

Wednesday, 15 May 2013

Meeting of the Health and Wellbeing Board

Thursday, 23 May 2013

3.00 pm

Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

The Membership of the Health and Wellbeing Board will be available after the adjourned Annual Council meeting on Wednesday, 15 May 2013.

For information relating to this meeting or to request a copy in another format or language please contact:

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Email: governance.support@torbay.gov.uk

HEALTH AND WELLBEING BOARD AGENDA

1. **Election of Chairman/woman**
To elect a Chairman/woman for the 2013/2014 Municipal Year.
2. **Apologies**
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.
3. **Appointment of Vice-Chairman/woman**
To appoint a Vice-Chairman/woman for the 2013/2014 Municipal Year.
4. **Minutes** (Pages 1 - 3)
To confirm as a correct record the Minutes of the Shadow Health and Wellbeing Board held on 21 March 2013.
5. **Declarations of interest**
 - 5(a) **To receive declarations of non pecuniary interests in respect of items on this agenda**
For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.
 - 5(b) **To receive declarations of disclosable pecuniary interests in respect of items on this agenda**
For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)
6. **Urgent items**
To consider any other items that the Chairman/woman decides are urgent.
7. **Operation of the Torbay Health and Wellbeing Board** (Pages 4 - 6)
To note the report above.
8. **Update Report - Adult Social Services** (Pages 7 - 9)
To receive an update on the current position of Adult Social

Services.

9. **Update Report - Clinical Commissioning Group** (Pages 10 - 11)
To receive an update on the current position of the Clinical Commissioning Group.
10. **Update Report - Public Health** (Pages 12 - 15)
To receive an update on the current position of Public Health.
11. **Update Report - Healthwatch** (Pages 16 - 17)
To receive an update on the current position of Healthwatch.
12. **Update Report - Children's Services** (Pages 18 - 42)
To receive an update on the current position of Children's Services.
13. **Torbay Safeguarding Children Board** (Pages 43 - 47)
To consider a report that provides a brief overview of the role of the Torbay Safeguarding Children Board.
14. **Performance Framework** (Pages 48 - 55)
To consider a report that seeks to establish a performance framework for the Joint Health and Wellbeing Strategy.
15. **Integrated Health Initiative** (Pages 56 - 68)
To consider a report that outlines the commitment from Government to integrate health and social care by 2018.
16. **Development of Mapping and Consultation Work in Torbay Organisational Audit** (Pages 69 - 88)
To consider a report that provides an update on work that has been undertaken to develop a clear picture of the variety and nature of organisations in the Bay.
17. **Priority 15 Improve Care for People Living with Dementia and their Carers** (Pages 89 - 190)
To discuss how the Health and Wellbeing Board can broaden and lengthen the whole community approach to dementia.
18. **Information Pack**
To note the contents of the information pack which is published as a separate document to the main agenda reports pack.

Agenda Item 4



Minutes of the Shadow Health and Wellbeing Board

21 March 2013

-: Present :-

Members of the Partnership:

Councillor Lewis (Chairman)	Torbay Council
Councillor Christine Scouler	Torbay Council
Councillor Bobbie Davies	Torbay Council
Debbie Stark	Director of Public Health
Richard Williams	Director of Children's Services
Caroline Taylor	Director of Adult Services
Sam Barrell	South Devon and Torbay Shadow Clinical Commissioning Group
Kevin Dixon	Local Involvement Network

71. Apologies and Changes in Membership

An apology for absence was received from Councillor Morey.

72. Minutes

The Minutes of the meeting of the Shadow Health and Wellbeing Board held on 21 January 2013 were confirmed as a correct record and signed by the Chairman.

73. Future Working of the Health and Wellbeing Board

Members considered a report that set out proposals for how Torbay's Health and Wellbeing Board operates once it is established by the Council at its Annual meeting on 15 May 2013. The Shadow Health and Wellbeing Board had received support from the Local Government Association in preparing for the formal introduction of the Board on 1 April 2013. The Regulations governing the health and wellbeing boards had been released and confirmed that the boards will be appointed as local authority committees with the majority of rules that govern council committees also applying to health and wellbeing boards. As a result an Article (setting the scene) and Standing Orders (the rules governing the operation of the Board) had been drafted taking account of the Act and Regulations.

Agreed:

- i) that, subject to the inclusion of a description of how the Local Safeguarding Children's Board fits with the Health and Wellbeing Board, the draft Article and Standing Orders be forwarded to the Adjourned Annual Meeting of Torbay Council to form the basis of the appointment of the Torbay Health and Wellbeing Board;
- ii) that the framework of the Work Programme be agreed and that the Director of Public Health identify topics for inclusion in the early part of the Work Programme; and
- iii) that work continue on outstanding development issues identified in paragraph 3.19 of the submitted report and that updates be provided to future meetings of the Health and Wellbeing Board.

74. Joint Commissioning

Consideration of this item was deferred to a future meeting of the Health and Wellbeing Board.

75. South Devon & Torbay Clinical Commissioning Group Integrated Plan

Members considered a report of the South Devon and Torbay Clinical Commissioning Group's (CCG) Integrated Plan. The Plan sets out the priorities and outcomes the CCG will be working with partners to achieve in the next three years.

