Item No 9

Adult Social Care and Health Overview and Scrutiny Committee

15th February 2012

Dementia Strategy Progress Report

Recommendations

(1) The Committee are asked to scrutinise and comment on the progress made to date.

1.0 Introduction and Context

1.1 The Living Well with Dementia Strategy 2011-2014, approved by Cabinet March 2011, is a joint strategy across health and social care. The overall aim of the strategy is to deliver high quality integrated services across the health and social care economy.

1.2 Dementia is a long term condition with a high impact on a person's health, personal circumstances and family life. Alzheimer's disease is the most common form of Dementia and is generally diagnosed in people over 70 years of age but it is also important to consider the needs of those who acquire early on set dementia. As well as having a profound and devastating impact on the individual, Dementia also impacts on the lives of family members and friends.

1.3 "Dementia results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills, and those skills needed to carry out daily activities. Along side this decline, individuals may develop behavioural and psychological symptoms such as depression psychosis, aggression and wandering, which complicate care." (National Dementia Strategy 2010).

1.4 Some key research findings are summarised below:

- 1.4.1 Providing people with a diagnosis decreases their level of anxiety and depression. (carpenter et al 2008) Only around 30% of people with dementia have a formal diagnosis made (National Audit Office 2007)
- 1.4.2 Early diagnosis and intervention have a positive effect on the quality of life of people with dementia (Mittelman et al 2007).
- 1.4.3 People often wait up to three years before reporting symptoms of dementia to their doctor (Alzheimer's Society 2002)
- 1.4.4 Early provision of support at home for people with dementia can reduce institutionalisation by 22% (Gaugler et al 2005). A brief

program of support and counselling diagnosis alone has been demonstrated to reduce care home placement by 28% (Mittelman et al 2007)

1.4.5 People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation, but this is not widely appreciated by clinicians, managers, or commissioners. (Royal College of Psychiatrists 2005)

2.0 Demographic and Policy Context

2.1 The JSNA suggests that in Warwickshire:

- The number of people aged 65 and over is expected to rise by 58% by 2030
- The number of people aged 85 and over is projected to rise by 134% between 2010 and 2030
- The number of people with Dementia based on national prevalence statistics is expected to increase from approximately 7,000 at present to 9,500 by 2021.
- The expected rise in the number of people under the age of 65 who will be diagnosed with Dementia will rise by 17% between 2010 and 2025.

2.2 The NHS Operating Framework for 2012/13 provides the management framework for health. For PCT's and the emerging Clinical Commissioning Groups it provides the focus for the coming year as the reforms across health are implemented. In the forward, David Nicolson, Chief Executive of the NHS, sets out four key priorities for the NHS; Getting the Basis Right Every Time, Maintaining a Grip on Performance, Meeting the Quality and Productivity Challenge and Building the New Delivery System. Incorporated into the Framework is a clear emphasis on services to people with dementia and their carers.

2.3 For Adult Social Care, the Quality Outcomes Framework for Dementia and the Vision for Adult Social Care continue to provide the performance framework for delivering excellent services and includes; Good Quality Early Intervention and Diagnosis, Living Well with Dementia, Better Care in a Care Home or Hospital Setting and reducing the use of Anti-psychotics.

3.0 Governance

3.1 The governance structure of Warwickshire's Living Well with Dementia Strategy is a result of a piece of focussed work with the Institute of Public Care (IPC) who critically reviewed Warwickshire's Dementia Strategy and provided solutions to the development of a robust joint governance structure to drive the delivery plan forward.

3.2 Significant time investment in establishing the governance structure has resulted in strong representation and membership from across the health

and social care economy including the lead GP for Dementia from the Clinical Commissioning Group. Attached as Appendix (A) is the governance structure which sets out the relationship and structures between the Health and Wellbeing Board and relevant health and social care bodies, including the voluntary and independent sector. Importantly the governance structure links to the Transformation Assembly, through its Dementia Ambassador, a carer, who sits on the dementia delivery board to ensure that service redesign has customers and carers at its heart.

3.3 Chaired by Councillor Compton, champion and lead councillor for dementia, the Board has recently invited and secured representation from Coventry to become a standing member of the Board. This accords with the Arden Cluster geographical responsibilities and provides opportunities for joint commissioning.

3.4 Two foundation project groups have been formed as well as one workstream. Each group has terms of reference and clear actions and products to deliver. Each project lead has overall responsibility for the delivery of the action plan and progress is reported to the Board on a 2 monthly basis.

4.0 Key Highlights

4.1.Attached as Appendix (B) is the Delivery Plan Progress Report outlining progress to date against key outcomes/targets. The following is a synopsis of some of the key highlights since the first Board meeting held in September 2011;

4.2 DH Funding – has ensured that progress is being made in developing a campaign to raise the profile of; the causal effects of dementia, the impact of being diagnosed with dementia and the support available. Seeking to build on the recent national dementia campaign, jointly, a media campaign is being developed which includes a countywide marketing strategy, the development of a dementia portal where people, including professionals, can go for information, advice and support.

