North of Tees Dementia Collaborative

End of Second Year Report December 2013- December 2014

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1. INTRODUCTION

The prevalence of dementia in the North East is higher than the national average, predicted currently to be 34,000 people, rising to 50,000 in 2030 (Smith and Otter, 2014).

This presents an enormous challenge to the organisations who are delivering services, in the context of changing demographics, technological advances, growing complexity of care and the drive for efficiencies (Bevan and Fairman, 2014).

The establishment of Dementia Collaboratives has a proven record for driving forward improvements and evidencing outcomes for people with dementia and the people who support them. (Darlington Dementia Collaborative, 2010-12 & Harrogate Dementia Collaborative, 2012-14). Subsequently, it has been recommended the feasibility of establishing Dementia Collaboratives across the North East should be considered by The Mental Health, Dementia and Neurological Clinical Network, North East Dementia Alliance and the ADASS themed network (Smith and Otter 2014).

However, the application of collaborative solutions and evaluation is complex. It takes time and dedication to achieve. It requires a foundation of networking, co-ordination and co-operation. It is not just about a common purpose and sharing resources but also the risks, responsibilities and rewards (Wolff, 2010).

The North of Tees Dementia Collaborative project commenced in September 2012, initially for 1 year, funded by the Clinical Commissioning Group (CCG). During this 1st year, 7 Rapid Process Improvement Workshops (RPIW) took place. This work has been reported on up until September 2013 in a Year 1 report (Murphy, 2013).

Following Year 1, the 5 statutory partners agreed to fund the project for a further year which would continue to contribute to the National Dementia Strategy (Department of Health, 2009). Although 2014 marks the end of the formal 5 year implementation period, many of the objectives still remain in need of implementation (Smith and Otter, 2014).

In addition, The Prime Minister's Challenge on Dementia: *Delivering major improvements in dementia care and research by 2015* (Department of Health, 2012) was incorporated into the terms of reference.

This report outlines the agreed areas of work and outcomes of the collaborative from December 2013 to end of December 2014.

2. BACKGROUND

Year 1 of the project was managed by a Project Lead, appointed 1st October 2012, with extensive experience in using the North East Transformation System (NETS) Quality Improvement System. Following the agreement to fund a 2nd year of the project, the initial Project Manager was unavailable to continue past September 2013. There was a delay of 3 months before a 2nd Project Manager was able to take up post, with a different skill set.

The year 1 report highlighted there was a limit to how much improvement activity can be tackled in a year and that the threshold had probably been reached by the North of Tees Dementia Collaborative. The requirement to work across at least 2 health and social care organisations for an event proved challenging. Event planning and delivery often involved the same decision makers and front line people with enough knowledge of the processes, making events difficult to resource and report out on. Year 1 resulted in complicated RPIWs that were not always able to explore processes as deeply as required because of the need to keep different organisations on board with the changes (Murphy, 2013).

In September 2013, a half day workshop was arranged to review year 1 and plan year 2. It was the intention to focus on the share and spread elements of the 1st year workshops at speed. However, 5 of the 7 year 1 improvement events encountered difficulties embedding the changes in the pilot areas, which included circumstances beyond the control of collaborative members, e.g. implementation of new IT systems and transformation of care services. This resulted in slower testing than originally envisaged. Therefore, many of the original workshops required revisiting in year 2 to maximise the value of the original work carried out.

This required further improvement events to be scheduled and the project governance, objectives, guiding principles and success criteria for year 2 remained unchanged from year 1.

The year 1 report detailed impressive outcomes, but the benefits extend beyond the quantifiable evidence from the event target sheets. There are huge consequential benefits in terms of networking, building cross organisational links, understanding each other's processes and generating the momentum for change in areas outside that selected by the Steering Group. Subsequently, engagement with and involvement by the voluntary, independent sector and service users and carers was strongly encouraged in year 2.

In September 2014, the Steering Group agreed funding remaining from year 2 of the project would be used to extend the project to end of March 2015.

The 5 statutory partners also agreed to fund a 3rd year of the project. It was agreed that organisations would struggle to resource a further extensive RPIW and Kaizen programme. It was proposed that change methodology that offers an alternative to lean should be explored.

Other than support from the Hartlepool and Stockton Clinical Commissioning Group (CCG) GP Dementia Lead, participation from GP's in improvement events in both year 1 & 2 has not been forthcoming. Exploration of this with GP's indicates that the requirements of the Quality Improvement System (QIS) methodology have contributed to this position.

The time between December 2014-April 2015 is to be used as a planning period and to deliver the final scheduled improvement event. Year 3 of the project will run from April 2014-2015.

3. YEAR 2 PRIORITIES

- Maximising the outcomes from the work carried out in the 7 RPIWs from year 1, which were at various stages of the implementation plan and required further work.

- A further improvement event to explore which areas of change needed further development, following the transformation of care within the North Tees and Hartlepool NHS Foundation Trust. The resulting re-organisation of most of the wards and staff teams had impacted on year 1 changes being rolled out at speed as planned.

- Spreading the benefits of the work carried out to prevent unnecessary admissions to A&E from care homes (RPIW 2) piloted in care homes to a further 56 care homes across Stockton and Hartlepool.

- Maintaining skills of collaborative work shop leads, requiring the scheduling of 2 RPIW's and a number of smaller Kaizen events to enable them to complete their training or recertify.

- An IT solution to facilitate access for all organisations to all standard documents developed by the collaborative, which numbered 127 by the end of the 4th improvement of Year 2.

- Explore different strategies for engaging GP's in collaborative working.

- Involvement of service users and carers in improvement activity.

- Linking with other local initiatives that contribute to the National Dementia Strategy (NDS) such as the Dementia Friendly Communities' Programme.

4. MEMBERSHIP OF THE STEERING GROUP

The 5 statutory partners funding Year 2 were:

- North Tees and Hartlepool NHS Foundation Trust (NT&H)
- Stockton Borough Council (SBC)
- Hartlepool Borough Council (HBC)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Hartlepool and Stockton Clinical Commissioning Group (CCG)

The Steering Group is scheduled to meet monthly, at venues across the two localities, and tasked with driving the project to deliver large scale change across organisational boundaries.

As identified in the priority areas, wide representation from the mixed economy of welfare was sought to maximise the opportunities to meet the National Dementia Strategy objectives.

In October 2014, the collaborative had a distribution list of at least 48 members with representation from the 5 statutory partners, voluntary sector and independent providers.

Although all members do not attend every meeting, access to their various organisational distribution lists, enables the collaborative to achieve its objective of networking widely for mutual benefit of people with dementia and the people who support them and promotes diverse engagement.

