Herefordshire and Worcestershire's Living Well with Dementia Strategy

2019-2024

Produced by:

NHS Herefordshire Clinical Commissioning Group | NHS Redditch and Bromsgrove Clinical Commissioning Group | NHS South Worcestershire Clinical Commissioning Group | NHS Wyre Forest Clinical Commissioning Group in partnership with Herefordshire Council and Worcestershire County Council

1. Introduction

Early diagnosis and access to support for those living with dementia and their carers remains a priority for Herefordshire and Worcestershire. Our Strategy sets out the Herefordshire and Worcestershire ambition to support people to live well with dementia.

It reflects the national strategic direction outlined in The Prime Minister's Challenge on Dementia which details ambitious reforms to be achieved by 2020.

The Strategy is informed by what people have told us about their experiences either as a person living with dementia or as a carer and is written for those people; specifically those with memory concerns, those with a dementia diagnosis, their families and carers, communities and organisations supporting them.

1. Introduction continued

Hereford and Worcestershire's Living Well with Dementia Strategy 2019-2024 has been developed in partnership with local health, social care and the voluntary and community sector. An important focus of our strategy is to move towards delivery of personalised and integrated care.

We have used the NHS England Well Pathway for Dementia to give us a framework that puts the individual and their carer at the centre of service development and implementation across health and social care. As a partnership, we are committed to minimising the impact of dementia whilst transforming dementia care and support within the communities of Herefordshire and Worcestershire, not only for the person with dementia but also for the individuals who support and care for someone with dementia.

We want the well-being and quality of life for every person with dementia to be uppermost in the minds of our health and social care professionals.
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

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2. What is dementia?

‘Dementia describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer’s disease, a series of small strokes or other neurological conditions such as Parkinson’s disease’ **‘Prime Minister’s Challenge on Dementia 2020’**

Prime Minister’s Challenge on Dementia 2020

Dementia is most common in people over the age of 65 but there are also a smaller cohort of people who develop ‘young onset’ or ‘working age’ dementia from as young as 35.

For most people the cause is unknown but there are some known causes or risk factors such as:

- Diseases and infections that affect the brain e.g. Alzheimer’s disease or meningitis
- Pressure on the brain e.g. brain tumour
- Lack of blood and oxygen supply to the brain e.g. stroke and head injuries
- Cardiovascular insufficiencies.

There is clear evidence that the earlier into the disease that dementia is diagnosed the better the outcomes for those with the illness and their informal carers, it will help with decision making and preparing the individual and their family for choices they will need to make in the future.

Links to further information about the different types of dementia are provided at the end.

3. Vision, guiding principles and aims

This strategy has been guided by principles developed by NHS England in their transformation framework. This 'Well Pathway for Dementia' is based on NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia We-statements from The National Dementia Declaration.

Our vision is that in Herefordshire and Worcestershire people with dementia can live well through the following guiding principles:

- Preventing Well
- Diagnosing Well
- Supporting Well
- Living Well
- Dying Well

Our new strategy focuses on people and patients so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

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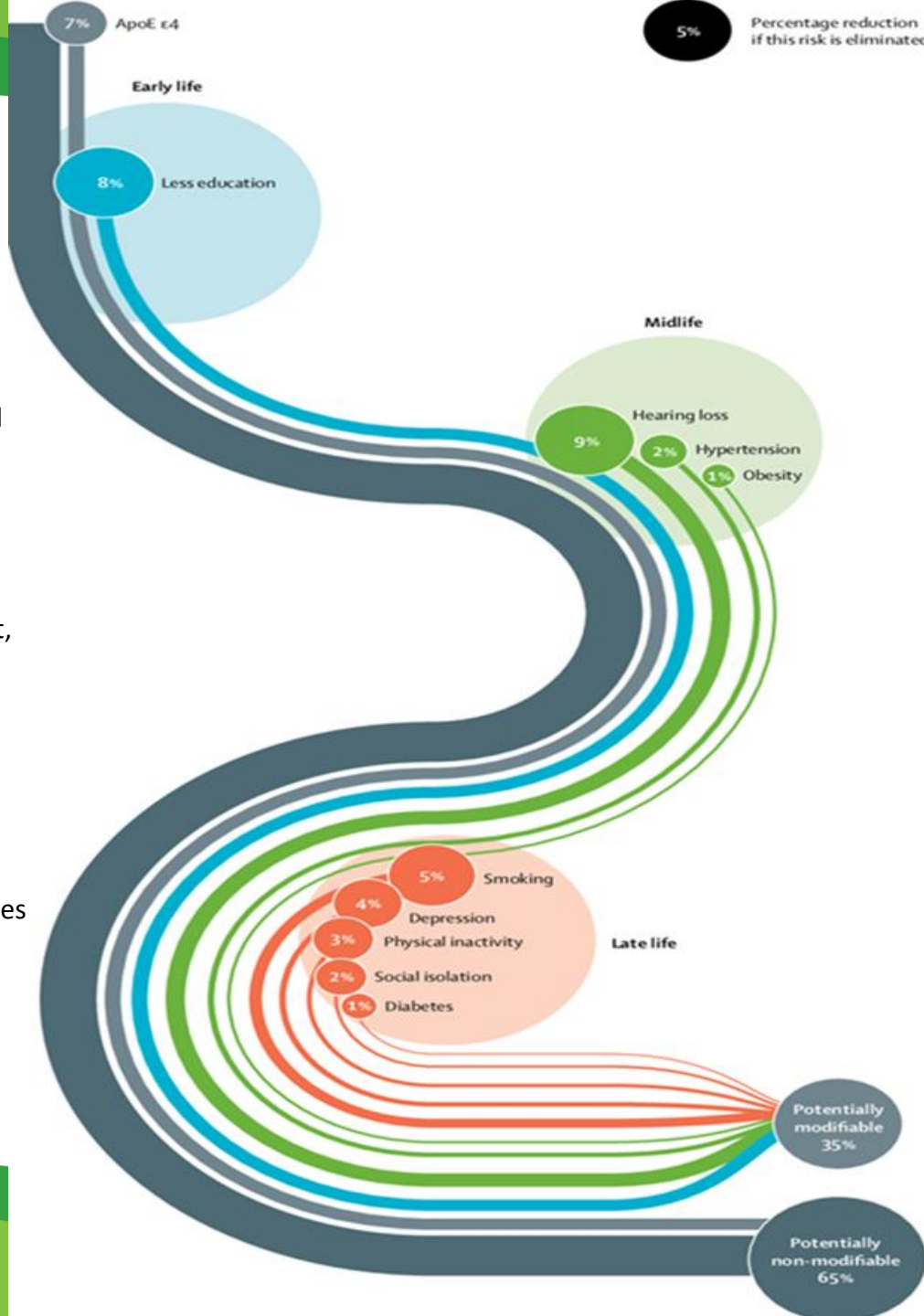
3.1 Preventing Well: Risk Factors to Dementia

- Age is the biggest risk factor but lifestyle, from childhood through mid-life and later life, has a considerable impact.
- A major study[1] estimated 35% of cases of dementia are attributable to a combination of modifiable risk factors: education to age 11–12 years, midlife hypertension, midlife obesity, hearing loss, later-life depression, diabetes, physical inactivity, smoking and social isolation (see Figure). Other factors could also be important, and further add to the preventable fraction. Recent data[2] supports the impact of higher alcohol consumption (>14 units/week) in increasing dementia risk. Other risk factors have biological plausibility but not yet conclusive evidence, including visual impairment, depression, sleep, living close to major road (air pollution) and dietary factors.
- Incidence could be therefore be decreased by reducing risk factors.[1,3] Supporting increasing healthy behaviours (stop smoking, be more active, reduce their alcohol consumption, improve their diet), loss of weight/maintaining a healthy weight, maintaining social engagement and managing hypertension in middle age, hearing loss, depression, diabetes and obesity all have potential to delay and prevent onset of dementia.

[1] Livingston et al, Lancet 2017. [2] Sabia et al, BMJ 2018. [3] NICE guideline NG16, 2015



4. National context and background

There are a number of national drivers that shape and influence the way the UK should address dementia as a condition

Prime Minister's Challenge on Dementia 2020

In February 2015, the Department of Health published a document detailing why dementia remains a priority and outlined the challenges the UK continues to face in relation to dementia.