Plans are also being scoped to introduce the TUG scheme across the health and social care workforce so that the concept of Every Contact Counts is used to assess people's vulnerability to falls and acted upon through the 'Exercise on Referral' scheme. Falls is one of the top reasons why someone with dementia can be admitted to hospital. If successful, there are plans to extend the TUG training to all commissioned home support services over the next 3 years. The action plan is attached as Appendix (c).

4.3. Support in the Community – the recently implemented home care framework has strengthened and widened access to services for people with dementia and their carers. Incorporated into the framework is the rapid response service and breaks for carers, which enables frontline teams t respond much more flexibility to the needs of families affected by dementia. Crucially, these new arrangements enable health and social

care staff to access timely support to avoid carer breakdown and reduce admissions to acute care.

A series of best value reviews have been completed on community support services. The outcome confirms that significant service redesign is required to reflect the demographic pressures and develop more equitable services across the County. Historical contracts are currently in place that need updating to reflect the profile of the current and projected future landscape of people living with Dementia in the County. In addition, customers and carers, through service reviews and focus groups have defined the priorities for effective dementia services. The outcomes of these will inform a series of workshops in March to redesign community support services. Part of the evidence base for service change will include the need to reduce spend on residential EMI care to invest in more community support to reduce/delay/stop a proportion of people from entering residential care. This also aligns to the need to reduce the numbers of people with dementia from entering acute care because of carer breakdown.

A key component of community support services will be the extended use of telecare and assistive technology which has real cost benefits in its application.

4.4.Care homes – the primary pressure on funding for older people mental health services is for Residential EMI care. Given the poor levels of diagnosis, coupled with recording that includes people with functional mental health issues, it is difficult to determine the proportion of spend in residential EMI care that is attributed to dementia care. However, we can conclude, given national evidence that this will increase as the population ages. This is the single most important area for service redesign which needs to have 2 primary objectives; firstly to reduce the number of people admitted to residential care and secondly to drive up quality of care using a person centred approach. Work is progressing in partnership with Professor Dawn Brooker of the Institute of Dementia Care at University Worcester to embed person centred practise within care homes using her theory of the VIPS model of care.

The table below illustrates the number of res EMI beds required over the next five and ten years respectively. This, coupled with emerging evidence that supporting people in the community reduces the need for res care beds and improves outcomes requires future investment in community support services. This combined with the push pull factors described in the strategy requires robust financial modelling to be applied to a)remain within budget and b) meet the increasing number of people projected to acquire dementia (As at 2010 projections suggest a dementia population of 7,200 growing to 9,000 in the next ten years illustrates the imperative to commission services effectively across the health and social care economy).

District	Client Group	Current demand for Social Care per district @ 2010	Projected demand (based on historical trends and projected population changes) for Social Care per district @ 2015	Projected demand (based on historical trends and projected population changes) for Social Care per district @ 2020
North Warwickshire	Residential EMI	58	83	108
Nuneaton and Bedworth	Residential EMI	121	174	225
Rugby	Residential EMI	63	91	117
Stratford	Residential EMI	75	108	139
Warwick	Residential EMI	77	111	143
TOTAL		**394**	**567**	**732**

4.5.MAS Pathway

Coventry & Warwickshire Partnership Trust have established a Task & Finish Group to review and improve the Memory Assessment Services pathway. Working in partnership with the clinical commissioning leads for dementia and adult social care commissioning, the group will focus on improvements to referral processes, throughput and post diagnosis support linking into the DH action plan as described in Appendix (C).

4.6Early on set dementia and the use of technology (Ipads) There is evidence to suggest that touch screen devices such as Ipads provide a useful tool in the care and support of people with dementia, in particular aiding restorative memory, supporting reminiscence and life story work, aid recall and person centred care planning, increasing interpersonal interactions, improve staff-resident relationships and improve quality of life. Our intention is to pilot the use of Ipad technology within a care home setting and with someone who lives at home to understand the benefits and outcomes of using this technology for this group. The hypothese tested will be that this will reduce challenging behaviours in people in a care homes setting and therefore reduce the levels of deterioration and expediency to acute care. For people living in their own homes to test the delay in needing ongoing long term care and support and delay in institutional care.

5.0 Key Risks and Issues

5.1**Risks**

Demographic Pressures – Over the next 10 years, and according to national projections, Warwickshire will see a growth of people with dementia by as much as 2,000 people.

Economic – the demographic pressures combined with an historical under investment in dementia services poses significant risks. This is coupled with the fact any available resources are focussed on residential care. To meet the economic and demographic pressures there needs to be a re-directing of

resources from secondary to primary and community care. This needs to be achieved by, well informed, joint commissioning.

National strategy / policy –increasing the amount of people diagnosed early with dementia whilst supporting people to live well with dementia are positive outcomes set both nationally and locally. However the challenge is that the programme of service re-design will require investment in services and specific investment in community support services to ensure that these outcomes are achievable.