This exchange of information has enabled collaborative members to contribute to other areas of improvement work that are external to the collaborative year 2 plan, discussed later in this report.

5. ADVISORY GROUP

Workable solutions need everyone involved to contribute, particularly those most directly affected by the issues. Identifying and gathering people is a step in the right direction (Wolff, 2010).

It was evident in Year 1 the perspective of service users and carers was a powerful tool for motivating the improvement team and driving change.

The collaborative sought service user and carer experiences via various collaborative partnership organisations, such as George Hardwick Foundation, Sanctuary Supported Living, Hartlepool Carers and Healthwatch bodies for both Stockton and Hartlepool.

In addition, an Advisory Group was established in partnership with Hartlepool Carers, to ensure there was a mechanism for capturing the feedback and experiences of service users and carers and updating them on improvement events. Invitations to join the group were extended through the quarterly project briefings.

The terms of reference for the group stipulated that members were to be given the opportunity to contribute by whatever means they felt able and they did not have to attend scheduled monthly meetings.

By December 2014, the Advisory Group had a total of 29 service user/carer representatives and 20 professionals who worked directly with service users and carers.

All 5 events scheduled in year 2 had a contribution of service user and carer perspectives, whether this was via a written statement, a representative or direct input.

6 CERTIFICATION OF WORKSHOP LEADS

At the end of the 1st year, 5 Workshop Leads remained from the original cohort of 7 to lead the 2nd year workshops, which continued to use the NETS Quality Improvement System.

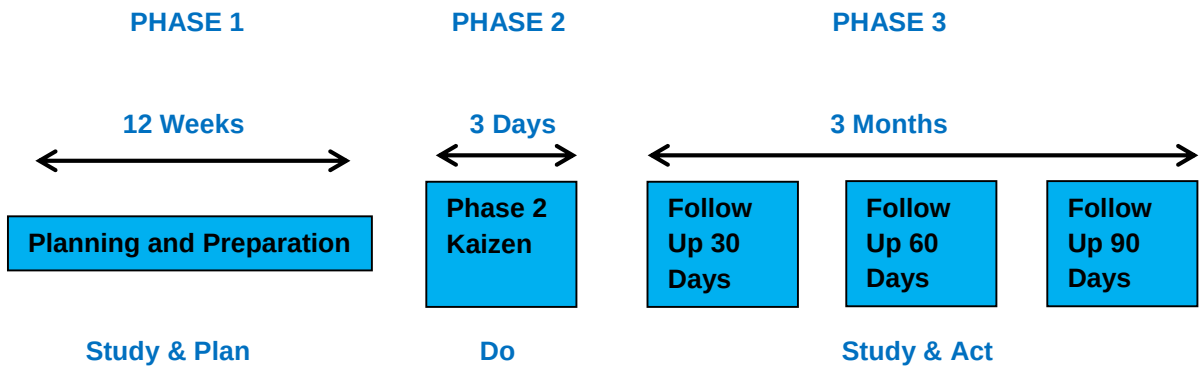
2 Workshop Leads required 1 RPIW or 3 Kaizen events to recertify. 2 Workshop Leads required a coach and 1 RPIW to complete their training.

The requirements and phases of an RPIW were discussed at length in the Year 1 report (Murphy, 2013).

Kaizens are shorter events than RPIWs. Phase 1 of a Kaizen event is similar to an RPIW, but Phase 2 takes place up to 3 days rather than 5. To accommodate this, training materials are condensed into half a day and work starts on the first day immediately after an ideas session by all participants. Work is carried out right through to the end of day 3 and no formal report out is held.A newspaper and target sheet are still developed to help with the implementation stage and monitor change.

In phase 3 the improvements are implemented and formal feedback sessions are scheduled for 30, 60, 90 days as for an RPIW.

Standard process for the planning and delivery of a Kaizen



By the end of July 2014, 3 of the 5 workshop leads fulfilled the criteria needed to complete the training or recertify. 1 partially trained Workshop Lead withdrew due to a priority organisational commitment in July. The final Workshop Lead will recertify in February 2015 following the final event scheduled for the 2nd year.

As 5 Workshop Leads were insufficient to resource the year 2 improvement event plan, 2 TEWV QIS Leads supported 2 Kaizen events, which was beneficial to their continued professional development

1 of the 4 Workshop Leads will no longer be available from April 2015, leaving 3 Workshop Leads to resource a 3rd year of the project.

The year 2 improvement topics were discussed and selected using the Steering Group meetings, rather than specific mapping events as in year 1.

As highlighted earlier, some year 1 improvement events were more challenging than initially anticipated for a variety of reasons and it was not feasible to continue with the agreed changes or roll them out at speed when faced with competing organisational priorities.

The Year 2 priority to maintain the Workshop Leads for the project presented the opportunity to deliver 5 improvement events (2 RPIWs, 3 Kaizens).

The themes chosen for improvement in the 2nd year were as follows:

Event/ Date	Topic	Objective
RPIW 2 Roll out (March 2013)	Preventing unnecessary hospital admissions for persons with a dementia from care homes	Roll out training to 56 care homes in Stockton and Hartlepool and provide kit to carry out regular physical assessment of residents.
Kaizen (February 2014) Revisit the Continuing Health Care (CHC) process addressed in RPIW 1 (January 2013).	Continuing Health Care – completion of the checklist.	Ensure patients and their representatives are informed at the onset of the CHC process what to expect on 2 pilot wards and monitor some of the lead/cycle times from the first event.
RPIW 8 (April 2014) New collaborative piece of work that linked with the work of the Acute Foundation Trust roll out of “Care of the dying patient”.	End of life care for people with dementia in a care home setting.	To assist 4 pilot care homes to meet the requirements of the Gold Standard Framework when delivering palliative care.
Kaizen (May 2014) Revisit RPIW 3 (March 2013) and RPIW 4 (May 2013) as both related to the delivery of care for people with dementia.	Managing behaviours of people with a suspected cognitive impairment that challenge staff in an acute hospital in-patient setting.	To support staff on 1 pilot ward to manage behaviours they find challenging and seek assistance from Liaison Psychiatry as required.

RPIW 9 (July 2014) Revisit RPIW 6 (July 2013) Assessment and agreement of a support plan for persons with dementia in the community & RPIW 7 (Sept 2013) improving delivery of domiciliary care for persons with dementia in the community.	Supporting people with dementia to live at home.	To focus on the review process and to facilitate comprehensive and timely reviews, involving all relevant parties to try and ensure level of care is appropriate.
Kaizen (February 2015) Develop work from RPIW 5 (June 2013) improving access to intermediate care and reablement for persons with dementia.	Improving the Specialist Dementia Practitioner role.	To improve the overall process and communication with other services, to make the most effective use of the role.

