Dementia Workstream Planning 2019-2024

Theme	Aims	Measures	Outputs	Actions	To do	Priority	Timeline	Lead
Preventing Well	**The City of Wolverhampton will be 'memory aware' and promote risk reduction through healthy lifestyles**	• Number of Dementia Friends and organisations signed up to the Demenita Action Alliance • Promoting public health and wellbeing to reduce the vascular risk factors for dementia in our City http://www.nhs.uk/conditions/dementia/dementia-provention • Increase the number of NHS Health Checks and utilisation of dementia screening tools	Promoting healthy lifestyles information with key messages about awareness, early intervention, prevention and risk factors for developing dementia	Targeted prevention messages in GP practices, both literature and screens	• **AGREE KEY MESSAGES**• • Map where and how we deliver messages • Develop a comms plan for information which may actually link in with any PH comms plan.			Public Health Comms and workstream leads
				Regular messages in carers newsletters	• Establish what is currently included in carers newsletters and how these can be improved? (will feed into above)			Lesley Johnson
				Targeted awareness by all agencies during Dementia Action week and business as usual	Who is co-ordinating this? Is it DAA or CWC?			All
				Ensure prevention messages and healthy lifestyles for people affected by dementia are included as part of public health events, literature and campaigns	public health communications as well as CWC/CCG/RWT			Ankush Mittal
				Ensuring existing campaigns feature dementia	who can we ask to check existing campaigns?			Comms
				Link dementia to healthy aging city initiatives and healthy lifestyles	public health communications?			Ankush Mittal
				Contact baseline of NHS health checks and measure the increase of the number of people taking them	• do we have the current data on how many? (PH?) • measuring - how often is data collected? • increase in numbers - do we have a target in mind for how much this will be and is there a national level for this to compare against?			Ankush Mittal
				Ensure Dementia Friends Sessions continue to be delivered in all areas of the community				Sue Eagle/LA
			Raising awareness to seek assessment early if there are memory concerns	Leaflets available in health services covering hospital, primary care and community settings (e.g. pharmacies)	• To produce leaflets unless these are already available. • What is the message we are sending and is this a national or local message? • Where and how they will be delivered • Funding for this?			PH/Comms
				Promote Memory Matters and Talking Points as ways to discuss early concerns	• Who and how can we do this? Care Navigators/Social Prescribing			Comms
				Continued service user, carer and provider engagement	• Who and how can we do this?			DAA
			Enable key staff such as community nurses, Dom care and care home staff are aware of prevention and risk reduction and where to signpost	Increase number of Dementia Friendly GP Practices	• how many do we have now? • what will be the target number? • How long to do this piece of work? 6/12/18/24 mths?			Primary Care
				Increase the number of NHS Health checks and the utilisation of dementia screening tools.	• Do we use dementia toolkit now and is it in place across the city? • public health to do this (Ankush?)			PH
				Promote dementia friendly training and sessions as part of inductions	•Each organisation will have its own recommended training regarding dementia awareness which is included in contracts and service specs but this is only relevant to staff's area of work. • more focussed training for front facing staff.			All
			Increase early diagnosis and access to targeted groups	All agencies to promote awareness and support information to BME communities, people with disabilities, deaf communities and those with co-morbidities.This includes people under 65.	• over arching comms plan making sure shared across agencies/stakeholders/communities			Comms & WS Leads

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Diagnosing Well	**People living with dementia in the City of Wolverhampton will receive a timely diagnosis with an offer of early support**	• Increase the rate of timely diagnosis • Reduce waiting times for a memory assessment • Offer early support at assessment, diagnosis and beyond	Continue to increase the rate of timely diagnosis	Work with NHS England to deliver targets in place	• What is the current target, where are we at now and how do we increase?			SF
				Memory Matters Service continues to raise awareness and strengthen referral to GP	• What/how do we strengthen referral to GP? • Do we already collect data on this to show improvement?			Lesley Johnson & Primary Care
			Reduced waiting times for a memory assessment	Strengthen and formalise the assessment process where people receive a diagnosis at RWT by ensuring the screening and cognitiion pathway is utilsed.	• What is the current pathway? • What are the blockages? • How do we improve the timeline?			David Bailey or Julie Willoughby
				Ensure GP's discuss diagnosis with patients when diagnosis is received and signpost to Dementia Navigator Community Service for post diagnostic support	• Is there a way to receive data regarding GP referrals to Dementia Navigator?			Primary Care
				Continue to strengthen diagnosis in acute settings	RWT			Julie Willoughby
				Offer dementia support at RWT through staff induction and utilising dementia outreach team	Who is co-ordinating this? Is it DAA or CWC?			?Julie W.
				Ensure BCPFT maintain assessment waiting times below the 12-week threshold	What is the current target? What plans are in place to improve? Timeline for this?			BCPFT/Sue Wells
				Explore a high quality memory assessment through the acheivement of MSNAP accreditation				BCPFT
				Explore the diagnostic role in community pathways such as pharmacies and community nurses and strengthen communication when a diagnosis is made to ensure post diagnostic support is available earlier on.	• What is currently in place? • Pathway = Public Health • How can we improve?			PH & Julie W.
				Improve diagnosis rates in care homes through early identification. Staff to receive appropriate training.	• Do we have any data yet from work commissioned by SF to Dr Jay around dementia in care homes? • Care homes/red bags have a similar form in place. Important to ensure the patient is involved in the process. Who would start this?			SF
				Care Navigators at GP surgeries refer to Dementia Navigtors Community Support Service and Carer Support Team	• To produce leaflets unless these are already available. • What is the message we are sending and is this a national or local message? • Where and how they will be delivered • Funding for this?			Primary Care