Agreed: that the South Devon and Torbay Clinical Commissioning Group Integrated Plan be endorsed.

76. Update Report - Clinical Commissioning Group

The Board was informed that the Clinical Commissioning Group (CCG) would be fully authorised on 1 April 2013 and would going 'live' without any conditions.

77. Update Report - Adult Services

The Board was informed that the commissioning of Adult Social Care by Torbay Council through Torbay and Southern Devon Health and Care NHS Trust ("the Trust") had been agreed for 2013/14 following approval of the Annual Strategic Agreement at Council on 28 February 2013. This was set within the context of the Trust being acquired by a Foundation Trust. The Council has a working party which relates to an overarching project board which will steer the project through to acquisition.

78. Update Report - Healthwatch

Members received an update from Kevin Dixon of Torbay Healthwatch who, advised that everything was going well with grant aid funding having been secured for a period of two years.

79. Update Report - Children Services

The Board was advised that Children's Services had received an unannounced inspection by Ofsted, with the findings being announced on 9 April 2013. Members were informed that Ofsted had specifically requested the Health and Wellbeing Board receive and take responsibility for overseeing the recommendations set out in the Inspection Report.

80. Update Report - Public Health

Debbie Stark, Director of Public Health explained that at Council on 28 February 2013 it was agreed responsibility for Public Health would be transferred to the local authority on 1 April 2013. Debbie further explained that the financial position for Public Health had been confirmed for two years enabling the base line to be covered and a reserve to be established.

81. Public Sector Equality Duty

The Board considered a report on the Public Sector Equality Duty (PSED). The PSED is enshrined within the Equality Act which gained Royal Assent in April 2010 and came into force on 5 April 2011. The PSED contains general and specific duties that apply to all public bodies carrying out public functions resulting in Torbay Council and the CCG having to comply. In light of this it is essential that the Health and Wellbeing Board looks at how the decisions it makes and the services that are provided affect people.

An Equality Impact Assessment has been undertaken of the Joint Health and Wellbeing Strategy and highlights a current lack of understanding and/or articulation of the impacts on all of those groups with protected characteristics and their experiences in relation to healthcare, access to healthcare and wellbeing generally.

Agreed: that, in accordance with the Equality Impact Assessment for the Joint Health and Wellbeing Strategy, a refresh of both the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy be undertaken by April 2014, to take account of the Public Sector Equality Duty.