Changes in Health provision – Coventry & Warwickshire Partnership Trust have developed a model of treatment and support in a home setting. Proposals are being developed to consult on replicating this model across the County. A recent Gateway Review highlighted the lack of consultation with people with dementia, their carers and with adult social care. Adult social care needs to ensure that the model does not result in a shift towards community based support without appropriate and relevant discussions and partnership arrangements secured.

5.2I**ssues**

Workforce – Quality of services remains a priority for both health and social care. The primary issue is to create a competent, confident workforce that delivers high quality services for this vulnerable group. Through CQUINN acute care is improving. For the care homes sector, focused work will begin in 2012 with University Worcester to introduce person centred care as the preferred model for Warwickshire care homes.

Quality of Care Provision – dignity and respect continues to be a challenge for all sectors of the health and social care economy in order to ensure that each individuals own needs are met. Individual initiatives, such as the Butterfly Scheme , help to raise the profile of quality but these are often isolation initiatives. To mitigate this plans are being scoped to introduce this scheme, using the Butterfly Kitemark, across the wider health and social care economy to increase and profile quality in care provision.

6.0 Conclusions and Next Steps

Steady progress has been made since the approval of the Dementia Strategy for Warwickshire. The time invested in partnerships has been well spent with good engagement across the health and social care economy, including the active participation of people with dementia and their carers.

There are pockets of excellent practice but these are not consistent across the County. The Dementia Board will drive forward and profile excellent practice and work to develop good practice across the County.

Quality of care remains a top priority for the Dementia Board across all services. Working with partners, including providers from the independent and voluntary sector, the workforce strategy will profile a training model that

embodies the principles of person centred care and will work to create a competent and cofident workforce.

The commissioning intentions for 2012/2013 include; establishing a model of good practice for community support services and re-commissioning these services to ensure equity of access, developing a robust workforce and training strategy for the health and social care economy and embedding the Care for VIPS as a model of person centred care within care homes in Warwickshire.

Background Papers

1. Living Well with Dementia Strategy 2011-2014
2. Dementia Strategy Delivery Plan 2011- 2014

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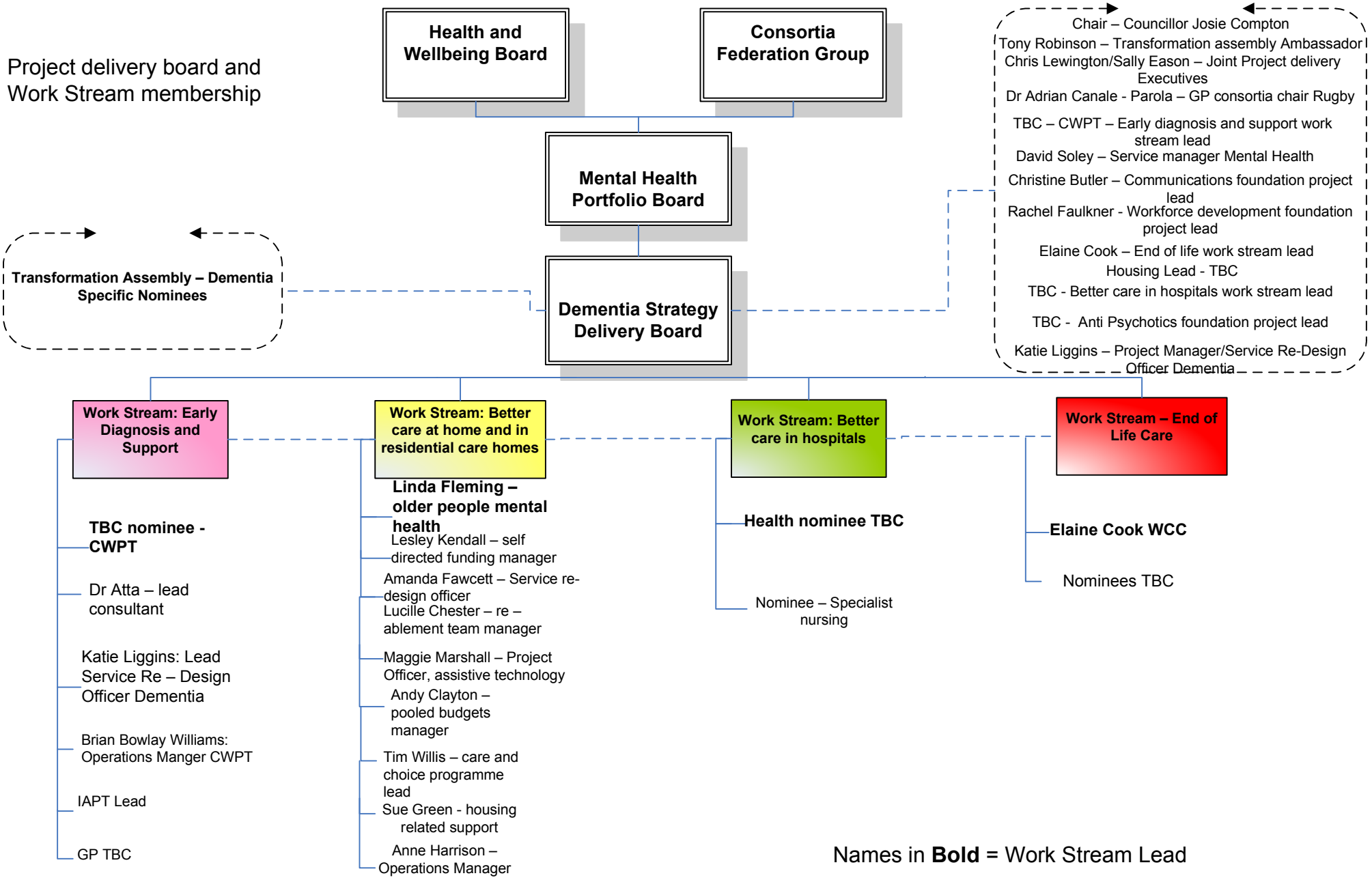
Project delivery board and Work Stream membership