All workshops were scheduled into the year 2 plan to enable all 5 remaining Workshop Leads to certify/recertify as required. By December 2014, 4 improvement workshops have been delivered and the final 1 is planned to take place at the end of February 2015, following the extension of the first year of the project to March 2015.

7. ACCESS TO STANDARD WORK PRODUCED

Through collaborative membership of the Dementia Friendly Stockton Project, an IT solution was presented to enable the collaborative membership to access all standard documents produced over the life of the project.

The North of Tees Dementia Collaborative Project Administrator oversees an area of the Dementia Friendly Stockton website and uploads documents onto the site. It is now possible with a username and password for all members of the collaborative to access all current documents in pdf format.

The master copies are kept on a Tees, Esk and Wear Valleys NHS Foundation Trust drive and are updated and replaced on the Dementia Friendly Stockton site as required to facilitate version control.

Website address is http://www.dementiafriendlystockton.co.uk

Username: collaborative; Password: 25ca3b6de1

8 YEAR 1 IMPROVEMENT EVENTS

8.1 Continuing Health Care

The original work in January 2013 focussed on improving the Continuing Health Care (CHC) process from completion of a checklist to decision support tool (DST) meeting. It completed its 90 day implementation phase and the outcomes were documented in the Year 1 report.

However, plans for the share and spread were affected by the transformation of care in the acute hospital trust, as highlighted earlier. Also there was evidence from service users and families, recently involved in the CHC process, that they were not aware that any eligibility screening had taken place until invited to attend a decision support tool meeting. This was contrary to what was expected following the year 1 event and 1 carer fed back that it felt like being asked to participate in a game without knowing the rules and an unfair disadvantage.

Further discussion with staff highlighted that further work was required to ensure the changes agreed in year 1 were being put into place and complied with the Department of Health guidance. An audit of CHC referrals received by the Discharge Team also identified some areas for further improvement and a 12 month review of the changes indicated some of the original targets required further monitoring.

The sponsorship of year 2 Kaizen event in February 2014, reflected the original event and the focus of the 3 days was to ensure patients and their representatives had the opportunity to be involved from the onset of the CHC process, understand the process and have the information they need to appeal, if required. The pilot site was the short stay unit (Ward 24) & Ward 42

The improvement event has now passed the 90 day implementation stage and is being developed further via monthly monitoring meetings.

What worked well:

- 70% improvement in the number of people being verbally advised at the start of the CHC process what to expect (based on sample of 10 notes from 2 pilot sites).
- Increase in the number of patients receiving/viewing copies of completed CHC checklists. CHC assessors now bring 2 copies to DST meetings, 1 for file and 1 for the patient and if unable to provide a copy, staff will show and discuss outcomes with patients.
- Production of a training pack. 90% of pilot ward staff were trained in the new process by a member of the Discharge Team.

- Use of a new flowchart with scripts to reduce variation and prompts for staff when assessing capacity of a patient. This appears to have addressed capacity and consent issues evident from the completion of documentation sent to the Discharge Team.
- Agreement that people going onto reablement/intermediate care would not have the checklist completed in hospital to facilitate earlier discharge.
- 10 laminated copies of the Department of Health public information leaflet on the CHC process were made available for use on the pilot wards as previously it was only available to download from Department of Health website.
- A single point at the CCG was set up with capacity to receive social work assessments electronically, to facilitate timely preparation for meetings.
- Referral to a DST meeting taking place and the length of a DST have both remained within the year 1 targets which means patients should be not be staying in hospital longer than needed whilst waiting for a DST meeting to be arranged and hospital staff are not spending more time away from patient care than needed.

Challenges:

Comment from participant in Continuing Health Care improvement event.

"Thanks again for facilitating such a well-structured and organised event, which I feel everyone benefited from the experience…..unless we take time out to make these improvements nothing is achieved!!"

- The implementation of some of the elements of the new process has been delayed due to post event issues relating to trans organisational responsibilities and resourcing the agreed changes. All of the new process is not yet ready for roll out.
- Identified champions on the 2 pilot wards responsible for training all permanent staff moved on but have now been replaced.
- The provision/audit trail of written information given to the patient and representatives.

Next steps:

- Continue to develop the implementation plan.
- Roll out practicable elements to other acute hospital wards.
- Research good practice in other areas.
- Share new process with mental health in-patient wards.

8.2 Managing Behaviours of People with a Suspected Cognitive Impairment that Challenge Staff in an In-Patient Setting

This kaizen event is the result of revisiting 2 RPIWs from year 1:

Assessment and decision making for persons with dementia admitted to an acute ward to ensure a timely and appropriate discharge (March 2013) & Managing behaviours that staff find challenging from persons with a dementia in an acute hospital setting (May 2013)

Both of these events were reported on in year 1 (Murphy, 2013). Unfortunately, progress with the new processes became difficult to sustain when the Hartlepool Hospital wards transferred to the North Tees site. Staff and ward changes resulted in the core pilot teams being dispersed to other areas and impacted on embedding the agreed changes and the collection of data to evidence improvement.

The May 2014 event, reflected the original sponsorship by the two health foundation trusts (NT&H and TEWV) and the pilot took place on the Holdforth Unit, University Hospital of Hartlepool. It is now out of the 90 day implementation period and the work is progressing through monthly monitoring meetings.

What worked well:

- Many of the outcomes from the previous RPIWs had remained in place or were revised for this pilot e.g. white boards above the bed containing key patient information, use of “All About Me” during a patient admission, the principles of the Carers Passport to negotiate joint delivery of care with staff during an in-patient admission and availability of key “memory” medications on wards.
- Dementia Awareness Week 2014 was used as an opportunity to publicise the changes the unit wanted to make which was covered by the local press.
- Policies and flow charts that would assist the new process were identified and work commenced on these: e.g. covert medication flow chart, close observation and challenging behaviour policies progressed in a Task & Finish Group for approval through the formal processes.
- Training and development issues were identified and work commenced on updating the dementia workbook for hospital staff, delivering Dementia Friends sessions and identifying other valuable resources.
- Core pathways and core principle documentation was updated.
- Regular intensive support and training for ward staff from Liaison Psychiatry is being provided to encourage new ways of working.