			People are offered early post diagnostic support at assessment, diagnosis and beyond	GP's are given messages on early support dementia friendly initiatives and continue to deliver on QOF targets	• Purpose to improve the experience of patient.			Primary Care
				Explore Dementia Navigators joining BCPFT at the end of assessment process to strengthen post diagnostic support	• Alzheimers provide Dementia Navigators and there are currently only 2 in place. • May need funding at some stage to increase numbers? • Could navigators be included in the co-location office? SE to speak to them.			BCPFT
				Community nurse teams know how to refer to Dementia Navigators	• Do they currently know how to do this? How can we ensure this is in place and does it require a measurement?			Community Nurses?
				Share information on support agencies, including benefits, carers support and Dementia Cafés on websites, leaflets, GP.	• will this be part of the Comms strategy.			Comms

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Living Well	**The City of Wolverhampton will be a Dementia Friendly City that supports people to continue to live**	• We will be accredited as a 'Dementia Friendly City' • Reduction in inappropriate prescribing of anti-psychotic medication • More people with dementia using self-directed support • More people with dementia and their carers connecting to support through their Navigator, who will use an asset-based approach to enable people to continue to live well • People have access to community support and information to prepare them for the future	More people with dementia and their carers connection to support through their Navigator, who will use an asset-based approach to enable people to continue to live well. Ensure high quality, appropriate post-diagnostic support is available to all including younger people, those with comorbidities and those from BME group	Ensure all agencies are referring directly to the Dementia Navigator Support Service delivered by the Alzheimer's Society	Do we have a list of all the agencies currently referring? Are there any gaps? How will we communicate this service?			Lee Allen
				Make links with BME groups, community and faith groups	DAA already and will continue to do this			SE
				Advertise all post diagnostic support available to the public and professionals	Who is co-ordinating this? Is it DAA or CWC?			SE
				Explore Dementia Navigators meeting patients at Assessments				SE
			More people with dementia engaged with agreeing advanced care plans and using self-directed support	Dementia Navigators will ensure a plan is in place that promotes independence and supports in planning for changes in the future	Dementia Navigators will take the lead on this and do 'This is Me'. Data on how many are done will be picked up through contract with CWC. Implementation/timeline for this to check success?			*TBC*
				An asset-based approach will be taken to support people in what they can continue to do , like to do and enjoy doing to enable people to live fulfilling lives. This includes healthy lifestyles, community activities, dementia cafes and benefit checks.	**MAP JAM SESSION IN MAY REGARDING SERVICES FOR MENTAL HEALTH DIRECTORY MAY ASSIST WITH THIS SECTION.**			*TBC*
				Information on where to go when things change will be readily available to avoid patients and carers entering crisis	• Do we have any data yet from work commissioned by SF to Dr Jay around dementia in care homes? • Care homes/red bags have a similar form in place. Important to ensure the patient is involved in the process. Who would start this?			*TBC*
				All agencies will encourage people affected by dementia to plan for the future with early conversations and refer where appropriate, to compassionate communities and dying well	• To produce leaflets unless these are already available. • What is the message we are sending and is this a national or local message? • Where and how they will be delivered • Funding for this?			*TBC*
			Continue the work of the Dementia Action Allicance and remain accredited as a Dementia Friendly Community	Deliver community events	**DAA to deliver**			DAA
				Increase members				
				Increase in number of dementia friends				
				Expand activity to schools and transport in particular				
				Ensure cultural, leisure and social opportunities are available and promoted				