The priorities identified within this are:

1) To improve health and care
2) To promote awareness and understanding
3) Research

Legislation

- Care Act 2014
- Equality Act 2010

Context

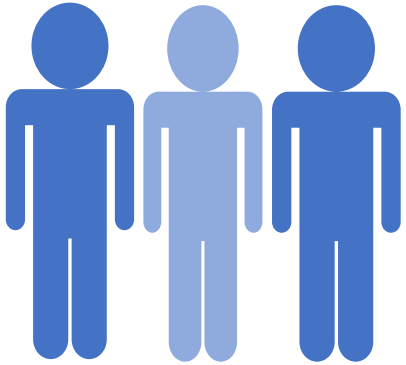
- Living Well with Dementia 2009
- Dementia 2015
- NHS & Adult Social Care Outcomes Frameworks and NICE Guidelines
- Fix Dementia Care 2016

National picture

There are currently 850,000 people living with dementia in the UK. 42,325 of these have early onset dementia.

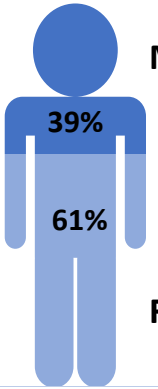
The number of people with dementia is forecast to increase to 1,142,677 by 2025 – an increase of 40%.

It is estimated that 700,000 (1 in 3) people in the UK will care for someone with dementia in their lifetime



In the UK 61% of people with dementia are female and 39% are male. There are a higher proportion of women with dementia as women tend to live longer, however, this does reverse when considering the data for people with early-onset dementia.

Gender

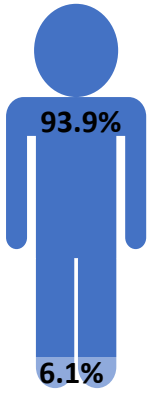


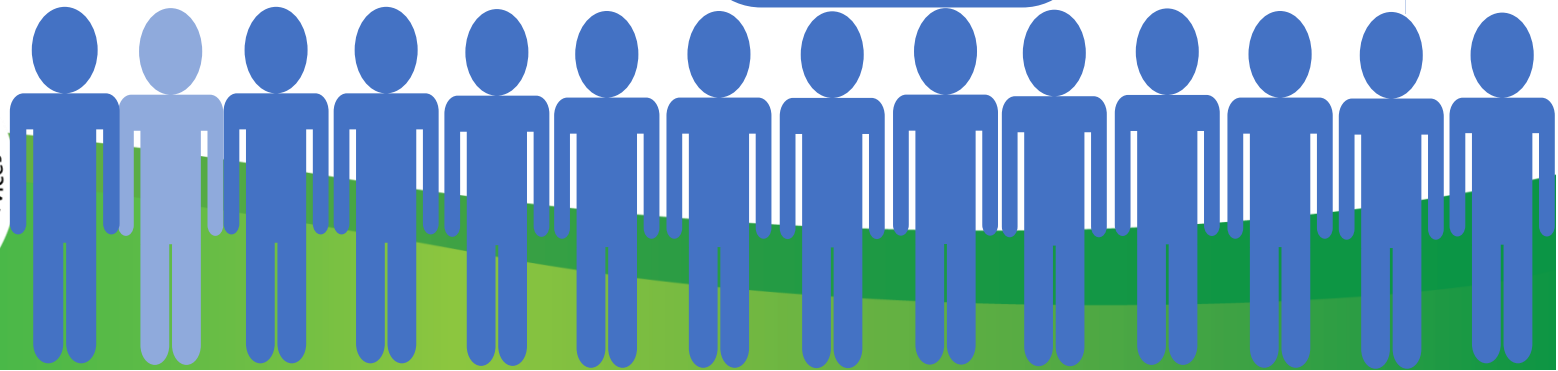
1 in every 14 of the population over 65 years has dementia

1 in 3 people who die over the age of 65 years have dementia. Dementia now accounts for 11.6% of all recorded deaths in the UK.

It is estimated that there are 11,392 people from black and minority ethnic (BME) communities who have dementia in the UK. 6.1% of all those are early onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities.

Dementia and Ethnicity





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Herefordshire and Worcestershire Living Well with Dementia Programme 2019-2024

National Outcomes

1. PM's Dementia Challenge 2020 Visit

- Reducing Risk
- Improved Health + Social Care
- Awareness + Social Action
- Research

2. NHSE Well Framework/Pathway

- Prevent well
- Diagnose well
- Support well
- Live well
- Dying well

H &W Outcomes

- **Driving STP wide culture change** through raising awareness and understanding
- **Early Dementia Diagnosis** and access to support
- **Supporting people** affected by dementia ensuring they have choice and control in decisions affecting their care and support
- **End of Life** Ensure person living with dementia dies with dignity and their families/carers experience compassionate support

Key Influencers

Priorities:

- Increase Dementia Diagnosis Rates (DDR)
- Integrated Community Dementia Pathway via Neighbourhood/locality teams
- Dementia Awareness &Support

NHSE

- Ambition DDR 67%
- 6 week referral to treatment by 2020
- Improved post diagnostic support
- Reduced inequalities
- Increased Advanced Care Plans (ACP)
- Proactive case finding
- NICE 2018

Dementia Strategy and Programme 2019– 2024

5 Core outcomes:
Prevent well
Diagnose Well
Supporting Well
Living Well
Dying Well

Supporting Initiatives

Increase DDR

- Pro-active case finding
- Improve coding in primary care (Data Quality Toolkit 2017)
- Harmonisation of GP register and specialist mental health
- DiADeM and DeAR GP Tools

Care Homes

- Collaborative approach to support Care Homes

Neighbourhood Locality Teams

- Place based approach
- Integrated community team

Communication and Engagement

- Shared vision and Campaigns

Education and Workforce Development

- Education Strategy to build dementia friendly practice across pathway delivery including Advanced Care Planning and End of Life care

DDR

- DDR Recovery Plan
- IST findings/action plan

Referral

- MAS pathway review to improve patient flow
- Steps to diagnosis
- Diagnosis of dementia (care homes)

Learning Disability (LD)

- Increase awareness & inclusion of LD in dementia services
- Align with LD strategy

Mild cognitive Impairment (MCI)

- Pathway in collaboration with WMSCN
- Pilot (locality)

Shared Care protocol to support medicines prescribing

Joint delivery plan across all partners

Workforce Development

Align with Frailty (ICOPE)

Dementia friendly Community

- Dementia Action Alliance
- Dementia Partnership
- Community resilience and capacity; Meeting Centre; Singing for The Brain, Dementia Cafés, Carers Support, Dementia Voices , young on-set
- Dementia Friends
- Dementia Connect and WISH
- IST Work Programme

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5. Local context and background

The Sustainability and Transformation Partnership (STP) in H&W is a partnership committed to improving health and social care to enable us to plan and be responsive to the needs of the whole population. This includes a dementia work stream to deliver the Well Pathway for Dementia

Local Dementia Delivery Plans reflect the key findings and recommendations of a dementia review undertaken by NHSE Intensive Support Team 2017
A further review was undertaken Oct 2018