- A clear decision making process to encourage staff to make appropriate referrals to the Liaison Psychiatry and the Dementia Specialist Nurse was developed through a poster for the unit wall, trigger tool for patient notes and a model file for use in ward meetings which contained all the necessary prompts, guidance and documentation.
- Liaison Psychiatry attend the unit following weekly multi-disciplinary meeting to discuss referrals.
- A more advanced training programme was agreed, to be delivered by Liaison Psychiatry staff to ward staff, addressing delirium and challenging behaviour issues.
- Funding was agreed to introduce “Therapeutic Support Workers”, trained in non-pharmacological interventions, engagement strategies and detractors to provide 1:1 care for people who require close observation to ensure patient safety.
- Intervention plans were copied onto pink paper to make them more visible and accessible placed in patient’s bedside file.
- Work was developed to involve patients in more activity during their stay that linked with their interests identified in the “All About Me” document and maintained existing skills through more contextualised activities that would be valuable when discharged home.
- Funding was made available for memory boxes and environmental changes required to promote meaningful activity and socialisation needs for patients and families.
- A Dementia Care Mapping exercise was carried out that highlighted further areas of work that needed to be progressed.
- Work was progressed in both local authority areas on the availability of a directory of services that can be accessed by hospital staff.
- Process Owners noted an improvement in understanding and language used when ward staff discussed patients.
- The target of admission to discharge within 28 days was met at 90 days.
- Identification of need and referral to Liaison Psychiatry is within 24 hours.
- The percentage of people admitted from home and discharged back home at 90 days was 72%
- The number of people inappropriately prescribed anti-psychotic medication has decreased steadily over the implementation period, reported as 0 in September and October 2014.

Challenges:

- Due to staffing and environmental challenges some of the work has taken longer than anticipated to get underway.
- The original timetable for delivering the advance training programme had to be revised.
- A questionnaire relating to staff confidence when managing challenging behaviour post changes was delayed past the scheduled 90 days, allowing for staff to receive the planned training.
- The carers passport documentation was not adopted as planned on the pilot unit, although the principles were adopted e.g. meal and parking concessions.
- Gathering the evidence for the target sheet proved problematic but the introduction of new documentation in October 2014 should assist with this in the future.

Next steps:

- Continue with the implementation of the plan in the pilot area.
- Roll out of elements ready to be shared with other hospital wards.
- Link work with Acute Hospital Dementia Strategy.
- Link work “All About Me/Carers Passport” documents with the Triangle of Care work being carried out in Tees, Esk and Wear Valleys NHS Trust.
- Link with external projects that can help with resources e.g. Life Story Work Network/Get into Reading projects/Dementia Champions.

8.3 Supporting People with Dementia to Live at Home

This event revisited 2 RPIW's held in year 1:

Assessment and agreement of a support plan for persons with dementia in the community (RPIW 6) & Improving delivery of domiciliary care for people with a dementia (RPIW 7) which was reported on in year 1.

Unfortunately the year 1 events encountered some difficulties, as detailed below, and reporting out ceased.

Stockton Borough Council experienced difficulties when the use of the "All About Me" document as the core assessment was challenged as fit for purpose and changes relying on IT solutions did not materialise within the timescales anticipated.

Hartlepool Borough Council required significant changes to their assessment processes and electronic care record system to implement the new process. Plans to hold internal improvement workshops to address this did not take place as planned and they anticipated they would not be in a position to take this work forward until April 2014.

The year 2 workshop in July 2014, was initially co-sponsored by Stockton and Hartlepool Borough Councils. However at Planning Meeting 3, Hartlepool Borough Council withdrew as they planned to carry out a root and branch analysis of their care services and did not feel in a position to make any changes to their processes before the outcome of this analysis.

"We were pleased to be invited and felt free to contribute the little we did, as and when we did. We felt included. It was reassuring to be amongst professionals dedicated to improving services for dementia patients and their carers".

Ian and Mary Mackie – Advisory Group members (July 2014).

The objective of this event was to improve on the social care review process and make productivity gains, by ensuring reviews were timely, involved the appropriate people and overall communication was improved. The team included both service user and carer representation alongside a wide range of health and social care staff. The event also revisited some of the resources developed in year 1 to support people to stay at home. Where the team thought the resource would add value to this event, it was included in the follow up action plan.

What worked well:

- Work developed in the previous 2 related workshops was revisited and incorporated into this event where identified as beneficial and needing further work.
- Documentation was reviewed, streamlined and standardised for setting up new home care packages, aiding clarity around the relevant information required to deliver good quality, safe care.
- Support and training guide for using IT to facilitate productivity gains.
- Inputting assessment/reviews directly onto computer saved approximately 30 minutes per worker, per visit when completing documents back at base.
- Sharing of patient identifiable information safely and more quickly electronically. This facilitates rectifying inaccurate and missing information quickly and saves further time if the information can be cut and pasted into domiciliary care documents.
- Standardising and mistake proofing of medication process. The work from the year 1 events is being progressed further and overseen by a Task and Finish Group. Medication errors are reported to have decreased.
- An evaluation of the use of a pocket sized guide developed for care staff in the year 1 event to promote the delivery of good care to people with dementia by domiciliary staff received 83 positive responses from a staff group of 160.
- Support/Training from specialist mental health teams to care staff and promotion of Social Care Institute for Excellence free on line Open Dementia Programme.
- Contingency plans to deliver emergency care in client's home until domiciliary care package can be implemented.
- New standard review process illustrated by a flowchart, incorporating better preparation and use of staff skills in relation to the complexity of review.
- Minimum standard agreed regarding offering carers assessments and using resources from other agencies where appropriate to train and support social care practitioners.
- Streamlining information given to service users and carers to make it relevant but not overwhelming.
- Template to capture views and key issues of all relevant agencies in advance of review, if unable to attend in person.

"The week certainly lived up to its title ... Rapid Process Improvement Workshop. Everyone pooled their ideas and shared information to bring about a better client centred service".

Beryl Magson – Carer (July 2014)

- Trigger sheet, where people have assistive technology in place, to raise an alert when there is a concern.
- Satisfaction surveys are centrally collated to improve performance monitoring.

Case Study: Improving medication management for front line home care workers

Following the RPIW in September 2013, which addressed the safe administration of medication, Brookleigh Caring Service appointed a Medication Manager who spent the first 6 months, observing medication practices and speaking with service users and carers to understand which areas needed improving. It was recognised that some clients had complex medication regimens and staff required more support and education to promote safe practice. A strategy was then developed to implement clear guidelines to support staff to work safely within a legal framework and provide staff with up to date knowledge about medication. To facilitate this links were made with a local training agency, pharmacies and GP's.

By April 2014, 10 medication champions were in place, competent to independently carry out unannounced observations of medication practices, complete medication risk assessments, check medication administration records and clients medication stocks and support staff with medication issues.

Every client assessed as needing level 3 medication administration now has an allocated medication champion who clients and informal carers can contact directly with any issues that arise. The champion will then liaise with the medication manager.