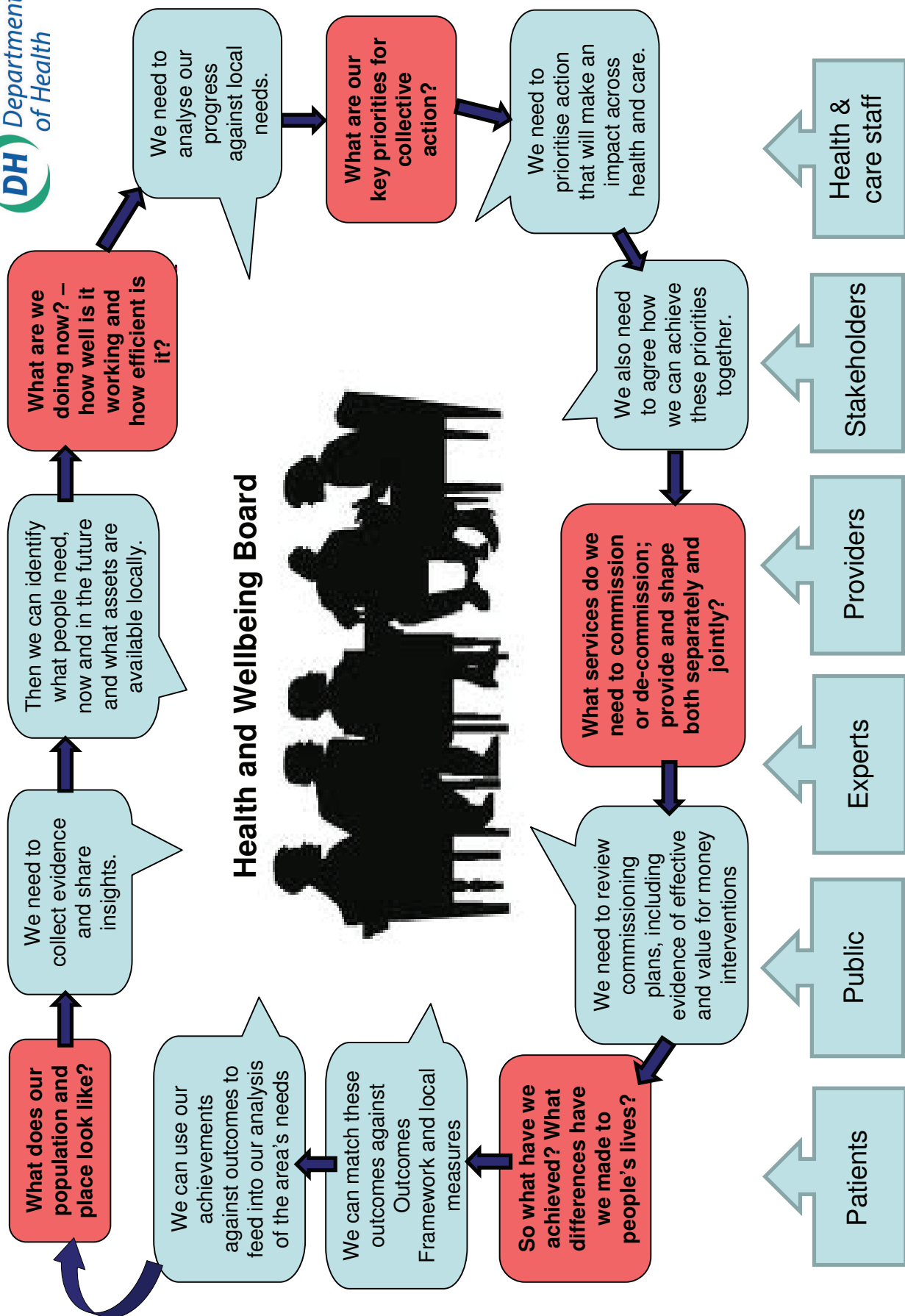
Chairman

Operation of the Torbay Health and Wellbeing Board

- Meetings of the Torbay Health and Wellbeing Board will be split into two parts
- The **first part of the meeting** will include a set of standard items together with other specific reports which members of the Board wish to discuss
- The standard items will be:
 - Updates from each “organisation” represented on the Board:
 - Children’s Services
 - Adults’ Services
 - Public Health
 - Clinical Commissioning Group
 - Healthwatch
 - Updates and performance information on each of the three outcomes within the Joint Health and Wellbeing Strategy
 - Children have the best start in life
 - A healthy life with a reduced gap in life expectancy
 - Improved mental health and wellbeing
- The purpose of these update report is to determine:
 - If any changes need to be made to future iterations of the Joint Strategic Needs Assessment
 - If any changes need to be made to future iterations of the Joint Health and Wellbeing Strategy
 - Which priority or priorities should be subject to further discussion at future meetings of the Board (possibly from performance not being as expected or particular barriers to delivery being identified)

- The **second part of the meeting** will be focused on a (previously identified) priority within the Joint Health and Wellbeing Strategy.
- With the agenda for the meeting, the Board will receive a background pack of information which will include:
 - Evidence base
 - National policy stance
 - Local policy stance
 - Resource base
- A member of the Board will be identified to lead the discussion on the priority and representatives from commissioner, provider or voluntary sector organisations will be invited to give details of the level of activity within Torbay.
- In good time prior to the meeting, Board members will be asked to think about how their “organisation” is contributing to the priority and, in particular, any feedback that they are receiving from their clients, patients or the general public about the issue.
- Board members will be able to bring someone from their organisation to contribute to the debate at the meeting
- The aim of the discussion will be to identify how the Board can “broaden and lengthen” the whole community approach to the priority. The Board will also be asked to confirm if the actions identified under the priority in the Strategy are the right ones and any issues which need to help inform the next iteration of the Joint Strategic Needs Assessment and, ultimately, the Joint Health and Wellbeing Strategy.
- An **information pack** will also be circulated with each agenda which will help ensure that links between these bodies are maintained and work is not duplicated. Updates will be provided from:
 - Adults Safeguarding Board
 - Children’s Safeguarding Board
 - Health Scrutiny Board
 - Stronger Communities Board
- Whilst not normally discussed, there will be an opportunity for Board members to raise questions or comments about the information contained within the pack.

JSNA & JHWS: explicit link from evidence to service planning



Involving partners and the community ensures transparency and accountability

Agenda Item 8

Title: Update Report - Adult Social Services

Wards Affected: All

To: Health and Wellbeing Board **On:** 23 May 2013

Contact: Caroline Taylor – Director of Adult Social Services
Telephone: 01803 207116
Email: caroline.taylor@torbay.gov.uk

1. Achievements since last meeting

- 1.1 The financial year end has indicated that the commissioning of adults services from Torbay and South Devon Health and Care NHS Trust has been concluded broadly in balance. This is a good achievement given the in-year pressures adult services have managed. Performance has been largely on track.
- 1.2 Dialogue with care homes as providers of services continues and the model of new banding and fees which was agreed by Torbay Council in February is in the process of being implemented
- 1.3 The Local Account (which summarises achievements and sets the policy context for adult services for the following year) and the summary of adults safeguarding (a multi agency approach) will go to the meeting of the Council in July 2013 for consideration.
- 1.4 The process of acquisition of Torbay and South Devon Health and Care NHS Trust continues with continued meetings of the members working group. It is expected that the final business case will go to formal evaluation in June with a Council decision in July followed by NHS processes for final decision and determination. The Council remains committed to the model of integration of health and social care.
- 1.5 Supporting People services continue to provide preventative services for voluntary people and a note of recent decisions is set out in the Annex to this report.