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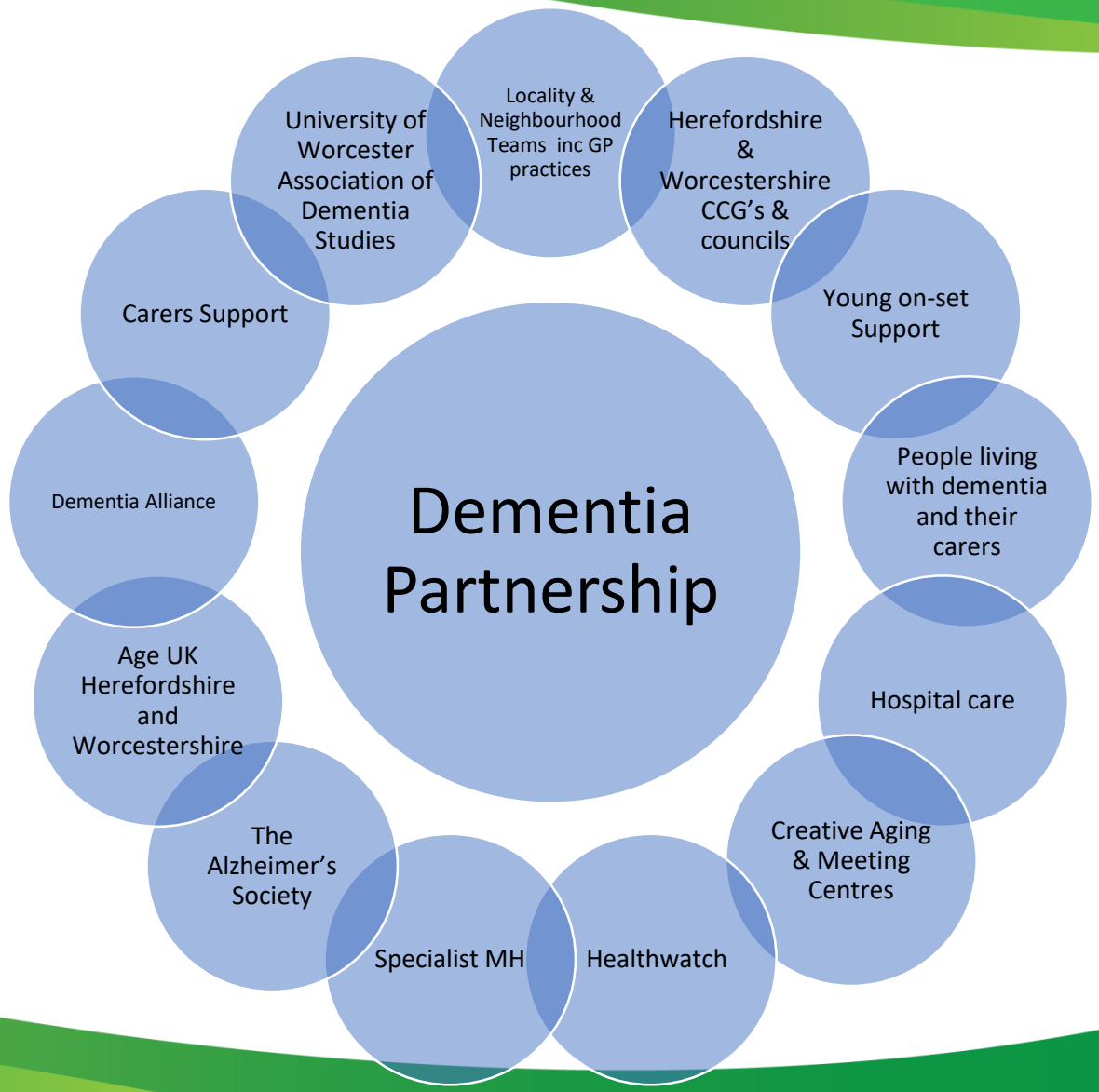
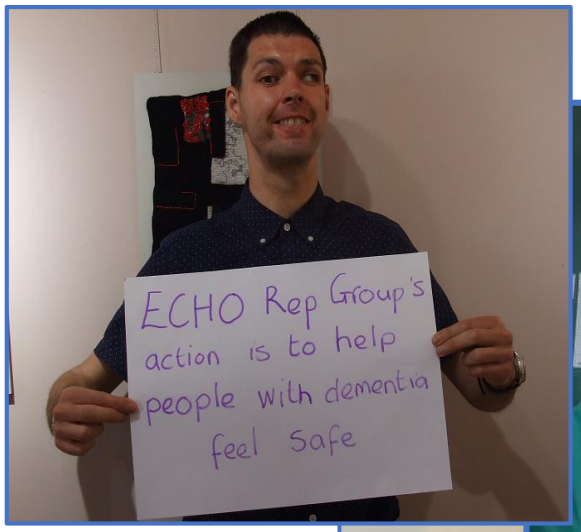
5. Local context and background

Each county has a Dementia Partnership Programme Board overseeing the development of a refreshed strategy and high-level delivery plan. The multi- agency partnership works to ensure that interdependencies are identified including but not limited to:

- Integrated locality Neighbourhood teams
- Carers Support
- Primary care
- Community and voluntary organisations
- Secondary Care
- Urgent and emergency care
- Planned care
- Mental health
- Prevention
- Medicines Management
- Learning disabilities
- End of life
- Continuing health care and personal budgets
- Information and support- WISH, ART



5. Local context and background



"Having contact with the Dementia Adviser Service has helped me to continue to be part of my community by enabling me to participate in the Focus on Dementia Network" (a local service user).

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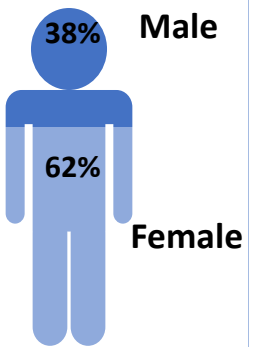
Local Picture

There are currently 12,456 people living with dementia across Herefordshire and Worcestershire (this number is set to increase to 18.669 by 2035).
592 of these people have early onset dementia.

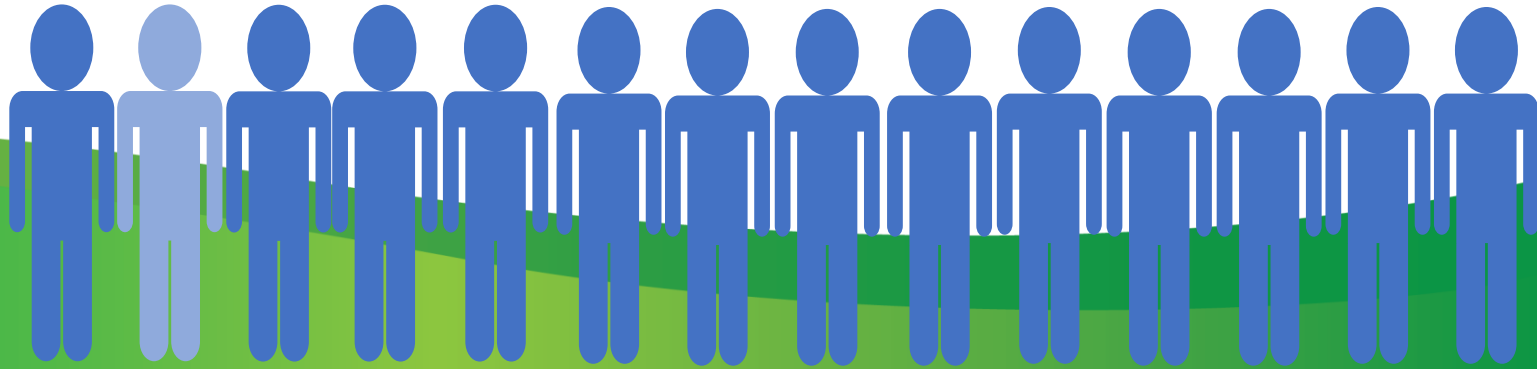
Across H&W 62% of people with dementia are female and 38% are male. This reflects the national trend.

Gender



It is estimated that there are 84985 carers across H&W. For further information relating to carers, see the draft H&W Carers Strategy.

1 in every 15 of the population of H&W over 65 years has dementia, reflective of the national trend



Local Picture

The dementia diagnosis indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia. The target set by NHS England is for at least two thirds of people with dementia to be diagnosed (67%). The national prevalence of dementia is 1.3% of the entire UK population equating to approximately 850,000 individuals.

Local NHS Diagnosis Rates (people over 65 years)

Herefordshire	South Worcs CCG	Redditch & Bromsgrove CCG	Wyre Forest CCG
58.9%	56.4%	64.6%	58.9%

(Percentages represent the proportion of people living with dementia that have a formal diagnosis as of Aug 2019)

Herefordshire

- Total Population 187,878
- 3116 individuals thought to be living with dementia
- 2966 of these are 65 years or over
- 150 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 46,102 which equates to 6.43% of this cohort of the population living with dementia

Worcestershire

- Total Population 607,971
- 8,748 individuals thought to be living with dementia
- 8306 of these are 65 years or over
- 442 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 127,811 which equates to 6.5% of this cohort of the population living with dementia

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Local Picture - What people tell us

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Local Picture

"Having support from a DA has reduced my anxiety and made me feel that I am not so dreadfully alone"

"memory clinic referral went smoothly along with appointment was an overview of what to expect .. experience was good, ongoing support excellent we have a remarkable CDN"

Person attending a Memory Morning Drop In

"It was a friendly setting where I was able to talk freely about my concerns without family members talking for me."

"Thank you so much for all the help you have given over the years. We would have been lost without you."

"'As always your support and advice is very much appreciated. You are such a help for people like us as individuals, and for the community as a whole"

"People really like the meeting centre as it runs for a good amount of time. For one gentleman, it gave his wife (carer) a break and he wishes there was more things like it where he could go on other days of the week."