Outcomes

- An advice and dispensation service can now be accessed up to 11pm with a local pharmacy.
- Pharmacists will attend reviews and offer training when requested.
- More timely response to medication queries using a direct line to the medication team.
- A 91% improvement in the number of medication queries against the baseline of 11 queries over 2 days.
- Front line staff feel more confident and supported and the central office working environment is less stressful with fewer medication queries to manage.
- More transparent culture around medication errors that informs a more responsive training programme and supervision sessions for staff
- Staff value the role of medication champion and are requesting to be trained and be part of the champion team.

For more information contact Brookleigh Caring Services: 01642 644777

Challenges

- CQC raised issue about paperwork for Hartlepool domiciliary care, despite the changes to the paperwork being discussed with them before implementation.
- Some staff needed extra support to adopt new IT practices.
- Direct access to local authority care management system.
- Capacity of administration support to prepare packs for review staff.
- Development of index to enable carers to access information as relevant to their circumstances.

Next steps:

- Continue with implementation of plan in pilot area.
- Explore productivity gains from direct access to Care Director.
- Explore elements of the workshop that can be rolled out to other teams and service providers.

8.4 Improving Access to Intermediate Care and Reablement for Persons with Dementia

The year 1 event, co-sponsored by the Acute Trust, Stockton and Hartlepool Borough Councils, addressed the issue of extremely low referral rates into reablement/intermediate care services for people with dementia and monitoring outcomes as detailed in the year 1 report.

What worked well:

- Development of comprehensive information pack relating to the services.
- Access to support from mental health workers.
- 90% of therapy staff in reablement and intermediate care received basic dementia awareness training and 100% for Community Integrated Assessment Team (CIAT) staff.
- The referral/access route into the service was standardised.
- Referrals for people with dementia into the intermediate care and reablement service increased by 80% based on combined figures over a 2 month period.
- The number of people with dementia achieving their outcomes in intermediate/reablement service was between 79-92%.
- 100 % of targeted staff were using the agreed dementia screening tool.
- 100% of people with dementia had timely access from reablement/intermediate care services to mental health services.

Challenges:

- Achieving timely referrals to memory clinic was affected by the need to ensure GP's were aware of referrals and provide a history, carry out a physical examination, look at current medication and carry out any investigations needed, to eliminate any treatable or reversible causes.
- Rolling out training where there are staff shortages.
- Comparison between 2 authorities whose reablement services are not defined the same way and operate very differently.
- Some data was collected for people with a confirmed diagnosis of dementia in one area and data collected for people with cognitive impairment in another.

This work helped identify further work required to tailor services for people with a dementia to maximise outcomes.

Next steps:

- Explore how improvements can be made to the Specialist Dementia Reablement Practitioner role in February 2015.
- Link the work of the North Tees Dementia Collaborative with the reablement outcomes of the Better Care Fund (BCF) programme.

9. NEW AREA OF WORK: END OF LIFE CARE FOR PEOPLE WITH DEMENTIA (2014)

In April 2014, a 5 day workshop was held with the overarching aim to make sure a care home resident had a peaceful and dignified death, with care delivered by a caring and respectful workforce.

The pilot period took place in 4 care homes, all registered with the Gold Standard Framework. An action plan was developed to roll out an improved process that would fit well with other work being currently carried out by the North Tees and Hartlepool NHS Foundation Trust around the care of the dying patient both within the hospital and community settings, and Hartlepool and Stockton CCG's implementation of Emergency Health Care Plans (EHCP). The event also linked with previous work from the collaborative relating to unnecessary hospital admissions from care homes and the quality of in-patient care for people with dementia. It is expected that the true picture of improvement will not emerge until the 12 month report out and the team will continue to meet monthly during this period.

What has worked well to date:

- Development of end of life rapid discharge from hospital documentation.
- Development of training matrix re: knowledge required to deliver good quality palliative care in different roles/environments.
- Linking work with roll out of other collaborative work, acute hospital implementation of "Care of the dying patient" and CCG implementation of Emergency Health Care Plans.
- Development of "My Future Well-being" tool to facilitate difficult conversations about end of life choices.
- Introduction of multi-disciplinary monthly meetings in the 4 pilot homes to discuss palliative needs of residents, which are well attended by the relevant people and raising issues to be addressed that will benefit all care homes in Stockton and Hartlepool.
- Increase in staff confidence to advocate providing palliative care within care homes where this is the resident's choice.
- The implementation action plans for the 4 pilot homes to promote good quality care .
- Reaccreditation of 3 of the 4 pilot homes with the Gold Standard Framework.
- Development of resources to support carers following a death and assist with closure from a service area.
- Analysis of the effectiveness of improved information sharing.

- Over the first 7 month period in the 4 pilot homes, 90% of residents died in the care home rather than hospital compared to the baseline of 74.
- Case analysis showed where residents were admitted to hospital it was appropriate.
- There was an overall improvement of the number of people with advanced care plans & DNAR's in place and receiving end of life care.
- There was 100% compliance in the number of relatives offered bereavement information & support, a 43% improvement against the baseline.

Regarding the letter developed for use with bereaved families by social workers in End of Life workshop, Maria Niland, a Hartlepool social worker commented:

"Feedback from Social Workers was very positive and it was felt that it could also be used as a "closure" letter when people are admitted to 24 hour care, which in itself is a form of bereavement"

Challenges:

- Meeting requirements of the Acute Hospital Committee for rapid discharge documentation exceeded original timescale.
- Funding to train care home staff in end of life care and achieve Gold Standard Framework accreditation.
- Commissioning issues around reducing unnecessary admissions to hospital.
- Accurate coding of residents, particularly when transferred to the care home from other environments with little accompanying information.
- Accessing nursing assessments for nursing home residents.

Next steps:

- Progress work to develop a directory of resources to promote good quality end of life care for care home residents via a commissioner led Task and Finish Group.
- Pilot the "My future well-being" tool to encourage discussions at early stage of dementia about end of life choices and monitor via a Task and Finish Group.
- Link with work in the 2 foundation trusts relating to care of the dying patient.

10. SHARE AND SPREAD: PREVENTING UNNECESSARY HOSPITAL ADMISSIONS FOR PERSONS WITH A DEMENTIA FROM CARE HOMES

The year 1 report (Murphy, 2013) outlined the main features and outcome of this event held in March 2013, sponsored by the Acute Trust and piloted in 3 care homes across Stockton on Tees and Hartlepool. The target sheets demonstrated significant savings for the health economy and benefits for care home residents. The Hartlepool and Stockton CCG agreed to fund the roll out of these changes to all the care homes across both localities in 2014.