2. Challenges for the next three months

- 2.1 The need to focus on delivery whilst the acquisition process goes through its determination is key. There is a risk that the changes through acquisition can be a distraction to continued service changes and involvement of service users. This is mitigated through good local working relations across the

health and care system and an emphasis on the focus on 'Mrs Smith' with shared vision and values.

- 2.2 The support to mental health service users through AMPA has been under stress and there is an action plan in place to improve this aspect of our work with Devon Partnership NHS Trust and the Health and Care Trust.
 - 2.3 Opportunities have been pursued to develop a pilot through the pioneer programme outlined by Norman Lamb MP (see separate agenda item) and there has been work with the community and voluntary sector to bid to the Big Lottery Fund for support to develop new activities to combat social isolation. Challenges are to ensure we have capacity to deliver these new opportunities.
 - 2.4 A holistic review of accommodation based care and support is being developed which will include care homes, domiciliary care, supported living, extra care housing. This will take account of the long term view of market for providers (including mental health) as well as physical fragility.
- 3. Action required by partners**
- 3.1 Partners across health and care will be asked to support the development work as a pioneer within health and care system (as per Norman Lamb pilot).
 - 3.2 They will also be asked to engage in the review of accommodation based support taking account of Torbay's Local Plan.
 - 3.3 There is a need for continued engagement in supporting the voluntary and community sector in having a joined up role in health and care in a financially sustainable way.

Annex

Summary of Partnership Commissioning Board decisions

Background Papers:

The following documents/files were used to compile this report:

None

Summary of Partnership Commissioning Board decisions

Relationship to Community Plan

- Improving adult safeguarding
- Closing the gap
- Delivering principles of early intervention and prevention in supporting communities
- Jointly engage and involve communities to resolve local issues
- Continue to provide value for money for our communities

Date of decision	Decision	Impact on communities & relationship to community plan	Financial impact
26.04.13	To reduce value of the Leonard Stocks Centre Contract by 5%.	Continue to provide value for money for our communities.	£16,100
26.04.03	Endorsed the proposal to adapt a phased approach to implementation of a fully integrated care and support contract with caveats on timescales.	<p>Delivering principles of early intervention and prevention in supporting communities</p> <p>Jointly engage and involve communities to resolve local issues</p> <p>Continue to provide value for money for our communities</p>	None

Title: Update Report –Clinical Commissioning Group

Wards Affected: All wards

To: Torbay Health & Wellbeing Board **On:** 23 May 2013

Contact: Dr Sam Barrell
Telephone: (01803) 652500
Email: Laura.jenkins@nhs.net

1. Achievements since last meeting

- 1.1 We took over our full commissioning responsibilities on 1 April, becoming a statutory body responsible for commissioning the majority of healthcare for South Devon and Torbay.
- 1.2 We have finalised contracts with the providers of services for the year 2013/14, including South Devon Healthcare NHS Foundation Trust, Torbay and Southern Devon Health and Care NHS, Trust, Devon Partnership NHS Trust (mental health services), and Rowcroft Hospice.
- 1.3 We have embarked on the integrated care learning network developed by The King's Fund to explore how to further integration across our health and care system, so that people benefit from seamless services coordinated around their own needs.
- 1.4 We are playing an active role at Board level in the South West Peninsula Academic Health Science Network, which brings together the NHS, universities and industry to harness the excellent innovative work being done and make sure it is spread and adopted.
- 1.5 The CCG is working with Devon Partnership NHS Trust to review and redesign mental health pathways of care, with a first engagement event for people who use those services, their carers and families scheduled for 11 June.

2. Challenges for the next three months

- 2.1 We will, as a care community, be bidding for selection as a Pioneer site for integration (see separate agenda item), under the programme announced on 14 May by Norman Lamb MP, Care and Support Minister. This has great potential benefit for our local population, as Pioneer sites will get expert-level support in joining up the system and modelling potential change.

- 2.2 The extent of some financial commitments in the current year remain unclear, particularly concerning the level of claims for continuing healthcare funding.
 - 2.3 The CCG will be carrying out simultaneous engagement about future community services across its five localities, to inform locality commissioning plans. This will be a comprehensive exercise likely to take place over several months to ensure the full involvement of local communities.
 - 2.4 We will after the 31 May deadline be assessing the Integrated Business Plan for the acquisition by South Devon Healthcare NHS Foundation Trust of Torbay and Southern Devon Health and Care NHS Trust.
 - 2.5 The new 111 urgent care number is due to come into use in our CCG area in June. The introduction of this service has been difficult in some areas of the country, with some shortcomings in the standard of service offered to patients. However, we are confident that we have taken the opportunity to take on board the learning from this early experience. The service locally will be run by South Western Ambulance Service NHS Foundation Trust.
- 3. Action required by partners**
- 3.1 Torbay Council is asked to work with us on the Integrated Business Plan assessment.
 - 3.2 Torbay Council is asked to play a full role in the bid for selection as a Pioneer site for integrated care.