Person with LD and dementia

"I do like the signs and I want to put my photo on my bedroom door."

Family carer of person with LD

"There is a definite change where my learning disabled daughter lives. I observe the person who has learning disability and dementia now listening to music through headphones, and the environment is dementia friendly. The rugs and patterns are all gone; the carers have really embraced the learning. The impact on other people who have a learning disability who live there is that they are more relaxed. They have stopped telling her to be quiet."

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Local Picture

Don't forget that those with a diagnosis of dementia may have other health issues , pathways must accommodate this as risk of overshadowing can occur without proper integration

"We need more drops-ins". Lots of groups in the area but not enough coordination between them, for example, everything seems to happen at the same time/day.

You will need to train your workforce to attune to the needs of younger, physically fitter people being diagnosed with dementia. How will they wish to be supported by you? People will expect to stay active, working and engaged in their community

Support staff to develop knowledge skills and confidence in advanced care planning at an appropriate time for the person and their carer, and managing end of life when the time comes

We need to keep talking about dementia and all risk factors associated with it …
Knowledge is Power

(Carer) "Professionals need to understand dementia can make people intolerant of waiting; noisy places but few have taken this on board"

Dementia can be a very lonely place, encourage open discussion and easier access to help available so that people are not scared of diagnosis and feel confident to make the necessary adjustments to live well

Reach out to communities to address their negative attitudes towards living next door to someone with dementia & how they can support them – its not all about the staff/professionals. We all have a role to play in addressing stigma

"Hard to find affordable, short-term, ad hoc respite – mother is settled at home and it would be better if someone could come to the home even if it was just for a few hours." - Family member

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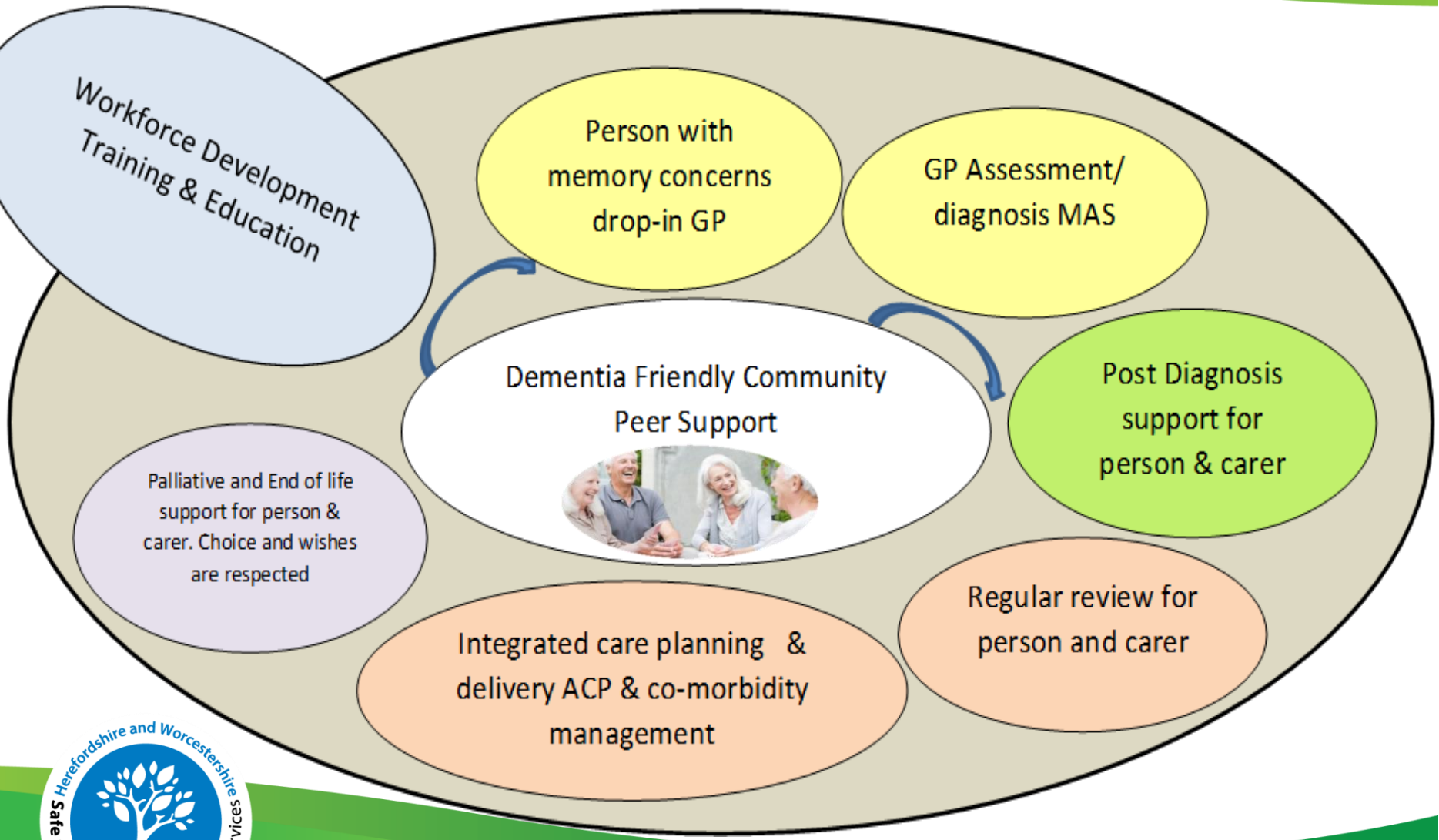
Dying Well
Living Well with Extra Care and Support
Living Well and planning for the future
Supporting Well
Diagnosing Well
Preventing well

A persons journey living with dementia



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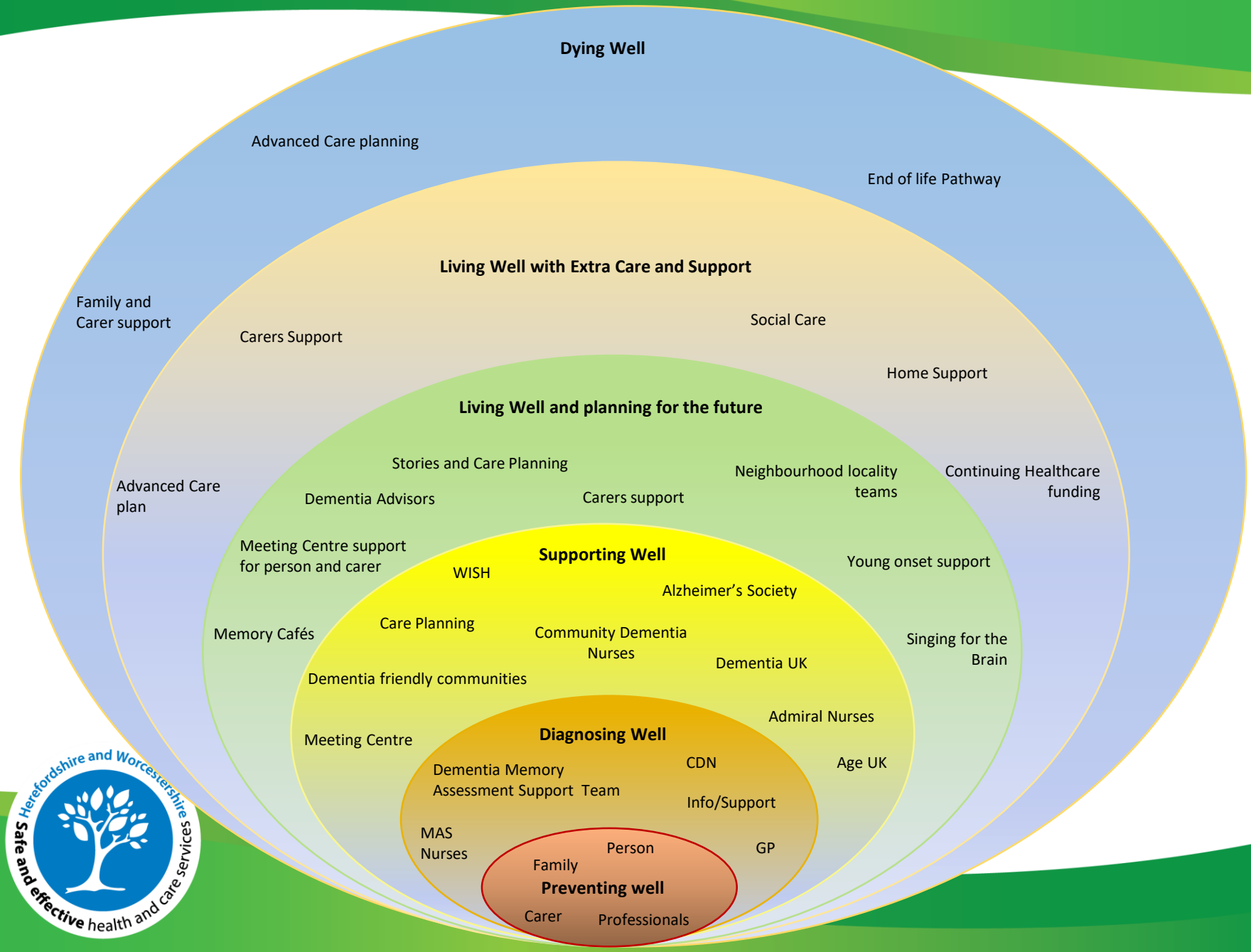
Herefordshire's and Worcestershire's Vision For Dementia