All care homes in Stockton and Hartlepool were invited to participate in a training programme. Each training session lasted 4 hours, delivered by Care Plus in conjunction with Newcastle College. At the end of the session care home staff are given the equipment and instructed how to carry out regular physical health monitoring , report concerns using a standard tool, complete the All About Me and Deciding Right documentation.

What has worked well:

- Phase 1 of the training programme in Stockton has already been completed and Phase 2 training for Hartlepool care home staff has one remaining session.
- All care homes that have attended the training sessions have received free equipment to regularly monitor the health of care home residents.
- Staff confidence has increased when reporting deterioration to health professionals
- Health professionals are able to make more informed decisions about the level of intervention needed for residents.
- Residents have all the information needed ready in advance to accompany them on the ambulance and for use in hospital to provide person centred care, if hospital admission is required.
- Data is being supplied by North East Ambulance Service and the Acute Hospital Trust relating to conveyance rates by ambulance to hospital and hospital admission rates for the care homes that have been trained, which is being interpreted by a business analyst for the CCG.

Challenges:

- The information taken into hospital with the resident does not always follow them around the hospital, updated and returned to the care home with them.
- Uptake of the training by the care homes is voluntary and this resulted in 80% of Stockton care homes and 68% of Hartlepool care homes booking onto the training by mid December 2014.
- Sustainability issues when kit needs replacing or new staff needs training.

"It was great to see first-hand, the work being conducted by the collaborative and the positive impact this work is having out in the community for people living with dementia."

"The overall outcome was very positive and I have to say the implementation of this training has been received well with not only the out of hours services but also with the GP's linked to the home"

Sharon Di Maio, Regional manager, Hill Care Ltd.

Next steps:

- Embed improvements into all care homes.
- Sustainability plan to be agreed.
- Consider piloting in further areas such as Extra Care Facilities, identifying which staff would be trained and which residents would receive monitoring, particularly where no services were involved.

11. DEMENTIA COLLABORATIVE PROJECT CONTRIBUTIONS TO OTHER AREAS OF WORK

The exchange of information through the collaborative network has enabled collaborative members to contribute to other areas of improvement work that are external to the collaborative year 2 plan such as:

11.1 Dementia Friendly Communities Projects (Stockton and Hartlepool)

The Prime Minister's Challenge on Dementia supports the development of Dementia Friendly Communities and has been championed by the Alzheimer's Society and the Dementia Action Alliance.

In November 2013, the Borough of Stockton-on-Tees became the first community in the North East to register with the national recognition process for dementia-friendly communities.

The North Tees Dementia Collaborative is supporting the work to make Stockton-on-Tees a more dementia friendly community and has become a member of the Dementia Friendly Stockton project.

In December 2014, 21 organisations had their applications to join the project approved from a wide range of backgrounds such as supermarkets, banks, pharmacies, transport and housing providers.

Hartlepool has also embarked on the process of working towards being a Dementia Friendly Community and benefitting from the work of Stockton's progress to date as a neighbouring community and researching good practice nationally.

The main issues are:

- getting evidence from people with dementia and carers about what would make it possible for them to live better in their community – the evidence will then be used to develop information and tools for organisations to help them meet the needs and aspirations of people with dementia
- creating a system of recognition so that places and organisations that want to become dementia friendly can use a symbol to show they are working to become dementia friendly

- being part of a network country wide that brings people and organisations together to change things for the better
- educating the public so that more people understand dementia and think about how they can make things better – the Dementia Friends Programme is a central part of this.

Department of Health Dementia Challenge website (October, 2014)

Next Steps:

- Dementia Voices Project - One of the collaborative partners, Cleveland Alzheimer's Residential Charity (Clevearc) has been awarded 2 years funding to deliver an advocacy/self-advocacy service for people with dementia which will contribute to the Dementia Friendly Communities' Project and the work of the North of Tees Dementia Collaborative.
- Increased engagement of people with dementia in the project.
- Wider promotion of the project
- Evaluation.
- Build outcomes from consultations into the 3rd year project plan.

11.2 Dementia Champions

A large number of collaborative partnership members have been trained as Dementia Champions by the Alzheimer's Society. This has meant that members of the collaborative can help deliver information sessions to the general public and organisations as part of the Dementia Friendly Communities and Dementia Awareness in Schools projects.

Next steps:

- Offer sessions to any interested parties in the North of Tees Dementia Collaborative network within the capacity available.
- Contribute to annual Dementia Awareness Events and Dementia Awareness in Schools Project.
- Increase number of Dementia Champions and Dementia Friends.

11.3 Dementia Awareness in Schools (Tees-wide)

Teaching Children about Dementia is a national initiative, part of creating Dementia Friendly Communities and the Prime Ministers Challenge on Dementia. In June 2014, TEWV hosted a 2 day event and invited a wide range of people to participate, including collaborative members, to develop a resource to teach children in Teesside about Dementia. At the end of the 2 days, teaching sessions across 3 primary school age ranges, information letters to parents and guidance for session facilitators were produced.

Next steps:

- Set up peer support group hosted by TEWV to oversee and help co-ordinate activity.
- Pilot the resources with children in schools and other external activities for young people using trained Dementia Champions.
- Use the resources for children developed by the Alzheimer's Society Dementia Friends Programme in conjunction with the work developed by TEWV and Stockton Borough Council Libraries.
- Evaluate.

11.4 Dementia Awareness Week 2014

Between 18-24th May 2014, a number of events took place across Stockton and Hartlepool localities to help raise awareness of dementia with the general public and to support people living with dementia or providing care. This included information sessions in health and social care buildings, public venues such as libraries and the event was delivered collaboratively by staff and volunteers from a range of health and social care agencies working in partnership. Some sessions were structured such as the Dementia Friends sessions and other were incorporated into activities such as history talks, dementia walks, café sessions and an ecumenical church service. Other events, such as street busking which was particularly successful, were designed to raise awareness with the passing footfall.

The annual Stockton report recorded 275 school children from 8 Stockton schools attended a dementia awareness session, using stories and games and at it was recorded at least 70 were engaged in conversations about dementia, whilst many more received information on dementia that had been provided by the agencies involved.

Feedback captured in the week indicated that people overwhelmingly thought that this kind of event had a positive impact on increased awareness and understanding of dementia.

Next steps:

- Extend partnership in 2015, to deliver more events in community venues across Stockton and Hartlepool.
- Use Dementia Friendly Communities Project membership, to maximise public engagement and awareness of dementia.
- Assist with the establishment of a Dementia Friendly Church Network.

11.5 Triangle of Care

The Triangle of Care guide, launched in July 2010 is a joint piece of work between the Carers Trust and the National Mental Health Development Unit. It outlines the 6 key elements involved to promote improved partnership working between service users, carers and organisations in mental health services.