Names in **Bold** = Work Stream Lead

Foundation project: Awareness and Understanding, Leads John Linnane / Christine butler

Foundation project: Workforce development, Lead Rachel Faulkner

Foundation Project: Use of Anti Psychotic medication, Lead TBC

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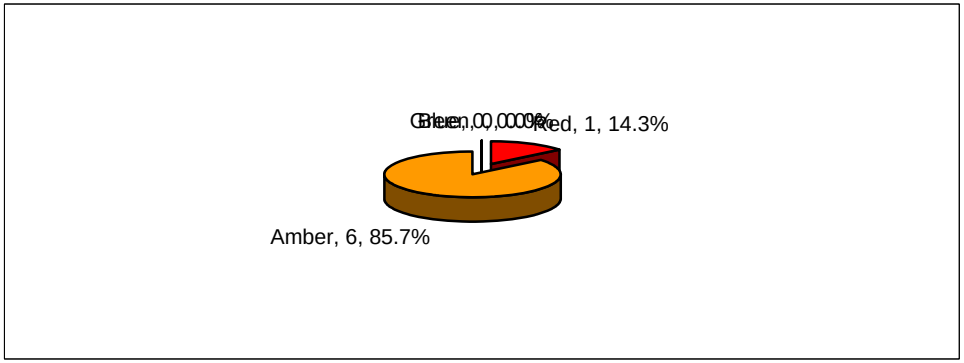
Living Well with Dementia Strategy Progress Report
March 2011 - February 2012

Objective Three (a): Better Care in a Residential Setting

Lead:



RAG Status Progress To Date (23rd February 2012)

Key Outcomes/Targets			
1	People with dementia can access good quality dementia care in residential and nursing homes across the County	Amber	
2	Care homes routinely use person centred care planning when working with and supporting people with dementia.	Amber	The Care Fit for VIPs - a toolkit for person centred planning for people with Dementia is a new tool developed by Professor Dawn Brooker. This tool will be introduced across residential and nursing care homes in Warwickshire over the summer 2012. A conference for providers is scheduled for April/May 2012 to demonstrate the tool and to encourage providers to sign up to it. It is our intention to introduce and use this model for all commissioned care homes for people with dementia. It will, over time, feature within our monitoring processes and will form part of an audit programme with our peer auditors (users from the transformation assembly who have been trained as peer auditors)
3	Care homes will be pro-active in their approach to challenging behaviour and avoid/reduce the use of anti-psychotics.	Amber	A pilot scheme to explore the mental health benefits of using technology is being introduced in 3 cohorts; people with challenging behaviour in a care home setting, people newly diagnosed and people with early on set dementia. Business case attached. Also see foundation 2

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4	People with dementia in an acute setting are seen as people first and clearly communicated with.	Amber	UHCW profiled the Dementia Suite with Alz Society. This concept is being scoped to explore the feasibilty of extending to care homes across the County. NHSW,last year, used the CQUIN scheme in this area to increase the dignitiy and respect of people with dementia in an acute setting. Further work is required in this area.
5	People with dementia will be returned to a familiar environment as soon as possible if admitted to hospital	Red	UHCW have appointed a liasion nurse to work across care homes and acute wards to reduce the number of people admitted from care homes and/or reduce the length of stay in an acute setting. this is available in coventry only and we will be exploring the feasibilty of extending this to Warwickshire. Evidence confirms that people with dementia remain in an acute setting longer than people who do not have dementia. And there is a higher proportion who are dischagred to residential care. An outline business case has been developed to exlore the feasibility of providing additional more focussed support to people post and pre a hospital admission to improve outcomes for people with dementia and reduce carer breakdown.
6	People with dementia will be supported to die at home if this is their choice and will receive dignified and appropriate end of life care.	Amber	NHSW lead the review of the End of Life Strategy. Adult social care have focused on and developed their end of life care approach within the remaining care