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7. Achievements of the previous Worcestershire Strategy 2009-2016

GP's have been supported to understand and promote key preventative messages as well as developing health checks and a dementia focused GP toolkit.

The memory pathway is well embedded across the area with good connections from primary care, an award winning memory clinic, post diagnostic support services through the voluntary and community sector and adult social care.

There has been a modernisation of the older adult mental health services to ensure that key objectives are met and to ensure that specialist services can complement the more generic development of health and social care services across the county. A new community and hospital based Dementia Pathway has been developed with a single point of access for people with dementia, carers and professionals

Worcestershire has a fully integrated personalised approach to dementia support, including an Admiral Nurses who have specialist dementia nursing expertise

Models of Peer Support have been developed to increase access to services.

Engagement with people living with dementia and their carers has been undertaken across the area to understand their experiences of the health and social care system to inform future work

Awareness raising has been undertaken by the Voluntary and Community Sector in the form of pop up road shows, GP training.

7. Achievements of the previous Worcestershire Strategy 2009-2016

Carers are supported through specific services, including advice, information, training and respite

Worcestershire has many Dementia Action Alliances and a number of dementia friendly practices.

The Johns Campaign has been adopted by all hospital trusts in all hospital settings

The Dementia CQUIN for assessment has been embedded in all hospital settings

A bespoke group has been set up specifically for people with Young Onset Dementia for PWD carers their family and professionals to meet

A Dementia training programme for Care Homes, Domiciliary Care and the wider community has been completed.

8. Achievements of the previous Herefordshire Strategy

Herefordshire Dementia Integrated Care Pathway promotes a person centred approach and is well embedded across the county with effective team working across GP practices, Memory Assessment Service and community dementia support offering post diagnostic support in collaboration with voluntary and community sector and adult social care.

Herefordshire continues to strive towards the 67% national target in relation to diagnosis rates with appropriate referrals being made to memory assessment services, underpinned by a shared care agreement

A review of our strategic approach helping to facilitate effective participation and involvement across programme board; partnership and alliances to maximise impact and productivity

There has been extensive work to improve clinical coding (DQT), data reconciliation across stakeholders within the pathway helping to improve communication and information sharing and ensure people have access to and receive timely diagnosis, information and support.

Expert voice of people living with dementia raising awareness of Living Well with dementia contributing to society and changing perceptions.

Auditing public services and spaces suggesting improvements which have been implemented Old Market, Cathedral.
Working on GP audit tools; participating in service improvement audits; staff development days & Co-facilitating dementia friends sessions

Carers are supported through specific services, including advice, information, training and respite care. Carers attend cafes and Singing for the Brain along with the person who has dementia. Dementia Advisors support the partnership of carer and cared for.

8. Achievements of the previous Herefordshire Strategy

Significant Awareness raising has been undertaken via Dementia Partnership and Dementia Alliances and Dementia Friendly communities who work diligently to help build a dementia friendly Herefordshire. Herefordshire Dementia Action Alliance achieved Dementia Friendly Status in January 2017.

Meeting Centre at Leominster and Ross on Wye offering a membership model where carers and people with dementia are enabled to be actively involved and included in their community

Partnership working has enabled the roll out and buy in to Dementia Friends at strategic level with people living with dementia actively involved in the delivery. There are over 5,000 dementia friends across the county helping to promote awareness and support communities and businesses to take actions towards a dementia friendly Herefordshire. A number of GP practices are already working to become dementia friendly practices

A partnership commitment to building awareness has led to a county wide communication network approach which continues to promote events; news; opportunities and strengthening links between WISH and Alzheimer's Society Dementia Information and Support web pages

Listening to people living with dementia and their carers to understand their experiences of the health and social care system to inform future work. Engagement with rural communities and older people via Healthwatch continues to help inform our delivery plan

8. Achievements of the previous Herefordshire Strategy

A bespoke support group has been set up specifically for people with Young Onset Dementia for people with dementia; carers; family and professionals to meet

Reaching into Under-participating groups: Learning disability and dementia a project led by Alzheimer's Society has helped build awareness and understanding across stakeholders and actions to improve experience of people living with LD and dementia and their ability to live well for longer

Memory Mornings – reaching into rural communities where people worried about their memory can talk access support in a non-clinical setting.

Building resources and continuous shaping of support for people affected by dementia. Admiral nurses are a new resource for Autumn 2018. A Dementia training programme for Care Homes, Domiciliary Care and the wider community has been completed along with clinical updates for various professional groups of staff.

Launch of supportive assessment tools to support diagnosis (DiaDem) and care planning
(ReSPECT) to ensure we establish early diagnosis and plan care more effectively in partnership with person and care/ family

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

To monitor achievements an annual dementia dashboard and highlights report will be produced for the Health and Wellbeing Board

The most important outcome of Herefordshire and Worcestershire Dementia Strategy is to ensure more people with dementia are able to live safely and with as good a quality of life as possible at home or in a homely setting for as long as they and their family wish.

To achieve this we have a key over-arching actions to ensure there is good information, advice and support for people living with dementia and for their carers and families so that people are more confident that they can live well and independently with dementia and have access to appropriate support and services when required

Overarching

	High Level Actions	Lead	Outcomes	Measure
1.1	**Priority 1** Strengthen leadership and accountability for delivery of the strategy	Clinical and Organisational Lead roles both counties. Dementia Partnership Programme. Programme Board	Dementia partnership programme board includes clinical and executive level leadership and accountability from across the system Clinical and Organisational Leadership roles are well established, promoted and recognised across partners Awareness of Dementia and the link with physical and mental health is clearly articulated within relevant strategies (including CYP; older people, LD LTC strategies (ICOPE/frailty/ageing well). An Annual dementia recognition awards recognises contributions to the following: 1. Communication 2. Leadership and management 3. Learning and Improvement 4. Special Achievement	Evidence of refreshed TOR and Meeting Notes Annual review of strategies via programme board Innovation and Achievements are recognised and rewarded
1.2	**Priority 2** Develop pro-active dementia support model within Locality and neighbourhood teams	Locality /neighbourhood teams (GP clinical leads; clinical/care leads across partner organisations)	Locality and neighbourhood teams have received dementia friends training and have access to tools and approaches to be pro-active in recognising dementia and providing care and support to people affected by dementia Training to support use of and increased use of contingency & ACP planning in care plans to include ReSPECT tool ReSPECT form content shared with family members where appropriate Shared care pathway in place Increased uptake and use of assistive technology	% of dementia friendly practices & no. teams with dementia friends Training Dialogue has occurred between health and social care professionals and/or advanced care plan in place No. of people using assistive technology at home