In 2014, TEWV signed up to the 'Triangle of Care' membership scheme and collaborative members identified that some of the work carried out in the year 1 & 2 improvement events would contribute to this approach.

Next steps:

- A project group has been set up to pilot ‘All About Me’, ‘Carers Passport’ and the revised CHC process in mental health in-patient units serving the Stockton and Hartlepool localities.
- Involve local carer support agencies in approach.

11.6 Stockton LiveWell Hub – One-Stop Shop for Dementia Resources

Following a successful bid to the Department of Health to redesign a Stockton Borough Council day centre facility according to research based dementia friendly design principles, the Mayor reopened the centre on 23rd May 2014, during Dementia Awareness Week. Part of this facility will house a one-stop shop for resources to support people living with dementia or issues relating to cognitive impairment in the Stockton Borough.

In June 2014, members of the collaborative joined with health and social care colleagues to develop this resource, which will include a satellite memory clinic, using a 3P event (**P**roduct, **P**rocess and **P**roduction Innovation) designed to develop a concept from a blank sheet. During this 5 day improvement event which was facilitated by TEWV's Kaizen Promotion Office, staff developed the key criteria and attributes for the centre and an action plan for the Steering Group.

Next steps:

- Members of the collaborative partnership will assist with establishing this resource to meet the needs of its visitors and share the learning with Hartlepool colleagues.
- The analysis of visitor information will help identify further areas where service improvement is needed.

11.7 Life Story Network

The Life Story Network, with Northern Rock funding, ran a project with Hartlepool Carers to deliver the Family Carers Matter programme to carers of people with dementia in Hartlepool and develop a sustainable model so that more carers may benefit over the longer term.

A 2 day programme, which focuses on communication, relationship and rapport with the person they are caring for using life stories as a method of remaining connected, was delivered to 18 carers. The Hartlepool programme is now mid-way and being evaluated by pre- and post-course self-assessments analysed by a PhD student.

Next steps:

- Share evaluation of programme.
- Build community capacity to deliver programme more widely, co-delivered with carers who have undertaken the programme and wish to remain involved.
- Project will explore contribution to the development of Dementia Friendly Hartlepool.
- Explore opportunities to deliver a similar project in Stockton with collaborative members.
- Explore benefits to link this work with the delivery of palliative care for care home residents.

11.8. Deprivation of Liberty Safeguards Administrative Process

A certified Workshop Lead took the opportunity to apply the methodology to a related area of work when changes to the Mental Capacity Act Deprivation of Liberty Safeguards (following the Supreme Court Judgment on the Cheshire West and Cheshire Council and Surrey County Council cases) resulted in a significant increase in the number of Stockton clients considered within the Safeguards. This judgement has impacted hugely on workloads for the range of professionals involved in completing the required assessments and authorisations to ensure that clients are not being unlawfully deprived of their liberty.

Applications from managing authorities in Stockton (residential and nursing care homes and hospitals), to deprive individuals of their liberty were administered by existing staff in Stockton Borough Council's Adult Strategy Team. Following the sharp increase in applications received and the workload pressures that had been identified within the team, a North of Tees Dementia Collaborative Workshop Lead used lean principles to review and refine the administrative process from point of receipt of an urgent DoLS, to the signing of the decision. Additional work also focused on the next stage of the DoLS process in producing and sending the necessary paperwork following the signed decision.

A summary report of the data collected was presented to managers and senior managers.

Changes to the process were implemented following a review of the data by the team carrying out the work.

From December 2014, a dedicated DoLS team was implemented to oversee the administration of DoLS applications in Stockton.

Next Steps:

- A Project Manager will be in post from February 2015.
- Original ideas forms are being revisited with a view to further implementing changes to the process and the function of the team will be reviewed in the medium term.

12. NATIONAL DEMENTIA STRATEGY

The scheduled improvement activity that has already taken place in year 1 & 2 has been linked to the National Dementia Strategy objectives. We have made significant progress with many of these objectives as detailed overleaf:

	OBJECTIVE	RPIW1 CHC 21.01.13	RPIW2 Prevent Attendance in A&E from Care Homes 04.03.13	RPIW3 Assessment and decision making for person with Dementia admitted to Acute Ward 18.03.13	RPIW4 Managing Challenging Behaviour in Acute Settings 13.05.13	RPIW5 Re-ablement 17.06.13)	RPIW6 Supporting people with a Dementia in their own homes 15.07.13	RPIW7 Improving delivery of domiciliary care for people with a Dementia 09.09.13	RPIW8 End of Life 31.03.14-04.04.14	Kaizen 3 Day Involving patients/ families/ reps at the onset of the CHC process. 26-28.02.14	Kaizen 3 Day Acute Care Kaizen 12-14.05.14	RPIW9 Supporting people with Dementia to live at home 14-18.07.14		
1	Improving public and professional awareness and understanding of dementia												5	Improving public and professional awareness and understanding of dementia
2	Good-quality early diagnosis and intervention for all												7	Good-quality early diagnosis and intervention for all
3	Good-quality information for those with diagnosed dementia and their carers												4	Good-quality information for those with diagnosed dementia and their carers
4	Enabling easy access to care, support and advice following diagnosis												4	Enabling easy access to care, support and advice following diagnosis
5	Development of structured peer support and learning networks												0	Development of structured peer support and learning networks
6	Improved community personal support services												6	Improved community personal support services
7	Implementing the Carers' Strategy												1	Implementing the Carers' Strategy
8	Improved quality of care for people with dementia in general hospitals												5	Improved quality of care for people with dementia in general hospitals
9	Improved intermediate care for people with dementia												3	Improved intermediate care for people with dementia

10	Considering the potential for housing support, housing-related services and Tele-care to support people with dementia and their carers												2	Considering the potential for housing support, housing-related services and Tele-care to support people with dementia and their carers
11	Living well with dementia in care homes												2	Living well with dementia in care homes
12	Improved end of life care for people with dementia												4	Improved end of life care for people with dementia
13	An informed and effective workforce for people with dementia												9	An informed and effective workforce for people with dementia
14	A joint commissioning strategy for dementia												0	A joint commissioning strategy for dementia
15	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers												0	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
16	A clear picture of research evidence and needs												1	A clear picture of research evidence and needs
17	Effective national and regional support for implementation of the Strategy												0	Effective national and regional support for implementation of the Strategy

18	Driving improvements in health and social care												11	Driving improvements in health and social care
19	Creating dementia friendly communities that understand how to help													Creating dementia friendly communities that understand how to help
20	Better research													Better research

13. COMMUNICATION

The project has used various communication mechanisms to ensure that internal and external stakeholders are kept informed of progress. These include:

- Monthly management update with progress on each improvement event shared with each partner organisation.
- Quarterly briefings for distribution through internal and external communications channels to all stakeholders.
- Presentation at GP Time Out Event.
- Presentation of improvement work to service providers.