			Carers and family support	Continue the assessment and support delivered by the Carer Support Team	Gather information on assessment & support delivered by CST Do we need to enhance this separtely or will it be captured in revised information/comms			Lesley Johnson
				Explore the development of the CRISP programme for carers	**SE to find out the cost of the CRISP programme cost.**			SE
				Ensure carers needs are assessed and support is in place to maintain their own wellbeing				
				Enable carers to access support and promote community support available to them.				
			Promote independence	Information on what is available is accessible in all community and statutory agencies				Dementia Care Navigators & Social Prescribing
				Navigators will make referrals to enable people to continue their independence by referring to assistive technology, welfare support and where to seek advice and guidance				
				Explore the possibility of commissioning Admiral nurses	Need to establish if their strategy has changed. If to be commissioned - funding and potential spec to be developed.			Andrea Smith/ Map Jam?

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Theme	Aims	Measures	Outputs	Actions	To do	Priority	Timeline	Lead
			People affected by dementia will have a named Navigator to connect them to the available support	All agencies to refer All services are equipped to signpost people to support, particularly for people who are receiving a late diagnosis	Can all agencies refer and do they know how to? Who is co-ordinating this? Is it DAA or CWC?			BCPFT & SE
			More people with dementia will have an Advanced Care Plan that includes end of life planning	Early conversations by all care co-ordinators to ensure the completion of an Advanced Care Plan - services are quipped to refer to teams that can complete plans Care plans should be personalised and specific on patient's wishes and deter hospitalisation which would cause further deterioration All patients will have a Care Plan and this will be based on 'This is me' - this should include information on mental capacity and lasting power of attorneys	Who currently completes the ACP? Is it within the EoL pathway? More detail conversations within work stream to look at this Are further comms or training required for staff completing these? Are further comms or training required for staff completing these?			how does this link in with ICA EoL? AS to speak to Karen Evans
			Integrated support for dementia is offered through health and social care teams and voluntary community organisations	Supporting Well strategy group continues to meet and ensures shared information to improve services by problem solving and sharing information. This may included shared protocols and training between services. Co-ordination of services to be improved and full offer of support to be mapped and implemented	Will Supporting Well work within monthly work streams to address this with whole group or set up separate meetings? Need to establish what protocols/training is in place already and what work will need to be developed/improved and timeline for this			**Supporting Well T&F group to look at this**
				Agencies make connections to existing services, such as the Frailty pathway and Telecare	Link in with Frailty work?			
				Explore Frailty Co-ordinators in GP clinics who will connect to health and social care services.	• Do we have any data yet from work commissioned by SF to Dr Jay around dementia in care homes? • Care homes/red bags have a similar form in place. Important to ensure the patient is involved in the process. Who would start this?			
				Report the impact of EPAC once rolled out - improve the expectations of GP's as care coordinators once EPAC is in place and Local Enhanced Service (LES) in place	• To produce leaflets unless these are already available. • What is the message we are sending and is this a national or local message? • Where and how they will be delivered • Funding for this?			
			Developing community teams to treat more peoeple in their own home leading to below (reduced admisisons)	Supporting Well strategy group continues to meet and ensures shared information to improve services by problem solving and ensuring actions are undertaken	continue review of Blakenhall and services? Is there a current timeline in place for this with proposed solutions to address any outcomes? **This has a separate T&F group looking at it which SF & Andrew W are involved in. Should be complete by December 2019.**			
				Explore GP groups who have an interest in dementia and service improvement	how will we approach this? Use Primary Care Team to make connections with GP's?			Primary Care