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Overarching

	High Level Actions	Lead	Outcomes	Measure
1.3	**Priority 3** Maintain effective engagement processes with people living with dementia and their carers	Dementia Partnership Programme Board	There is an established model which partners follow to support patient and carer involvement and participation in pathway design and service improvement processes Patient and carer feedback are utilised to inform service improvement and enhance patient/carer experience Partners collaborate creating shared opportunities facilitating patient and carer involvement and participation Patients and carers participate in the dementia partnerships.	Evidence of Patient and carer satisfaction and working with people affected by dementia through: Task and finish groups • 1:1 meeting • Surveys • DPB • Working with community & voluntary organisations • Healthwatch
1.4	Partner organisations ensure their wider policies, strategies and specifications are dementia friendly, i.e. support preventing, diagnosing and living well with dementia; and all partners are aware of their safeguarding responsibilities	CCG's, Public Health, Herefordshire Council, Worcestershire County Council & Dementia Partnership Dementia Programme Board	Health and wellbeing of people affected by dementia are central to the decision-making of partner organisations All partners are aware of potential safeguarding and risk of harm for people affected by dementia and are clear on their roles and responsibilities and are familiar with local procedures to follow where there are concerns.	Evidence of dementia focus within key strategy, policies and specifications
1.5	Promote opportunities to participate in research to people living with dementia and their carers throughout the entire dementia pathway Implement Join Dementia Research (JDR) NHS toolkit NHS JDR Toolkit	Dementia Programme Board	Contracts with providers include a commitment to facilitate access to research opportunities People with dementia and their carers participate in national and local research opportunities Research Opportunities are discussed and promoted at Partnership meetings	Number of research opportunities available in the county
1.6	Undertake forward planning to ensure diagnosis and post-diagnostic support is designed to meet growth in dementia prevalence in over 65s and aligns with relevant strategies (Housing Frailty and EoL Strategy) PHE Fingertips Data and Rightcare and CCG data packs	CCG's, Herefordshire Council, Worcestershire County Council and Partnership	There is a regular programme of joint strategic needs assessment between LA and CCG commissioners which is used by all partners to inform local dementia service planning.	Timetable is a regular agenda item for programme board With task and finish as required

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Preventing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
2.1	**Priority 1** Ensure **lifestyle interventions** (e.g. MECC, NHS Health Checks, workplace initiatives) and communication campaigns maximise the opportunity to reduce risk factors and raise the prevention message around dementia (e.g. using Public Health Dementia Risk Reduction Toolkit messages	CCG's, Public Health, Herefordshire Council and Worcestershire County Council	Increase in healthy behaviours that reduce the risk of dementia Increased awareness and understanding of risk factors for dementia across the life course. Increased awareness of Dementia and the link with Physical and mental health An ongoing local coordinated campaign across health and social care economy, led by Public Health, informing the public about; • Dementia risk reduction • Signs/symptoms of dementia (leading to timely diagnosis) • Benefits of early diagnosis • Preventative actions e.g. NHS HC uptake; physical activity Reducing modifiable risk factors e.g. smoking in key populations; alcohol consumption, early hearing loss detection and utilisation of hearing aids to improve independence and prevent cognitive decline. Behavioural Insights methodology is used to engage, understand and change behaviours (e.g. lifestyles or seeking diagnosis) in key at risk communities	Awareness of Dementia and the link with physical and mental health is clearly articulated within relevant strategies (including CYP; older people, LD LTC strategies (ICOPE/frailty/ageing well). All healthy living messages with reference dementia alongside heart disease and cancer. MECC is widely embedded Number of people trained in MECC; and where available, records of MECC healthy conversations on risk behaviours Evidence of close monitoring via increased uptake of NHS HC and effective follow-up and management of core dementia risk factors diabetes, blood pressure, obesity, high groups including Parkinson's, Stroke, smoking, embedded in Primary Care. Public Health have a lead role in the Dementia Partnership & Programme Boards	A time table for annual review of relevant strategies via programme board by Dec 2019 Dec 2019 Public Health Data/ Monitoring in place by Dec 2019 Sept 2019
2.2	**Priority 2** **Use of insights and intelligence** to understand the current picture across the Strategy areas and to target insights to understand and change behaviours.	Public Health and CCG's	Locality/Neighbourhood teams have access to and are acting upon data on dementia prevalence and expected prevalence and performance (Dementia Dashboard).	JSNA provides up to date intelligence at a local and STP wide scale, including data for forward planning. Dementia, and risk factors, are included in Locality /Neighbourhood team profiles For local action	Current timeframes may require review to align future JSNA at county & STP level Sept 2019

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Preventing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
2.3	**Priority 3** **Reduce inequalities:** Addressing inequalities around accessing a dementia diagnosis and services is a key strand of our pathway work and fundamental to early diagnosis and support A joint Equality Impact Assessment and Quality Impact Assessment will be undertaken by CCG's and Council partners to support strategy implementation. Work with partners to continue to ensure clearly signposted, robust culturally competent and locally informed services and post-diagnostic support pathways	CCG's, Public Health, Herefordshire Council, Worcestershire County Council & Dementia Partnership Dementia Programme Board NHS England (Prison Health)	Identify the key inequalities in dementia diagnosis. Targeted initiatives to promote prevention and increase early diagnosis, and tailored support for people living with dementia, identified through intelligence. This may include; • People with Learning Disabilities • People from BAME communities • Rural and farming communities • Prisoners • Other seldom heard groups	Campaign/Programme of initiatives agreed i) targeted activity to address the inequalities ii) ii) reduction in inequalities (where feasible within time period	Programme outline n place for Dec 2019 Targets agreed from April 2020

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Diagnosing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
3.1	**Priority 1** *Find, treat and support*: further reduce the diagnosis gap and inequalities in diagnosis by Delivering a timely diagnosis in line with national ambition and patient wishes Promoting memory pathway and use of supportive diagnostic tools Ensuring care home residents with dementia are included on dementia registers and by working with professionals looking after patients with vascular related conditions to identify memory problems earlier Proactively targeting hard to reach or seldom heard groups Maintain a high standard of data recording and completeness across dementia diagnosis and care pathways	Dementia Programme Partnership Primary Care, CCG's, MH Trusts, Admiral Nurses & CCG Quality Care Home Team, Health and social care partners	An established proactive case-finding culture across services and a referral pathway between MAS and Long-term condition services (diabetes, heart failure, Parkinson's disease, MCI, stroke service, Learning Disability and expert patient programmes) is in place to support seamless transition into the dementia pathway. DeAR GP tool is used to support care home staff and enhance communication between care homes and GP practices. DiADeM Tool is widely used to support diagnosis in the community.	Dementia Diagnosis rates in Herefordshire and Worcestershire are in line with national ambition (NHSE) including for people with LD. There is evidence of robust data recording and reporting processes across partner organisations and a rolling programme of data harmonisation and peer reviews in place across all pathways. DDR work programme continues each county in line with Deep Dive self -assessment 2018 Monthly meetings with NHSE Plan and process agreed and implemented.	Sept 2019 Monthly DDR monitoring /reporting Ongoing End Sept 2019 End of Sept 2019
3.2	**Priority 2** Address local stigma and negative image of dementia which is creating fear and a sense of hopelessness within our aging population	Public Health, CCG & Dementia Partnership and Programme Boards, Herefordshire Council and Worcestershire County Council	Communities are empowered to champion the benefits of early diagnosis Neighbourhood/Locality support is available for people who are reluctant to be assessed and receive diagnosis	All partnership/programme board members are dementia friends Communication and engagement strategy established to achieve consistent language used to describe dementia and the promote the benefits of early diagnosis. Local Media are partners in dementia communication and engagement delivery. Patients and carers participate in promoting positive messages about living with dementia. Herefordshire and Worcestershire are working towards becoming dementia friendly counties with local supportive communities	Sept 2019 Dec 2019 Dec 2019 Ongoing Sept 2019

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Diagnosing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
3.3	**Priority 3** Review local Pathways to include Mild Cognitive Impairment Frailty and Ageing Well	CCG and providers, Memory Assessment Services Community Dementia Service Primary Care CCG/Specialist MH provider	A recognised and fully supported pathway in place to; • Identify, code and review patients with MCI. • People with MCI and their carers have access to drop ins at locality/neighbourhood level which provide information and support about self-care and when to seek further help. • The Rockwood clinical score is used to identify patients with frailty to support early intervention. • The diagnosis pathway includes access to appropriate IAPT services for people living with dementia and those with a non-dementia diagnosis (MCI) and their carers • IAPT workforce and services are trained and skilled to provide interventions which support people with dementia and MCI and their carers	Process and pathway agreed for implementation In place In place In place In place	May 2020 Sept 2019 Sept 2019 Sept 2019 Sept 2019
3.4	**Priority 4** Expansion of memory drop-ins across both counties, delivered collaboratively by dementia professionals and volunteers in partnership with people with dementia.	Dementia Partnership and Specialist community dementia team (CDN/DA) Alzheimer's Society/Age UK/ Admiral Nurses	Support is available, reaching into and tailored to rural and BME communities, offering support for those pre-diagnosis and the worried well.	Review of current provision in progress to determine future provision	Dec 2019