Key	
	Not started or Off Track
	In Progress
	Good Progress being Made
	Completed

Living Well with Dementia Strategy Progress Report
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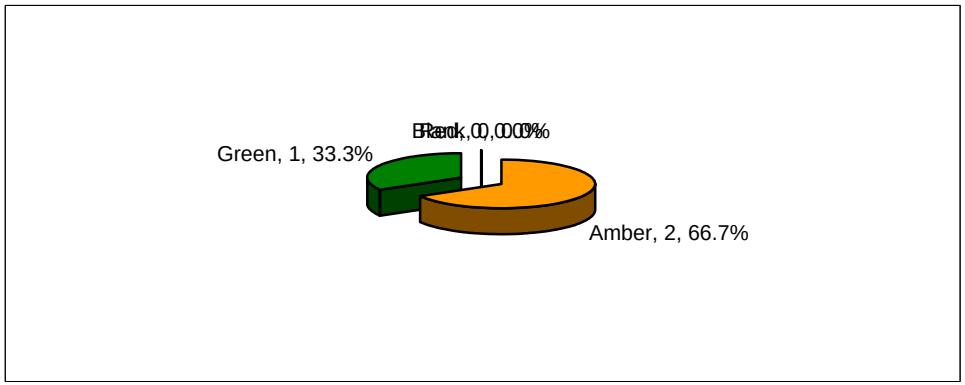
Foundation: Awareness & Understanding

Lead: John Linnane



Key Outcomes/Targets		RAG Status	Progress To Date (23rd February 2012)
1	People are more knowledgeable and informed about the potential causes of dementia linked to lifestyle choices.	Amber	DH have provided a one off sum of £97k to be spent on post diagnosis and support. The action plan supporting this must be a joint plan between health and social care. The action plan has been developed and incorporates an element of public health promotion on the causal effects of some dementias. The action plan also includes the development of the TUG initiaitve which is a simple method of assessing someone's risk of falling. Plans are to incorporate this into the Every Contact Counts initiative and train people in its application - this will then form part of a patients referral to the 'Exercise on Referral' to improve people's mobility and stability and reduce the risk of falling. The public health healthy living campaign will feature an element of dementia and the lifestyle factors associated with dementia.

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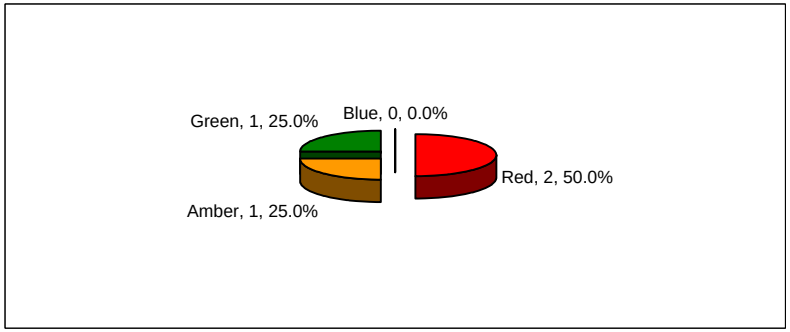
2	People are more informed about dementia and know where to go for support and information	Amber	We are currently scoping an awareness raising campaign about dementia that would be directed at various audiences such as customers, carers, the wider public as well as health and social care staff and partners. The campaign will aim to; Provide greater insight into the possible causal effects of dementia Provide insight into the impact of dementia on people and families once diagnosed Raise awareness of services / support available and where this can be accessed The approach and key messages are currently being scoped and we envisage that this campaign will begin Spring 2012 and will be complete by Autumn 2012. We are linking with partners in health and Coventry and Warwickshire partnership trust as part of this.
3	People are able to make their views and preferences known about their care and support needs and have access to advocacy services, including independent mental capacity advocate (IMCA) and living wills when required.	Green	People with dementia and their carers have been involved in the service reviews for dementia services. (Copy available on request). Focus groups have also been held in some of the Alz Cafes and plans are developing to include people with dementia and carers in the supporting people in the community workshops. Advocacy services are currently being reviewed with the intention to recommission these services over the next year - people with dementia and/or their carers will be involved in scoping and shaping these services. The County Council currently has a commissioned IMCA service that is available to FACs eligible customers.Part of the development of DH Action Plan and one off funding including Info and advice and the development of an information portal on dementia which will be hosted within WCC's web pages – this will be a one stop resource for Gp's, professionals working with people with dementia, customer and carers and will sign post onto other useful resources and provide localised information of support and services available.