Appendices

None

Background Papers:

None



Title: Update Report –Public Health

Wards Affected: All wards

To: Health and Wellbeing Board **On:** 23 May, 2012

Contact: Debbie Stark

Telephone: (01803) 207350

Email: debbie.stark@torbay.gov.uk

1. Achievements since last meeting

- 1.1 Public Health commissioners have transferred to Torbay Council. Two new members of staff have been appointed to the posts of Public Health Consultant (medical) and Health Protection (nurse). Two existing staff however, have recently been offered posts in the NHS.
- 1.2 The Public Health Outcome Framework has been reviewed and priorities for Torbay identified on the basis of current performance and relevance to our population. Despite improvements over recent years, Torbay remains an outlier on outcomes for alcohol, teenage conceptions and the associated smoking in pregnancy and breastfeeding. Two vaccination outcomes have also been included as priorities, but these will be commissioned by NHS England now under the new arrangements for the NHS.
- 1.3 The work of building relationships between the new Community Hubs, the community and other agencies is progressing. A questionnaire in the Hele/Watcombe area has identified that the top issue the community would like support with is the achievement of healthy weight through diet and exercise. This coincides with the new requirement for GPs to ask questions on exercise as part of the QOF funding regime and a joined up approach is being identified. Barton Academy has asked the Community Hub to support them with children who are regularly not in school and the team have reported the early identification of new families with additional needs from their links with the Housing team.

2. Challenges for the next three months

- 2.1 Members will recall that the Community Hub work has started in the Watcombe/Hele area. The interim report on progress to date and suggestions for the roll out of the Hubs to other areas of Torbay will be available for the next Health and Wellbeing Board.

2.2 The outbreak of measles in Wales has provided an opportunity to remind local parents to check the immunisation status of their school age children. A catch up campaign has commenced through local GP practices.

3. Action required by partners

3.1 The alcohol strategy needs to be refreshed and this will be undertaken under the banner of the Health and Wellbeing Board. Stakeholder involvement could be the topic of a future H&WB Board forum meeting.

3.2 The Public Health team and the Clinical Commissioning Group are exploring opportunities to support businesses to encourage health and wellbeing in their workforce. The TDA and Communications teams are supporting this work.

3.3 A peninsula healthy weight network has been established and the views of stakeholders are being sought. Could partners please circulate and encourage feedback (Appendix 1).

Appendices

Appendix 1 – Briefing Paper - Obesity

Background Papers:

The following documents/files were used to compile this report:

None

Briefing Paper – Obesity

The Development of a Peninsula Wide Healthy Weight Strategy (Cornwall and Isles of Scilly, Devon, Plymouth and Torbay)

For the attention of: Health and Wellbeing Board, Local Authorities, Clinical Commissioning Groups (CCGs), Healthwatch, Public Health England, NHS Commissioning Board.

Key Points

- Obesity is an important cause of ill health and premature mortality.
- Obesity levels have increased significantly since the mid 1990s and obesity is predicted to affect more than half of adults and a quarter of children by 2050.
- The annual costs of obesity to society are an estimated £2 billion in Peninsula.
- There is a need for coordinated action and leadership at local community and strategic level.
- A Peninsula Healthy Weight Network has formed to bring together all organisations with a responsibility for promoting a healthy weight and commissioning support services.
- This Network plans to develop a Peninsula Wide Healthy Weight Strategy, with locally developed action plans linked to Health and Wellbeing Boards.

What is the issue?

Obesity, diet and lack of physical activity are, after smoking, the most important causes of ill health and premature death. Obesity substantially contributes to the risks of hypertension, diabetes and heart disease, respiratory problems, several cancers, Alzheimer's disease and renal failure. Morbid obesity is associated with 9 years loss of life – equivalent to life-long smoking. If trends continued at the current rates it is estimated that 60 per cent of men, 50 per cent of women and 25 per cent of under-20-year-olds could be obese by 2050¹.

There is particular concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. Obese children may also suffer psychological problems such as social isolation, low self-esteem, teasing and bullying. Obesity among children and young people is closely linked with socioeconomic status. Children from more deprived backgrounds have higher levels of obesity.

In 2015 the annual costs to the NHS of diseases related to overweight and obesity (BMI >25kg/m² or more) in the Peninsula is estimated to reach £495.5 million (half a £billion). When indirect costs (such as loss of earnings) are included, obesity costs society an estimated £2,016.7 million (£2 billion) in the Peninsula².

¹ Tackling Obesity: Futures Choices - Foresight Report (2007)

² National Heart Forum (2008), Healthy Weight, Healthy Lives: a toolkit for developing local strategies, Costing tool.

What have we done so far?

From 2006 *Healthy Weight, Healthy Lives : A cross governmental strategy for England*³ provided a framework for tackling excess weight nationally through five key themes and targets. However, *Healthy Lives, Healthy People: A call to action on obesity in England*⁴ (DoH, 2011) emphasises the limitations of top down approaches and the need for local leaders and communities to take their own decisions. The Public Health Outcomes Framework will measure progress on excess weight, physical activity and diet as well as premature mortality associated with obesity⁵.