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.1	**Priority 1** **Workforce Development Education and Competency Development** A co-ordinated approach to ensure the principle of personalised dementia care is embedded and we achieve high levels of expertise throughout the dementia pathway Increased training and support for informal carers to support them in their carer's role and to facilitate improved health and wellbeing for carers Consider ways in which the Dementia Core Skills Education and Training Framework (including tiers 1, 2 and 3) can be utilised Dementia Training Standards Framework	STP One Herefordshire Education/Workforce Development Dementia Partnership Carers Support Advocacy Providers	Education and training review across all partners Improved and increased education, training and opportunities for skills development for all (including informal carers) who are involved in the care and support for people affected by dementia Training opportunities are available and aligned to the different stages of dementia progression. Care Home and Domiciliary Care staff at all levels have access to specialist level dementia education to enhance knowledge, skills and competencies enabling them to identify people with symptoms of dementia and deliver person centred care Dementia skills training is embedded within all contracts with Care Home and Domiciliary Care Providers Carers programme offering specific support for people caring for someone with dementia All partners deliver assessment, management and support for people living with dementia and their carers in accordance with NICE Guidelines (NG97) Increased awareness and utilisation of advocacy services amongst health professionals to signpost people with dementia and their carers.	Establish baseline Training programme in place Contracts Audit (annual) Number of referrals to advocacy from all areas in the dementia pathway	Dec 2019 2019 and on-going April 2020 Commence March 2020 Monitoring of referrals in place from April 2019
4.2	**Priority 2** Review and promote dementia information and support to ensure it includes the well pathway stages with appropriate signposting to local community support opportunities /groups. Develop Information and advice resources to be made available for people attending peer support groups (e.g. drops-ins; Meeting Centres) Ensure information and advice resources are accessible to and accessed by people with additional needs or challenges to reduce health inequalities	CCG, Memory Assessment and community dementia teams with Dementia Partnership	There is an established consistent approach to ensure everybody affected by dementia has timely access to information advice and support People living with dementia and their carers have access to a range of trusted information – (including digital and non-electronic options). A single point of access (SPA) and road map signposts people to local dementia information, care and support MAS and Hospital and provider services use standardised information packs for people who are newly diagnosed and carers packs for their family/friends Standardised welcome/Information packs are also issued at community support including cafes, drop ins and meeting centres Visible local media campaigns are part of an on-going programme of communication and engagement	All partners are signed up to local communication strategy to achieve consistent approach	2019 commencement and aim to achieve within 12 months

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.3	**Priority 3** **Putting Technology Enabled Living at the heart of dementia care** Commission Ensure Technology Enabled Living services (TELS) to provide appropriate responses and support for dementia –and train staff and voluntary groups in the potential for technology to support people with dementia and their carers. Commission TELS to make best use of Assistive Technology Opportunities within Dementia and by doing so move from Reactive to Proactive support models, including: • Prompts/reminders – supporting activities of daily living • Passive monitoring of activity and trends • Social Isolation – encouraging connectivity • Prompts/reminders – reminiscence robotics	Herefordshire Council & CCG Commissioning Herefordshire Council Adults & Communities WVT Operational Delivery STP	Progressing to a proactive, personalised and predictive approach to technology enabled integrated health & care services Condition-specific management providing services tailored to the unique needs of each patient, improving safety and user experience Monitoring and responsive moving from reactive provision to personalised, proactive and predictive care. Social engagement keeping users engaged in their community, fostering social inclusion and its associated benefits. Selfcare & wellness supporting users to take an active role in their wellbeing with positive lifestyle choices. Care planning & administration reducing waste, automating common tasks and co-ordinating to maximise efficient use of resources. Activities of Daily Living reassuring friends and family and supporting greater independence for longer.	This will be measured through a robust outcome-based quality monitoring programme.	Commission from 2020 and on-going
4.4	Improve knowledge of and access to risk reduction lifestyle activities for people with a diagnosis of dementia through signposting and referral pathways as appropriate (e.g. leisure and informal physical activity, healthy lifestyle service, community brokers) from health care professionals, including primary care and MAS.	Public Health/Memory Service/ Community Dementia /Primary care	Increased uptake of healthy lifestyle activities by people with dementia (especially vascular dementia) and people diagnosed with MCI Information sharing on community activities and other services implemented as part of drop-ins and post diagnosis support groups (link with Talk Communities)		Commence 2019 and review annually
4.5	Improve provision of care and support at home and residential care for people living with advanced or complex dementia workforce access Dementia Care Training Standards Framework	CCG's, Herefordshire Council and Worcestershire County Council	People living with advanced or complex dementia have access to a range of local care options including access to personal health budgets in line with CHC criteria.	Maintain current assessment framework and processes Personalisation and meaningful day initiatives	Ongoing Review in accordance with national guidance Annual Quality Assurance visits

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.6	Continue to create responsive community services which promote reablement and effectively manage crises for people affected with dementia either at home or in a care home Review and implement Enhanced Health in Care Homes Vanguard Learning Guide	Locality Teams In-reach team; CCG quality nursing team; Dementia Wellbeing Service (AGE UK HW) Admiral palliative care team	Neighbourhood and Locality teams have access to • Hospital avoidance service (out-reach support) • Specialist advice and support when managing a crisis • Responsive home care services to help dementia patients maintain independence and reduce social isolation A network of support for care homes facilitates advanced dementia care planning including implementing palliative care and End of Life care pathways. Non-clinical community support is key to enabling people to remain at home within their communities. Wide promotion of the Community Dementia Service and Dementia Wellbeing Service (including easy access through the Wellbeing Hubs).	Evidence of increased access/utilisation of these services via wellbeing hubs	Agree process for monitoring by end of Dec 2019 with view to annual review
4.7	Continue to focus on improving the in-patient experience and hospital discharge pathways	Acute & community trusts, CCG's, locality teams, Herefordshire Council, Worcestershire County Council	Hospital wards and departments are dementia friendly environments and are signed up to NDAA Dementia Friendly Hospital Charter Dementia Champions are identified and work collaboratively to increase dementia awareness Patient experience questionnaires confirm patient choice and control is respected Patients with deteriorating dementia are identified earlier for additional support during the discharge process Carers are supported and encouraged to participate in care and discharge planning.	Discharge pathways reviewed and changed where appropriate Dementia is reflected in discharge plans including care home capacity	Sept 2020
4.8	Continue to develop integrated dementia palliative and end of life care delivered at locality and neighbourhood team level so that planning for last days of life is a seen as a crucial element of good dementia care. Alignment with Ageing Well/ Frailty/ Palliative and EoL programme of education about a range of topics on recognising and supporting people in the advanced stages of dementia (GP master class/sessions)	CCG/ all dementia providers and partners community dementia services	A skilled multi-professional neighbourhood/locality team supported by dementia end of life specialist and care home liaison teams working together to identify, register and support people in the community and in care-homes who need palliative and EoL care. Local professionals feel confident in having conversations about: • death and dying; • completing advanced care plans and ReSPECT forms. discussions & conversations about death and dying; • encouraging people to complete living Wills and lasting powers of attorney so that personal end of life wishes is recorded and respected Carers and families receive emotional support when the person they are caring for is in the last days of life. Monitoring and review of care home residents with dementia includes palliative and advance care planning and this is accurately recorded on EMIS.	No of people on locality teams EoL registers Locality Team (MDT) meetings Evidence of representation where applicable	Agree process for monitoring by end of Dec 2019 with view to annual review