14. YEAR 2 AWARDS & ACKNOWLEDGEMENTS

14.1 Making a Difference Awards 2013

The project was nominated for the Tees, Esk and Wear Valleys NHS Foundation Trust Making a Difference Awards 2013. There were over 190 nominations and The North Tees Dementia Collaborative was shortlisted in the category of Working in Partnership with other Agencies.

At the award ceremony on Friday 21 March 2014, The North Tees Dementia Collaborative was highly commended.

14.2 Edge Award - Dementia Awareness with Children Project

Karen Morris, Stockton Health and Well Being Librarian won in the "Social " category at the 5th Edinburgh Edge awards in February 2014, for the work she has been carrying out in Stockton schools, particularly as part of Dementia Awareness week. The Edge awards are about innovation in public services and organised by Edinburgh City Libraries.

14.3 Dementia 2014: A North East Perspective

The positive work of the North of Tees Dementia collaborative was acknowledged in Dementia 2014: A North East Perspective (Smith and Otter, 2014) and featured in the Case Studies paper.

15. Lessons Learned (including SWOT analysis)

A recent global survey identified 3 reasons why corporate transformation efforts fail (Bevan and Fairman, 2014).

1. They run out of energy (change fatigue).

2. They lack the skills and capabilities in transformational change, particularly related to sustainability.

3. Transformation plans are too top down and fail to engage the front line workforce.

It was acknowledged at the beginning of the report that a collaborative was always going to be a complex, challenging project. By the end of year 1 there was evidence to some degree, all the above elements are having an impact on the delivery of agreed changes within the timescales anticipated.

However, the wealth of information contained in this report illustrates that there have been real tangible benefits from the work of the collaborative members for people with dementia and their carers. Target sheets are only part of the story and the actions on the newspaper tell the real story of the commitment to continue to find solutions to the obstacles encountered in making change for the better. It is hoped the work can still be developed further as the project enters a 3rd year.

Overleaf is a Strengths, Weaknesses, Opportunities & Threats (SWOT) analysis which has been compiled from contributions from the North of Tees Dementia Collaborative membership.

SWOT analysis

Strengths	Weaknesses
• Increased profile and recognition of the work being undertaken in Stockton and Hartlepool. • Good networks established to share information. • Strengthening of working relationships between organisations at a range of levels. • Steering Group members have a wide and diverse range of experience, skills, knowledge and perspectives that can be drawn on to encourage creativity & innovation. • All collaborative work is shared with an advisory group and welcomes the contributions of service users and carers in a variety of formats. • Financial commitment to continued joint working across 5 statutory organisations for a 3rd year. • Dedicated Project Lead and administration to maintain momentum of joint working. • Clear objectives (NDS) shared goals and jointly agreed terms of reference. • Delivery against implementation of the National Dementia Strategy and clear links to Better Care Fund (BCF) strands. • Systematic approach to looking at areas to be analysed. • Where improvements have been made these seem to be sustained. • Where issues are properly understood specific task and finish groups have been established [as 'part of the day job'] to drive projects forward, e.g. "end of life" working and "medical checks in care homes." • Collaborative's input outside the workshop programme has supported / is supporting the development of dementia Friendly Communities [Stockton and Hartlepool]. • Collaborative has also become a means of sharing innovative activity, e.g. Life Story Network's Family Care project.	• Large variation in the level of commitment of the partners. • Implementation across 5 diverse organisations with competing agendas and equally diverse governance arrangements has meant problems with timely implementation for planned actions. • Current methodology can be viewed as very time consuming. It is difficult for some organisations to support front loading of time and it is not always well understood by organisations. • Limited certified Workshop Leads. • Intellectual property rights issues places constraints on the sharing of training resources with organisations not licensed with NETS. • Difficult for those not well informed to understand terminology & roles, especially Process Owner and Sponsor. • Rigidity of process & requirements to keep to given techniques causes inflexibility. • Lack of continuous involvement from Process Owners and Sponsors. • Virtually all workshops have had too large a scope which impacts on outcomes, "buy-in" and implication. • Where problems have occurred between partners about implementing change, the steering group has not had sufficient influence to affect change, [e.g. CHC checklist "no" letter to be given to patient or family/carer].
Opportunity	**Threats**
• Favourable political, health & social care climate – Care Act, implementation of Better Care Fund. (BCF). • Increased accountability through Better Care Funding programme. • Access to other existing networks improving dementia care (NHS clinical networks, NEDA, Newcastle University, South of Tees Dementia Collaborative) to promote the share and spread of good practice. • Increasing interest in partnership working from a wide range of stakeholders. • Steering group offers ongoing forum for revision of existing programme of work and planning of new work. • Steering Group offers opportunity to share lessons learned. • Opportunities for joint working between different teams and agencies can have an possibly unintended result of break down barriers –"Them and Us" can become "We!".	• Change to political climate. • Transformation of care services & changes to working practices can result in delay/barriers in implementing changes. • Financial environment for all partners is extremely challenging. • External time pressure from other initiatives, imperatives & organisational priorities can destabilise working and impact on momentum and the sustainability of improvements. • Where roll-out involves multi agencies and especially those outside the partnership [statutory, voluntary or independent sectors] and where involvement is voluntary, effective implementation has met barriers and has been blocked. • Time commitment to attend improvement event workshops and steering group. • Variation in buy-in to methodology. • Limited certified workshop leads. • Improvements often rely on a limited number of motivated individuals who become overwhelmed, and if unavailable further work is threatened.

16. Year 3 Priorities:

Following the confirmation of funding for a 3rd year from the 5 statutory partners, the Steering Group is currently considering the priority areas for year 3. The proposed focus of a 3rd year would be:

- Continuing to extend the membership to new organisations.
- Reviewing governance arrangements.
- Promoting a change agent culture within organisations, with identified Improvement Leads.
- Embedding and sustaining the changes agreed to date.
- Supporting change in new areas identified by one or more partners.
- Linking with the Better Care Fund work strands.
- Spreading elements of the work that would benefit other areas.
- Curating knowledge on good practice in other areas.
- Exploring alternate change tools and evaluation methods.
- Contributing to work external to project plan where benefits for people with dementia are identified.
- Maximise joint working by establishing links with the South of Tees Dementia Collaborative, North East Dementia Alliance, Clinical Network Northern England and North East Dementia Hub.

17. References:

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