In the Peninsula each locality has taken a different approach to 'promoting healthy weight' or 'tackling obesity', in very different contexts. However, not one local area in England has yet achieved a reversal in the upward trend in obesity. This will take long term strategic action. As public health teams move into local authorities this is an opportunity to raise the profile of obesity, showcase the best from each locality, and take a coordinated and cooperative approach. The most recent NICE guidance *Obesity: Working with local communities*⁶ recommends coordinated action and leadership at local community and strategic level.

What we plan to do

A *Peninsula Healthy Weight Network* has been established which aims to bring together all organisations with a responsibility for promoting a healthy weight and commissioning support services. These should include: Local Authority Public Health; CCGs; Public Health England and the NHS Commissioning Board.

This Network plans (in principle) to develop a Peninsula wide Healthy Weight Strategy to promote Healthy Weight through developing shared strategic objectives and intelligence. This Network will not replace local decision making since action plans will be agreed with stakeholders locally and link to local Health and Wellbeing Boards.

We will keep you informed of progress with regular updates if you request this.

What we would like you to do

1. Note the key points of this briefing and the importance of obesity as one of the leading causes of premature death in the population.
2. Recognise that we all have a role in ensuring our local environment, communities, workplaces/schools and family lives promote a healthy weight.
3. Raise the profile of healthy weight within your organisation and workforce; we suggest you designate a 'champion' to lead on behalf of your organisation.
4. Feedback your views to us following this briefing and let us know if you would like to receive updates rachel.wigglesworth@nhs.net

³ Department of Health (2006) *Healthy Weight, Healthy Lives : A cross governmental strategy for England*

⁴ Department of Health (2011) *Healthy Lives, Healthy People: A call to action on obesity in England*

⁵ Department of Health (2012) *A Public Health Outcomes Framework for England 2013-16*

⁶ National Institute for Health and Clinical Excellence (NICE) (2012), Public Health Guidance 42, *Obesity: Working with local communities*

Title: Update Report –Healthwatch

Wards Affected: All

To: Health and Wellbeing Board

On: 23 May 2013

Contact: Pat Harris

Telephone: (01803) 402751

Email: pat.harris@healthwatchtorbay.org.uk

www.healthwatchtorbay.org.uk

1. Achievements since last meeting

- 1.1 Thursday 9 May 2013 saw the official opening of the new offices for both Healthwatch Torbay and Torbay Carers Services. Based at Paignton Library and Information Centre, the opening plaque was officially unveiled by Councillor Christine Scouler, Executive lead for Adult Social Care and Older People at Torbay Council. Dignitaries and guests were joined by Torbay MP Adrian Sanders and other guests from Torbay Council, Torbay and Southern Devon Health and Care NHS Trust (TSDHCT), South Devon and Torbay Clinical Commissioning Group, Torbay Hospital League of Friends, and the Ambulance Trust.
- 1.2 Simon Culley has been appointed as the Healthwatch Torbay Communications Lead, and has facilitated us going live on Facebook and Twitter, in addition to developing our website, and a marketing strategy which will support our promotion to the general public.

The link to the website is: www.healthwatchtorbay.org.uk

He has met with both the CQC and CCG to discuss the working relationship and has introduced himself to various relevant communications leads, including at TSDHCT and Torbay Council. He is also working on new promotional leaflets to be distributed to relevant stakeholders across the bay.

We have already featured in the Herald Express and on BBC Radio Devon, and Simon is currently working with the Herald on a patient-led double page spread feature on how the recent changes will affect the public, and is also discussing the possibility of a regular Healthwatch Torbay column. Our Twitter account has successfully attracted 100 followers so far and has already seen relevant interaction with health and social care users.

- 1.3 In line with the 'Summary Report: Issues relating to local Healthwatch regulations' (Department of Health, 2012), which states that "Healthwatch will be a strong voice for children and young people, as well as adults, in both health and social care", Healthwatch Young People's Service was launched at South Devon College in March 2013, for second year Level 3 students.

The group started in late 2012 and has been working with the Healthwatch Youth Coordinator, looking at gaining young people's views in relation to health services in Torbay.

Torbay Youth Power (TYP), Healthwatch Torbay's young people's forum, have expanded in membership, trained as Young Inspectors, ran a further more in-depth school nurse consultation, and developed their own section of the website, posters and leaflets. Working with Level 3 health & social care students, they devised and delivered creative consultations to 150 students at the launch, which will be rolled out to youth projects to ensure wider representation. TYP are now working with Young Devon on their young people's mental health project. The Youth Coordinator has also developed twitter and Facebook accounts, networked with schools to develop a young people's ambassador network, developing relationships with Vol Youth Groups and making strategic links and impact via membership of the Local Authority Positive for Youth Board.

- 1.4 To ensure close working with the Council, and embedding our work in the priorities of the Health and Wellbeing Board, meetings have been set up to look at baseline assessments in terms of the Joint Strategic Needs Assessment (JSNA) in Torbay, with a focus on priority issues such as mental health, weight management, and other areas which fit with the Health and Wellbeing strategy.

2. Challenges for the next three months

- 2.1 Now that Healthwatch Torbay is officially up and running, we need to recruit more volunteers and are in the process of developing a revised induction programme which will ensure that we can promote our partners and the work that needs to be done in Torbay, in return for the time and commitment of quality people
- 2.2 The limited funds available to Healthwatch locally require us to continue to look for opportunities for income generation by undertaking paid project work.