	Key
	Not started or Off Track
	In Progress
	Good Progress being Made
	Completed

Living Well with Dementia Strategy Progress Report
March 2011 - February 2012

Foundation: Workforce Development

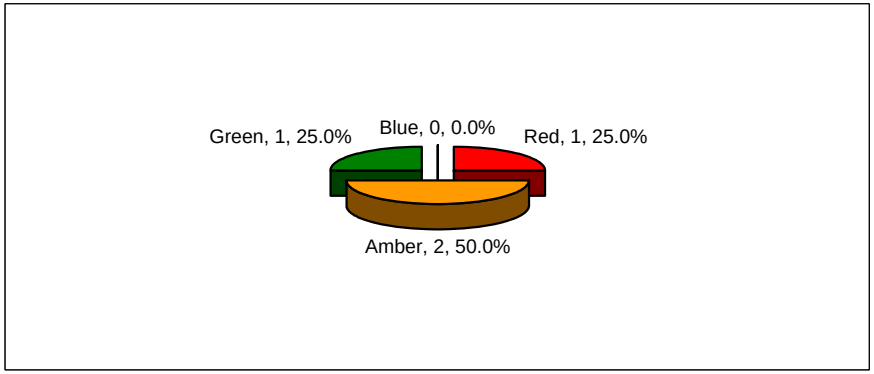
Lead: Rachel Faulkner



Key Outcomes/Targets		RAG Status	Progress To Date (23rd February 2012)
1	Staff across health, social care and providers are 'dementia aware'. They are offered dementia awareness training at the point of induction.	Green	Dementia essentials training – due to take place during February and March 2012. This will take the form of half day training sessions delivered to a wide range of front line staff from health, social care and PVI sector. The workshops aim to provide a broad level of understanding and awareness about dementia and how this effects individuals and the wider family. The course content has been designed in line with the common core principles for supporting people with dementia as published by Skills for care. The delivery of the training will incorporate the use of carer co – facilitator's who are carers of people with dementia who will offer their viewpoint and insight into their experiences by presenting at the session which will add a 'real' element to the training.
2	Staff within the health and social care workforce are skilled and confident to effectively support people with dementia.	Red	Care fit for VIPS - Care Fit for VIPS is carefully researched, practical and tool for care home mangers and is based on Professor Dawn Brooker's widely recognised VIPS framework of person-centred care. The toolkit is designed for use by care home managers for them to decide how well they are delivering care at the moment and to help identify priorities. they can also use it to find useful information and resources covering all aspects of person-centered dementia care and can use the tool to plan, test, and record ideas for improvements.
3	Review, improve and deliver the carer education and support programme (CESP) for carers of people with dementia.	Amber	The carer education and support programme has been running for many years with much success. The programme is currently being reviewed to incorporate changes in legisaltion, practice and support. Additionally, the countywide carer support services, Guidepost, have been commissioned to establish peer led training/support groups for carers with the express intention of delivering good training and information that leads to peer led support groups at a local level.
4	Secure Dementia Champions in each frontline teams.	Red	Not yet started.

Key	
	Not started or Off Track
	In Progress
	Good Progress being Made
	Completed

Foundation Project: Anti-Psychotics



RAG Status Progress To Date (23rd February 2012)

Key Outcomes/Targets			
1	Joint work with care homes, clinicial commissioning groups and GPs to reduce the use of anti psychotics	Amber	There is a small consultant led pilot project in the North of the County working in care homes to to reduce the use of anti psychotics. It is in the early stages.
2	Joint work with Acute Trusts and Care Homes to reduce number of admissions to acute care.	Amber	Refer to Better care Item 5.
3	Through evidence based research establish models of good practice using person centred approaches to manage people with challenging behaviours.	Red	Not started yet.
4	Explore the feasibility of using carers as health surveillance to learn early infection signs and to administer antibiotics to reduce admission to acute care.	Green	This pilot study, led by Dr Bart Sheehan, is in the early stages. A project team has been estabished with 2 carers as members of the team. 10 carers have been invited to attend an education session and taught how to; measure and record temperature, pulse, breathing rates and have given feedback about the training and it application within a home setting. Next steps includes research grant application and large scale bio-psycho-social research during 2012.

Key			
	Not started or Off Track		
	In Progress		
	Good Progress being Made		
	Completed		

Action Plan
Post Diagnosis Support

Aim: To devise a joint plan of how dept of health funding for post diagnosis support will be spent. £97k duration and start date to be confirmed.
Objective: PCTs and local authorities need to agree appropriate areas of investment in memory services and the outcomes expected from this investment. Example for this include; *provision of advice and support including information about local care and support services; follow up and review services including peer support, assessment of carers' needs and advice and support on planning for the future*

Suggested Action	Brief Description	Actions	Cost	Lead area
An information Portal for Dementia	A joint health and social care information portal where a range of information is stored and can be accessible by; • People with dementia (early – mid stages) • Carers and wider family • Professionals • General public In particular the portal will contain; • Local information and links to sources of national info • Advice • Signposting • Referral forms for practitioners • E – learning platform • Have a strong link to the pathway and display this as a visual for customers and carers	Full scoping exercise to determine needs, requirements and design of portal Joint workshops with key partners to scope out the 'dementia customer journey' Identify potential barriers at each stage of the journey, and the key points for info and support. Engagement with key partners e.g CWPT redesign of their pathways Carer and customer engagement on pathways – what is the typical customer journey – what should it be like, what information is required at each stage, how should this be delivered. Scope potential of hosting e – learning via portal Newly defined pathway for dementia is developed and agreed upon – which informs the development of the information portal.	**£10,000** Promotional costs Worker time to develop and input the information Design costs Planning costs – holding focus groups with cust and carers	Sign off via main dementia project board- Need to set up project team for this with designated development officer time.

