and carers of people living with dementia and professionals, in the community and other settings. Admiral nurses seek to improve the quality of life for people with dementia and their carers and families. They use a range of bio-psychosocial interventions that help people with dementia and their families to live well with the condition and develop skills to improve communication and maintain relationships. The Admiral nurses offer specialist support and education to other professionals working with families and people with dementia.

With respect to admiral nurses, the central Norfolk CCGs are delivering a two year pilot admiral nursing service, commencing November 2017. Within Norwich CCG the admiral nurses will be supported by dementia support workers.

The service is available from peri-diagnosis to post bereavement and is open to referrals from primary care.

The service will be subject to an independent evaluation throughout 2018/19.

Priority 3 | Dementia Friendly Practices

- In partnership with voluntary sector organizations, in particular the Alzheimer’s Society, work with primary care to improve the experience of patients living with dementia when attending their GP practice including:
  - Increasing dementia awareness and understanding for all practice staff
  - Adaptions to some aspects the physical environment such as dementia friendly signage
  - Availability of up to date and relevant information
  - Effective communications between the patient and the surgery

Dementia Friendly Practices

General practice often acts as a gatekeeper for key aspects of care for people with dementia. For many it is the GP practice that opens the door to information, support and planning; GPs often provide the information and signposting needed to access support; and GPs hold responsibility for care plans and reviews for ongoing management.

People with dementia can struggle with remembering to attend appointments, navigating the physical environment of the practice, expressing their concerns in the short time available with the GP, and recalling details of discussions regarding their care.

It is therefore ever more important that the systems and processes of general practice are geared up to support people with dementia.

Priority 4 | Access to Education and Training
- To ensure that there are education and training opportunities available to the health and care sector and to community and voluntary services to support communities to care and support those people living with dementia and their carers and families.

### Priority 5 | Communications and Engagement
- To ensure that clear communication and opportunity for public engagement and co-production are at the centre of our dementia strategy delivery plans

### Priority 6: | Strategy Management
- To form a Central Norfolk Dementia Programme Board to oversee the delivery of the priorities of this strategy document. Membership of this group will include representation from commissioning, providers of health and social care and the voluntary/community sectors

### 4.5 Partnership Working
The central Norfolk CCGs will work with partner organisations to deliver their plans, in particular with:
- GP Practices
- Dementia UK
- Age UK
- Alzheimer’s Society
- Norfolk and Suffolk Mental Health Care Trust
- Norwich Community Health and Care
- Norfolk and Norwich Hospital
- Social Care

### 5. Reporting and Governance
Progress against strategy objectives and each CCG’s action plan will be overseen on a monthly basis by the Central Norfolk Dementia Programme Board.

Each CCG will be responsible for reporting progress to their respective programme Boards, Governing Bodies and Clinical Executive Teams.

The central Norfolk CCGs will report collectively to NHSE via the Enhanced Focus Dementia meetings.

The strategy will be reviewed in Q4 of 2017 and where needed refreshed. The action plans for 2018 will be developed for implementation in the 2018/19 year.

Central Norfolk CCG members will be kept up to date on strategy implementation via updates within the Members Newsletter. Members of the public will be informed through ongoing communications including via the CCGs’ websites, involvement in Patient and Participation Groups and where appropriate through co-production.
Leadership for the strategy implementation will be supported within each CCG by a Clinical Lead, who will champion the work being taken forward and provide clinical advice and governance.
i Norfolk and Waveney STP Plan
ii Living Well with Dementia - a National Dementia Strategy 2009
iii Nice Quality Outcomes 2010 QS30, QS1
iv NICE – Dementia Clinical Guidance CG42
v Prime Minister’s 2020 Challenge on Dementia
vi “Dementia: A state of the nation report on dementia care and support in England 2013
vii Norfolk Health and Wellbeing Board 2014 – 2017 strategy