3. Action required by partners

- 3.1 We do need our partners to continue to continue helping to publicise and support the development of Healthwatch Torbay in any dealings that they have with the public and the media, including schools - which has been a challenge.

Title: Update Report – Children’s Services

Wards Affected: All Wards

To: Health and Wellbeing Board **On:** 23 May 2013

Contact: Richard Williams
Telephone: (01803) 208401
Email: Richard.williams@torbay.gov.uk

1. Achievements since last meeting

- 1.1 Ofsted carried out an inspection of local authority arrangements for the protection of children from the 25th February to 6th March 2013. The Inspection was unannounced and considered the key aspects of a child’s journey through the child protection system, focussing on;
- The experiences of children and young people and effectiveness of the help and protection that they are offered
 - The effectiveness of multi-agency arrangements for identifying children who are suffering, or are likely to suffer harm from abuse or neglect
 - The provision of early help and the effectiveness of the Local Authority and their partners in protecting children if the risk remains or intensifies.
- 1.2 The Inspection team consisted of 6 Inspectors and they considered over 100 cases during the Inspection
- 1.3 The overall effectiveness of the arrangements to protect children was judged to be adequate and in the cases they looked at ‘no children and young people were inadequately protected or at risk of significant harm’. There are three key judgements made and the outcomes for each one indicated:

Quality of Practice	Adequate
Effectiveness of help/Support	Adequate
Governance and Leadership	Adequate

- 1.4 It may seem curious to celebrate an “adequate” judgement but two key factors influence this. Firstly, Ofsted have raised the bar on their inspection process whereby up to a third of authorities recently inspected have now become inadequate and only three out of over 50 have received a “good” judgement (with none going outstanding).

The second factor is a reflection on the journey that we have been on to turn the service around in a relatively short space of time.

2. Challenges for the next three months

- 2.1 Children's Services has had a short celebration as a result of the inspection judgement and a slightly longer opportunity to reflect on the past journey of improvement and the essential changes that now need to be made to secure the continuous improvement process.
- 2.2 It is anticipated that the Department for Education will now withdraw the requirement for a Children's Improvement Board and will look to Torbay to put in place formal arrangements to ensure the continuation of our improvement programme. They will put in place transition arrangements for a further six months before formally moving Torbay out of intervention. These arrangements have yet to be confirmed in writing with the Department for Education.
- 2.3 The responsibility for the continued improvements in child protection services from a partnership perspective sits with the HWBB. The Board, therefore, needs to formally note the attached inspection report and act on the areas for improvement. To achieve this it should set up a small Executive sub group of senior officers who will report back to the HWBB on progress. The group should also take on responsibility for the wider improvement process as contained within the Children's Partnership Improvement Programme.
- 2.4 The HWBB will also need to formally set up a relationship with the LSCB as detailed in the subsequent report on this agenda. The LSCB will provide the partnership scrutiny to improvements and formally report on progress to the HWBB

3. Action required by partners

- 3.1 That the Ofsted Inspection report be noted.
- 3.2 That a Partnership Executive be established as a sub-group of the Board:
- to ensure continued improvements in child protection services and to act on the areas for improvement identified within the Ofsted report;

and that the membership of the Executive be:

Director of Children's Services
Executive Head - Safeguarding and Wellbeing (Torbay Council)
Representative of Devon and Cornwall Police
Director of Nursing and Professional Practice – Torbay and South Devon Health and Care NHS Trust
Head of Quality Governance – Southern Devon and Torbay Clinical Commissioning Group
Headteacher representative – nominated by Torbay Association of Secondary Heads

- 3.3 That the protocol arrangements with the Local Safeguarding Children's Board, as recommended in the accompanying report, be agreed.
- 3.4 That the Chairman of the Health and Wellbeing Board together with the Chairman of the existing Children's Improvement Board formally respond to the Department for Education detailing these arrangements.

Background Papers:

The following documents/files were used to compile this report:

Ofsted Final Report

Inspection of local authority arrangements for the protection of children

Torbay Council

Inspection dates: 25 February – 6 March 2013
Lead inspector: Christopher Sands HMI

Age group: All

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Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Torbay Council is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Torbay Council, the local authority and its partners should take the following action.

Immediately:

- ensure that a robust oversight of the children with disabilities service action plan is in place with regular monitoring
- review all children on child protection plans for two years or more to ensure that adequate progress is being made and that no children are subject to plans unnecessarily
- ensure that language used within assessments, reports and plans is jargon free and appropriate to the child, young person and family
- ensure that casework supervision is used to track progress effectively on child protection plans
- ensure that strategy meetings, discussions and child protection section 47 enquiries are signed off by a senior manager to support practice improvements and consistency.