Action Plan
Post Diagnosis Support

Suggested Action	Brief Description	Actions	Cost	Lead area
An awareness raising campaign about dementia and potential links to lifestyle risk factors	Dissemination of clear messages to partners linking the promotion of healthy lifestyle advice and the prevention / delay to the onset of dementia. awareness raising campaign will be delivered on three separate levels: ▪ Lower Level Awareness-Embed the prevention/delay of the onset/progression of dementia into regular healthy lifestyle messages throughout Public Health. It is recommended that internal guidance be produced informing partners within the health service and more widely, highlighting the importance of reinforcing messages around dementia. E.g. one of the benefits of stopping smoking, exercising more regularly and eating healthier foods is the delay/progression and possible prevention of the onset of dementia, this message would also be incorporated into Making Every Contact Count and brief intervention. ▪ Early Diagnosis Awareness – develop a campaign of support materials/brief advice for people who have had been diagnosed with dementia and may want to know more about what they can do to manage their condition. Information can also be provided at this point for family members and detail ways in which they can support their friend/family member. Links here will be made to Books on Prescription, Wellbeing Centres, IAPT and Making Every Contact Count. Early intervention – including providing good information, support	Identifying and agreeing levels at which awareness should be targeted Engaging with key stakeholders and audiences in planning approach to campaign and design of associated materials Research and produce guidance Marketing / dissemination Design and branding of materials to be consistent with that of the other materials produced as part of strategy development. Production of materials	**Approx cost: £2,000**	Public health Interface with Awareness and understanding foundation project and overall projects marketing strategy and comms plan.

Action Plan
Post Diagnosis Support

Suggested Action	Brief Description	Actions	Cost	Lead area
	and care – is designed to help a person with dementia deal with the challenges of their diagnosis and to aspire to a meaningful and positive life. There is a clear and prolonged window of opportunity for health and social care professionals, third sector and other support services to play an important role in making early intervention a reality. ▪ GP Dementia Signposting – guidance will be provided to GP's on where they can signpost patients who want to access services around dementia. Material can be developed that succinctly summarises services available to patients and important links made to Books on Prescription, Wellbeing Centres and IAPT. ▪ Awareness raising particularly designed for carers, information in a clear and digestible format e.g Q&A's etc			
Extension of Books on prescription (BOP) service	The current BOP service does not include texts on dementia. Early research is that most titles are novels/biographies rather than self - help and are aimed at the carer. Their would also need to be suitable text for those with early on-set dementia. How scheme works: • You are given a book prescription by your GP or mental health professional. • You then take this to your local library, where staff will help find the book or audio CD. • BOP collections are located in 17 libraries, and they can be obtained at any library in the county. • If you are not already a member of the library you can join immediately using the book prescription as identification and take the book/s home.	The extension of the BOP service to include dementia would require; • Research • Scopping • Identifying clinically approved literature • Purchasing texts • Updating promotional literature • Preparing reviews on certain texts • Increasing capacity of stands in libraries	**Approx £8,000**	Public health Interface with Awareness and understanding foundation project

Action Plan
Post Diagnosis Support

Suggested Action	Brief Description	Actions	Cost	Lead area
	• Books are issued for 3 weeks and can be renewed if no-one is waiting for them. • The recommended books are also available for anyone to read.	Also – work around developing the pathways to the texts e.g use of the 'prescription by key H & SC colleagues and raising awareness of this.		

Action Plan
Post Diagnosis Support

Suggested Action	Brief Description	Actions	Cost	Lead area
Incorporate dementia messages into Making Every Contact Count (MECC)	Public Health's proactive engagement with all stakeholders continues to be at the forefront of its core business commitment. Public Health's intent is to secure and widen the range and reach that positive public health messages can have across Warwickshire. In turn, supported by the right agreements, our active engagement with partners, and resulting shared commitments to common priorities will enable us to achieve much improved Public Health outcomes for the people of Warwickshire. By carrying out planned skills transfer work with our stakeholders we will enable more front line staff to opportunistically raise, challenging health and well-being issues with the public and with confidence. As part of MECC, we will aim to incorporate messages around dementia into a portfolio of tools that can be used by partner organisations to build capacity amongst their staff.	MEEC – in planning phase at the moment, it will shortly be piloted with some stakeholders – then aiming to rollout to re – ablement staff and then onto other key stakeholders. The work would also link to that of the portal e.g signposting people onto this facility	**£NIL** – this can be incorporated into the development of MECC	Public health
Integrating dementia into Exercise on Referral	Referrals are made by registered health professionals to local leisure centres. It offers individuals with specific health conditions a personalised 12 week programme of physical activity, with the support of a qualified exercise referral instructor, normally in a local leisure centre. Aim is for individuals to become, and continue to be active, in order to benefit their health. There is a cost to the patient, normally at reduced prices, determined by the leisure centre. Usually aimed at those at the early stages but also applies to those at later stages with support of their carer. The current course the instructors undertake is delivered by Warwickshire College, currently this does not cover dementia within the curriculum and	Research potential outcomes for people with dementia and carers of this service. Specification of new training programme for instructors incorporating dementia awareness Referral criteria adjusted to include dementia this is communicated with all key stakeholders and publicised Scope potential linkages with	**Approx: £20,000** .	Public health Interface with Awareness and understanding foundation project Coventry & Warwickshire Partnership Trust