Supporting Well	**People living with dementia in the City of Wolverhampton will receive support that adapts to changing needs with access to good quality secondary care.**	• Integrated support for dementia is offered through health and social care teams and voluntary or community organisations • People affected by dementia will have a named Navigator to connect them to the available support	Reduction in admissions to acute care	Review respite and day support for people affected by dementia and develop a new model in line with modernised day services and incorporating new health community team input	There is a challenge around people with dementia increasing and what happens when their condition gets worse. Do we have enough acute care in communities to support this? We need to future proof the service. What do we have now? What will the new model look like? Timeline for review and development?			SF/SE or Andrew Wolverson.
				Map independent community services such as Age concern sitting service, carer support and extra care schemes	•Each organisation will have its own recommended training regarding dementia awareness which is included in contracts and service specs but this is only relevant to staff's area of work. • more focussed training for front facing staff.			Map Jam/ Dementia Navigators
			Improving the quality of care in the community to reduce unplanned admisisons, delayed discharges and placement breakdowns.	Rapid Intervention Team already treating people in care homes and at home. This offer to be formalised to support hospital avoidance	What do RITs currently do, is there data to support? Timeline for offer to be 'formalised' if not already in place? **Redesign of Community Model**			Rachael Berks
				Develop a bespoke community team that offers clinical support to care homes and to people in their home. Particularly to improve outcomes for patients where hospital admission often provides further challenges and confusion. Explore mental health teams home treatment team and crisis resolution model.	What will this look like? Will it require additional funding?			
				Explore a targeted training and support package to those homes with high admissions to hospital	Could this be linked in with QNA team? Would require data around homes with high admissions due to dementia and symptons. Who has this data? Could training be linked in with additional training offered to other services?			SF/SE
				Explore Dementia Outreach Team and expanded offer in hospital to home	liaise with Julie Willoughby. What is the expanded offer? Is this sufficient? **Redesign of Community Model**			
				Develop D2A and Reablement pathway to ensure staff and professionals are able to support people with their primary goals with a dementia diagnosis	Timeline for development? Will this be incorporated into the existing D2A work?			Tracey Chappell/Nicky Hack
				Formalising the way we work with Integrated Care Alliance to ensure outcomes are monitored and recorded	BCF may be the delivery model for ICA work - formalise how this will link in for reporting purposes. Determine outcomes and align. **Redesign of Community Model**			PH?
				Work with care home, domiciliary and care home staff to equip them in supporting people with dementia	Refers back to training - do we need to refresh training or possibly provide bespoke training? Cost implicaiton.			SF/SE
				Quality assurance teams to share best practice within care homes to raise improvements in dementia friendly environments and activities	Discuss how this would be shared?			SE
				Explore national models of community support and targeted support for people with advanced dementia				PH
				Explore Admiral nursing programme to deliver training to health professionals	Need to establish if their strategy has changed. If to be commissioned - funding and potential spec to be developed.			MAP JAM?
				Ensure all agencies have and refer to This is Me/About Me document - continued use in Red Bag.	How does this link in with ICA EoL? Check with Karen Evans			AS to speak to Karen Evans

			Excellence in Dementia Care I	The Trust will continue to develop and deliver the Excellence in Dementia Care programme through the development and delivery of RWT's Strategy and campaigns.				RWT/David Bailey

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Theme	Aims	Measures	Outputs	Actions	To Do	*****NOTE******	Priority	Timeline	Lead
Dying Well	People with dementia in the City of Wolverhampton can die with dignity and respect	• Develop a clear understanding of the end of life pathway and the support available for people affected by dementia, including families and carers • Reduction in unnecessary hospital admissions within the last year of life • Bereaved carer's views on the quality of end of life care received to improve outcomes	Develop a clear understanding of the end of life pathway and the support available for people affected by dementia, including families and carers	Share the pathway within the End of Life strategy - ensure criterion are as flexible as possible to provide a person-centred approach. Ensure information is given to people about mental capacity and lasting powers of attorneys.	Does the current EoL pathway need reviewing to ensure criterion are as flexible as possible? Make contact with EoL team to discuss? How is this given now? Do we need to revise the information and how it is shared?	**This needs to be discussed with ICA EoL group before any actions assigned.**			
				Ensure agreed documentation is in place for teams who can complete Advanced Care Plans, advanced directives and refusal for treatment and that they are aware of responsibilities.	Who currently completes the ACP and? Does the current ACP do what we want it to do?				
				Continue the work between quality teams and care homes to equip staff with difficult conversations and ensure correct documentation is in place	Who is co-ordinating this? Is it DAA or CWC?				
				Build on the work between Compton Care and CCG to ensure staff are confident to deliver this pathway and promote available training on end of life care conversations.					
			Reduction in unnecessary hospital admissions within the last year of life	Explore the expansion of low-level palitive care and support					
				Promote rapid discharge to home pathway as this is currently underutilised	this is currently utilised. How do we promote the service more?				
			Bereaved carer's views on the quality of end of life care received	Promote Bereavement Hubs that provide advice and opportunities to connect with people who are in the same position as you	• Do we have any data yet from work commissioned by SF to Dr Jay around dementia in care homes? • Care homes/red bags have a similar form in place. Important to ensure the patient is involved in the process. Who would start this?				
				Continue to deliver Dying Matters awareness weeks and promoting conversations	• To produce leaflets unless these are already available. • What is the message we are sending and is this a national or local message? • Where and how they will be delivered • Funding for this?				
				Ensure support plans and plans in place are used to respect patient's wishes					
				Ensure everyone has access to information to enable a good death					
			Test the pathway	Undertake a walkthrough of all dementia interfaces and services. This will enable further understanding to develop areas and share good practice.					