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Living Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
5.1	**Priority 1 CARERS -** Develop joint working with Carers across the two counties, to ensure they are recognised as partners in care and fully involved in and supported for all elements of the process	CCGs & Dementia Partnership All Providers	Carers are included in decisions made about the person with dementia who they care for. Carer feels listened to and information about the cared for person is appropriately shared Carers are valued and supported in their role and their own needs are recognised. Carers have access to information, advice and support to assist them in their caring role, enabling them to look after their own health and wellbeing, including support with form filling and education sessions for carers.	This will be measured through a robust outcome-based quality monitoring programme including; • a survey of family carers, to assess the extent to which they feel recognised as partners in care, involved valued and supported and have access to information and advice flexible and aligned to their needs.	from 2020 and on-going
5.2	**Priority 2** Continue to build and extend dementia friendly communities through the contribution of community and partnership working http://www.dementiafriends.org.uk Dementia friendly communities Housing charter http://www.dementiaaction.org.uk	LA Education Dementia Partnership CCGs & Dementia Partnership All Providers Dementia Action Alliance Locality /neighbourhood teams (GP clinical leads; clinical/care leads across partner organisations)	An established protocol to support organisations to become dementia friendly There is greater awareness and involvement by the community in local drop-ins A Dementia Friendly Housing Charter and guidance toolkit in place with all housing partners signed up Dementia friendly local environments (e.g. Hairdressers) to support people to remain connected to their local community Schools/Colleges are participating in dementia friends training and intergenerational activities promote dementia awareness and understanding A network of dementia friendly community pharmacists, podiatrist, dentists, opticians supporting people with dementia linking in with drop-ins to help with sign-posting and earlier identification for diagnosis and support. Primary Care Networks promote dementia friendly opportunities. Locality and neighbourhood teams have received dementia friends training and have access to tools and approaches to be pro-active in providing care and support to people affected by dementia. GP's with special interests in each locality routinely share best practice Increased use of contingency & ACP planning in care plans ReSPECT Tool implemented to guide ACP process across professionals and teams Shared care pathway Increased update and use of assistive technology (DOLS)	This will be measured through a robust outcome-based quality monitoring programme including; • a survey of groups including people with dementia, family carers, service providers, religious organisations to assess the extent to which the counties are dementia friendly and the action needed. • A review of the establishment of local alliances to implement dementia friendly communities involving people with dementia and family carers. The Dementia Action Alliances provide a co-ordinated approach in delivery of priorities An increase in the number of organisations, businesses, Council departments and community groups signed up to the local Dementia Action Alliance working together to achieve dementia friendly status.	from 2020 and on-going

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Living Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
5.3	**Priority 3** Work collaboratively to achieve a co-ordinated patient-centred pathway across partners	CCG's, Herefordshire Council, Worcestershire County Council and Dementia Partnership All Providers	Patients and carers are partners in care planning Partners collaborate to achieve a seamless pathway which promotes and respects patient and carer choice and control The Red Bag Initiative is adopted	A clear pathway and process exists enabling adaptations in the home and access to assistive technology to support independent living	from 2020 and on-going
5.4	**Priority 4** Ensure commissioned carer support services are evidence based and service monitoring captures delivered activity including; provision and uptake of community respite care, respite beds and a range of options.	CCG's, Herefordshire Council, Worcestershire County Council	Respite care is available when needed to support carers in their carer role A range of responsive and flexible respite options available in localities and neighbourhoods.	Maintain current assessment framework and processes Evidence of personalised and responsive respite initiatives	Ongoing Review in accordance with national guidance Annual Quality Assurance visits

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9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Dying Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
6.1	**Priority 1** Continue to develop integrated dementia palliative and end of life so that planning for last days of life is a seen as a crucial element of good dementia care. Alignment with Frailty/ Palliative and EoL programme of education about a range of topics on recognising and supporting people in the advanced stages of dementia Strengthen links with carers support, frailty and End of Life work streams (including the introduction of ReSPECT and EoL integrated pathway development).	CCG/ all dementia providers and partners community dementia services	A skilled multi-professional neighbourhood/locality team supported by dementia end of life specialist and care home liaison teams working together to identify, register and support people in the community and in care-homes who need palliative and EoL care. Staff supported with Advanced Communication Skills as a key competence. My future wishes advance care planning for people with dementia Professionals feel confident in having conversations about: • Death and dying • **Advance care planning** and completing the ReSPECT tool • encouraging people to complete living wills and lasting powers of attorney so that personal end of life wishes are recorded and respected. Carers/Families have access to GP services during OOH for support with crisis management (behavioural, psychological symptoms of dementia) Monitoring and review of care home residents with dementia includes palliative and advance care planning and this is accurately recorded on EMIS. Carers and families receive emotional support when the person they are caring for is in the last days of life and have access to bereavement support. The provision of responsive services is comparable with those for people with terminal physical health conditions with hospice standard care.	Evidence of representation where applicable Increased numbers of patients receive ACP	2019 Commencement and work in tandem with Palliative Care and End of Life work programmes
6.2	**Priority 2** People with dementia are supported to die in their preferred place of death, taking account of their expressed wishes end of life care plan.	Herefordshire & Worcestershire palliative care team network/forum, CCG and GP leads	Established baseline for the proportion of people with dementia who die in their preferred place of death, or other end of life care planning discussions. An audit processes is in place to monitor; **a)** Number of people living with dementia with a recorded preference of place of death **b)** Number of people with dementia who are supported to die in their preferred place of death **c)** An audit has been undertaken to confirm; discussions to support planning of last days of life are undertaken and appropriately acted upon. *This could benefit from working with the wider Herefordshire & Worcestershire palliative care teams networks/forums*	Established Baseline and audit process Service Specifications are designed to facilitate an improvement in these figures.	2019 Commencement and work in tandem with Palliative Care and End of Life work programmes Ongoing into 2020

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10. Useful websites and Supporting Documents

Context

NHS England Well Pathway for Dementia: england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Further information about the different types of dementia: nhs.uk/conditions/dementia-guide/Pages/dementia-choices.aspx and alzheimers.org.uk/info/20007/types_of_dementia

Prime Ministers Challenge on Dementia: gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Living Well with Dementia: gov.uk/government/uploads/system/uploads/attachment_data/file/168221/dh_094052.pdf

Dementia 2015 – Aiming Higher to Transform Lives (report by the Alzheimer's Society): alzheimers.org.uk/info/20093/reports/253/dementia_2015

NHS Outcomes Framework & Adult Social Care Outcomes Framework Nice Guidelines

https://www.nice.org.uk/guidance/ng97 https://www.nice.org.uk/guidance/ng16https://www.nice.org.uk/guidance/ta217

https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions

Fix Dementia Care 2016: https://www.alzheimers.org.uk/our-campaigns/fix-dementia-care

NHS Digital Patients Registered at GP Practice (as of 1st November 2018): https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/november-2018

Application of prevalence rates from Dementia UK 2014 Update: https://www.alzheimers.org.uk/about-us/policy-and-influencing/dementia-uk-report

RCGP and Marie Curie Daffodil Standards UK General Practice Core Standards for Advanced Serious Illness and End of Life Care https://www.eolc.co.uk/uploads/20180423-Daffodil-briefing-v3.pdf

A guide to the support people should get from local services in England if they or someone they know have been diagnosed with dementia https://www.gov.uk/government/publications/after-a-diagnosis-of-dementia-what-to-expect-from-health-and-care-services

Hidden No More APPG Report Dementia and Disability https://www.alzheimers.org.uk/about-us/policy-and-influencing/2019-appg-report

Assistive Technology https://www.wmahsn.org/what-we-do/Digital_Health

10. Useful websites and Supporting Documents

Legislation

Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Equality Act 2010: https://www.gov.uk/guidance/equality-act-2010-guidance

Local Policy

Herefordshire Council Health and Wellbeing Strategy 2015-2019: https://www.herefordshire.gov.uk/download/downloads/id/3677/health_and_wellbeing_strategy.pdf

Worcestershire County Council Health and Wellbeing Strategy 2016-2021 http://worcestershire.moderngov.co.uk/documents/s8318/Health%20and%20Well-being%20Strategy.pdf

Herefordshire Carers Strategy: https://www.herefordshire.gov.uk/directory_record/3416/carers_strategy

Worcestershire Carers Strategy: http://worcestershire.moderngov.co.uk/documents/s5437/6b%20Carers%20Strategy%20Draft%20Final%20DRAFT%2030%204%202015.pdf

Herefordshire Housing Strategy:

https://www.herefordshire.gov.uk/download/downloads/id/8436/interim_housing_strategy_2016-2020.pdf

https://www.herefordshire.gov.uk/directory_record/4808/homelessness_review_and_prevention_strategy

Herefordshire Learning Disability Strategy: http://councillors.herefordshire.gov.uk/ieDecisionDetails.aspx?ID=5164

Herefordshire JSNA: https://factsandfigures.herefordshire.gov.uk/understanding-herefordshire

Worcestershire JSNA: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

Alzheimer's Society Local Dementia Profile Herefordshire: https://www.alzheimers.org.uk/sites/default/files/2019-07/ldp_herefordshire.pdf

Alzheimer's Society Local Dementia Profile Worcestershire: https://www.alzheimers.org.uk/sites/default/files/2019-07/ldp_worcestershire.pdf