Action Plan
Post Diagnosis Support

Suggested Action	Brief Description	Actions	Cost	Lead area
	therefore, this highlights an opportunity for us to work with the college in shaping the course curriculum in the future. An area Public Health could support the development of is an e-learning course on dementia specifically targeted at the instructors delivering the Exercise on Referral Scheme. Public Health's Reader in E Health & Wellbeing Interventions could work jointly with WCC's Learning and Development team to develop an e-learning course aimed initially at instructors, but also offered to wider frontline workers, such as care support staff and health workers. The benefits of this approach would include, amongst others; a greater understanding of the impact healthier lifestyle choices can have on dementia, an increase in referrals for patients with dementia to Exercise on Referral and an increase in the understanding and tolerance of dementia as a mental health issue. EOR would benefit people with dementia because increased exercise and a good level of physical health helps to protect against many conditions, including dementia. Regular physical exercise helps to keep the heart and vascular system healthy. This helps to reduce a person's risk of developing vascular dementia, which is caused by problems with the circulation of blood to and around the brain. Regular exercise will also delay the onset of dementia, so even if a patient has been given an early diagnosis, there is a lot that can still be done to sustain that person's quality of life. By engaging carers in this process, healthier lifestyle messages can be embedded and sustained into the future care of the person with a dementia diagnosis.	TUG, identify staff to be trained to complete TUG assessments Commission and plan training for these individuals Identify follow on pathway post TUG assessment and linkages to exercise on referral scheme. Commission training for instructor that is dementia specific – potentially e – learning. Also wider training for all front line workers who could complete a TUG and incorporate this into an e – learning package.		

Action Plan
Post Diagnosis Support

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	Suggestion – potential linkages to TUG assessment (time up and go) A TUG assessment is a quick assessment undertaken by anyone working with a person to determine the time it takes them to get up out of the chair and move – anything over 14 secs – the person is at risk from falls. An action for those that do not pass the TUG assessment could be strength and balance work delivered by the exercise on referral scheme Reduced falls contribute to reduced admissions to hospital, thus reducing costs and the psychological effects on the person with dementia of being admitted into hospital and lost confidence etc. TUG's currently completed by community mental health teams but this can be widened to other h&sc professionals – whoever goes into the person need to know about the assessment and what to do with this information following this.			
Carers education programme	Carers education and support is used as a source of post diagnosis support for the main carer that can help them to understand the diagnosis and prognosis of the person they care for which helps them to manage at home, supporting the person with dementia for as long as possible. The focus of this training needs to be that it is joint – H&SC e.g specific carers education programme that is themed and focuses on practical help such as understanding diagnosis/prognosis, managing challenging behaviour – can result in a referral for on – going peer support (stroke model of carers peer support) Vol sector would hold sessions with carers on other matters such as benefits etc	Scope need for training Devise preferred model Define training and support offer to carers post diagnosis – e.g peer led support groups, links to existing Guideposts contract, training – health and then social focus.	**£20,000**	Workforce development foundation project

Action Plan
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	Potential good outcomes as not being able to manage behaviours is one of biggest reasons for being admitted to hospital (see carer feedback)			
Awareness raising training for staff	A skilled and competent workforce is essential when facilitating and supporting the person with dementia and their carer to easily access services and to be well supported following a diagnosis. Generic awareness raising training needs to be developed for frontline staff who work across health and social care. This could be in the form of an e – learning course and could be available via the information portal. Linkages to Skill for Care Common core principles for supporting people with dementia.	Define scope of training Training to be joint across health and social care Decide on training method to be used e - learning etc Identify costs for developing / promoting training.	£12,500 – already costed as part of WFD spends for this year **An additional £12,500 to extend this further**	Workforce development foundation project – being picked up as part of 'dementia essentials' project.
Gp's educative exercise	Linking to the development of the web portal, conduct focused work with raising awareness of support and services available to people and importance of early diagnosis either by; Commissioning training sessions or e learning to be utilised during Gp's protected learning time. Or to employ a dedicated development worker post who will liaise with and link to GP's across Warwickshire.	Define preferred methods Identify types of e-learning or training to be commissioned Decide on methods of deployment of training materials or dedicated worker	**£20,000**	Workforce development foundation project Main dementia delivery board
Total			**£92,500**	