DEMENTIA
An ageing population means the number of people living with dementia is expected to rise by 40 per cent by 2020. Early diagnosis is a national priority, identified in the National Dementia Strategy and championed by Government, including the ‘Prime Minister’s Challenge on Dementia’. West Suffolk CCG aims to address low rates of dementia diagnosis and this is a major focus of the Mental Health Business Group in 2014/15.

WORLD ALZHEIMER’S MONTH
The theme for World Alzheimer’s Month in September 2014 is “Dementia: Can we reduce the risk?”
This is focusing on ways we may be able to help reduce our risk of developing dementia with brain healthy lifestyles.
For further information, please visit: http://www.alz.co.uk/world-alzheimers-month
Dementia - 5 Key Messages
1. It’s not a natural part of growing old.
2. It’s caused by diseases of the brain. The most common of these is Alzheimer’s.
3. It’s not just about losing your memory - it can affect thinking, communicating and doing everyday tasks.
4. It's possible to live well with it.
5. There’s more to a person than the dementia.

MEMORY ASSESSMENT AND THERAPY SERVICES
Author: James Dawson, Redesign Project Support Manager, West Suffolk CCG
Memory Assessment is a dedicated service provided by Norfolk and Suffolk Foundation Trust, with a multi-disciplinary workforce of experienced dementia nurses, occupational therapists and integrated social work. Specialist Psychologists offer individual neuropsychiatric and behavioural therapies.
WSCCG has commissioned NSFT to provide greater throughput to deliver timely diagnosis and interventions for people with mild to moderate dementia. It will give all patients who fulfil the referral criteria a person-centred service. It will empower people with dementia and their family carers to make informed decisions about their care, maximising quality of life and increasing the potential to live well with dementia. The service helps reduce the risk of crises later in the illness and enables the patient to be cared for at home for as long as possible while this is the preferred place of care. There is a strong ethos towards psychosocial interventions, education and signposting. This involves the opportunity to discuss the diagnosis with a nurse and have proposed medication explained, and discuss coping strategies for the patient’s and family carer’s issues. A range of guided hand-outs are available for carers with numbers for discussion, and information. Referrals are accepted from GPs (referral forms on the WSCCG website). The operating hours are 0900 - 1700 Monday to Friday.

LIAISON PSYCHIATRY AT WSFT
Author: David Martin, Psychiatric Liaison Team, WSFT
The Liaison Psychiatry Service at West Suffolk Hospital started in 2013 and is now a team of eight nurses, psychiatrists and admin support. It is commissioned to see anyone in the hospital who has a mental health need and will soon be extending the service to age 13 and over.
The service is now a dedicated liaison team based within the hospital and is thus more accessible to hospital colleagues. This means strong working relationships with all wards can be developed, while teaching and learning opportunities for staff working across the hospital can be identified.
This model of liaison came from work in Birmingham which demonstrated money can be saved if an acute hospital invests in liaison psychiatry. This is particularly the case in working with later life and dementia patients.
A significant proportion of elderly hospital patients will have either diagnosed or undiagnosed dementia. By being involved at the earliest opportunity to help with assessment and diagnosis, psychiatry aims to help ensure an elderly person with dementia is on the right care pathway with the right support for their needs. This should reduce length of stay and improve outcomes.
**SUPPORTING PATIENTS WITH DEMENTIA AT WSFT**

**Authors:** Julie Fountain, Lead Nurse for Dementia & Frail Elderly, and Maggie Woodhouse, Dementia Practitioner, West Suffolk NHS Foundation Trust

We aim to improve hospital experience for patients with dementia and their families by providing appropriate assessment, care and treatment pathways, and signposting to appropriate services and ongoing support.

**Supporting staff:**
- Offer a programme of induction and mandatory training for staff, also bespoke team and one-to-one sessions.
- Dementia champions within wards and departments, with education and support enabling them to:
  - act as a resource for staff
  - support staff to deliver patient-centred dementia care
  - signpost staff and carers to support services.

**Supporting patients:**
- Use a forget-me-not symbol by the bedside and introducing a blue wrist band, which highlight to staff that the patient has dementia, so may need to communicate differently.
- Use a booklet called 'This is me’ which gives staff personalised information and tailored care.
- Enhanced the environment on one ward using dementia-friendly design to aid patients’ navigation; also provided a day room to promote social interaction or quiet time.
- There is a team of trained volunteers supporting patients with dementia on the wards: talk, use reminiscence materials, play games and listen to music.

**Supporting carers:**
An initiative to support the patient’s family carer while the person they care for is in hospital was launched in October 2013 at West Suffolk Hospital.

Family carer information packs are available on the wards and contain:
- Family carer badge
- Information leaflets for carers
- Carer feedback form.

**A RE-ABLEMENT APPROACH TO DEMENTIA CARE**

**Author:** Marilyn Harvey, Dementia Care/Adult Safeguarding Lead, Suffolk Community Healthcare

Suffolk Community Healthcare launches a pilot project: a re-ablement approach to dementia care for people with long-term complex physical conditions

Patients with complex physical and cognitive disabilities can be more effectively enabled to live in the community if their care is integrated, holistic, re-ableing and aspirational. Such programmes can bring about improved physical health, memory, orientation, changes in behaviour, increased levels of involvement in day-to-day living tasks and community interactions. A shift of care provision from reactive to proactive is likely to be valued by patients/carers whilst also reducing the risks associated with a crisis.

Suffolk Community Healthcare’s dementia CQUIN scheme will pilot and evaluate two elements being considered as part of a countywide integrated service; a re-ablement programme working in partnership with others and a case management approach to dementia care practice. Evidence from other geographical areas has shown that the above approach reduces more costly interventions, including acute admissions to hospital, referral to secondary mental health services and premature admissions to care homes.

The pilot project is being driven forward by a multiagency steering group, chaired by Fiona Whitfield, the Head of Nursing and Professional Practice. Suffolk Community Healthcare also recently appointed a Dementia Link Practitioner in both West and East Suffolk.

For more information contact Marilyn Harvey@suffolkch.nhs.uk

**DIST (Dementia Intensive Support Team)**

**Author:** Helen Gray, Team Leader, Dementia Intensive Support Team

The Dementia Intensive Support Team (DIST) is a multi-disciplinary team working within West Suffolk in both the community and West Suffolk Hospital.

It has the following aims:
- To promote and maintain independence for people with dementia
- To help people with dementia who can be treated at home to avoid unnecessary admissions to hospital
- To help people leave hospital as soon as possible with the right care and support
- To help people avoid moving into care homes while they can still be supported in their own home

DIST offers a flexible service to support people affected by dementia. The team works to stabilise situations, develop people’s capacity to maintain their independence and allow for clearer assessment of ongoing needs.

The team delivers person-centred care. They work with those who find it difficult to engage and access the care and support they need, those labelled as challenging, and those whose dementia places them at risk of neglect or places others at risk.

The team will undertake comprehensive assessments and assist in developing care plans so a person’s needs to be met. They provide advice and education to carers and family members where required. There are no barriers to where the team will work.

The input of the team is short term, although timescales can vary depending on the situation. The team usually works with service users for an average of 12 weeks.

DIST Team Leader in west Suffolk, Helen Gray, explained: “We are keen to promote independence and prevent unnecessary time in hospital for people experiencing dementia wherever possible. We know, from past experience, that outcomes can worsen when people experiencing dementia are in hospital and that, once there, they are more likely to be perceived to need long-term residential care.

“We recognise that the earlier we become involved, the easier it is to work with a situation so we offer an open referral system, which means that carers and other professionals can contact us directly for advice and input.”

You can call Helen Gray on 01284 733260.