Within three months:

- ensure that actions and timescales are included within the Health and Wellbeing Board strategy document to enable the Board to become effective in monitoring and supporting the improvement progress

- ensure that improvements in the quality of practice are securely evidenced and embedded through the implementation and monitoring of quality practice standards
- ensure that the Public Law Outline has become fully embedded within practice and is being used to best effect
- ensure that changes in social worker following the removal of a child protection plan are undertaken at a time most appropriate to sustain improved outcomes and which is right for the family
- ensure that the advocacy service is used to best effect by enabling more children and young people to attend and for their voice to be heard at child protection conferences
- ensure that children in need plans are in place for all children receiving services and that the plans are clearly set out with measurable actions and outcomes
- ensure that child protection plans are clear with measurable actions and outcomes on which to support monitoring of progress
- ensure arrangements are in place to actively recruit permanent child protection conference chairs
- ensure sufficient capacity to meet statutory requirements for private fostering arrangements
- ensure greater clarity between the individual responsibilities of the Torbay Safeguarding Children Board and the Children's Improvement Board.

Within six months:

- ensure that services for perpetrators of domestic abuse who are not known to the youth offending or probation services have access to services to address their patterns of abuse
- implement a systematic approach to gaining the views of children, young people and their carers at different stages of intervention and to use this in monitoring, evaluating and planning service delivery
- ensure that the learning from audits and complaints is embedded within practice through a systematic mechanism of audit and quality assurance.

About this inspection

4. This inspection was unannounced.
5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.
6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.
7. The inspection team consisted of four Her Majesty's Inspectors (HMI) and two local authority secondees.
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Torbay Council has approximately 27,700 children and young people aged 19 and under¹. This is 21.1% of the total population. The proportion of state-funded pupils entitled to free school meals based on the January 2012 School Census is above the national average (Torbay 17.6%, national 16.9%). Children and young people from minority ethnic groups account for 6.3% of the total statutory school age population, compared with 25.4% in the country as a whole. The largest minority ethnic groups are Mixed (1.3%), Any Other White Background (0.8%) and Asian (0.6%). The proportion of, state funded, compulsory school age pupils whose first language is believed to be other than English is below the national figure (Torbay 3.2, national 15.2).
10. At the time of the inspection, 199 children were subject to a child protection plan. Children's social care teams were providing support to 1003 children and young people. Children's social care services which undertake child protection work include a safeguarding hub consisting of a

¹ Census 2011. Office for National Statistics

dedicated contact and referral centre and two initial response teams, five safeguarding and family support service teams, a children's integrated disabilities service, an intensive family support service, one family centre, which undertakes pre-birth assessments, and an out of hours emergency duty service. Prior to the inspection, the child protection aspect of work with children with disabilities was transferred to the safeguarding and family support service.

11. Early help and support is managed through family services. The help and support is provided through a wide range of services including three children's centres, two locality teams and the Family Intervention Project. At the time of inspection, family services was being restructured to create a new integrated service delivery model based around:

- A Better Start (0-5)
- A Good Childhood (5-11)
- Good Prospects (11+)

The new model creates a family solutions service (0-11) and an integrated youth service (11+). Access to these services is managed through the safeguarding hub, integrated working coordinators and a multi-agency allocation panel process.

Overall effectiveness

12. Overall effectiveness is **adequate**. The remodelling of the social work service at the point of receiving contacts and referrals has contributed to a significant improvement in timely and appropriate decision making. Redirection to the common assessment framework (CAF) process is leading to more children and families receiving effective help.
13. The Torbay Safeguarding Children Board (TSCB) has developed and successfully implemented the 'child's journey' which has enabled an increased understanding of thresholds and levels of need. Feedback from partner agencies confirms that this is having a positive impact and has also increased the partnership's confidence and engagement in children's social care services.
14. Children, young people and their families are being helped more effectively through appropriate decisions being made at the point of contact in children's services for a CAF resulting in an increased use of the CAF. Targeted support service interventions, more efficient assessment and care planning processes combined with allocation resource panels are all contributing to more effective support services which are delivering improved outcomes.
15. Sharing of information between partner agencies is becoming more effective and is well supported with schools and some other agencies having access to the basic information on the council's electronic information system. This enables agencies to see which services are already involved and whether a CAF has been completed.
16. From the point of the new leadership team being established and a revised improvement plan being put in place, a comprehensive audit of children's social care case files has been conducted. The principle reason for this was to ensure that children and young people were being appropriately protected. This audit has resulted in the identification of poor practice and decision making in the past (referred to within this report as the legacy) with remedial actions being taken. For example, re-assessments being undertaken leading to some children being placed on a child protection plan or being subject to care proceedings. The inspection noted the improvements made in current social work practice with the benefit of comparing past practice with more recent work. However, the overall quality of practice remains variable. The council now has in place standards which are to be used to intensify the focus on improving the quality of practice. The inspection did not identify any systemic failures leading to children being inadequately protected and no cases were referred back to the senior managers where children were identified as not being appropriately protected.
17. Leadership and governance arrangements are adequate and are showing signs of delivering improved services and outcomes. For example, through

the restructuring of services which has resulted in an increased focus on earlier identification and intervention, improved partnership working and more consistent decision making at the point of contacts and referrals being received. The council acknowledges that the pace of change in some areas has been slower than expected, for example in achieving a consistency in the quality of practice. due in the main to the need to establish a clear structure for service delivery combined with recruiting permanent staff. The council is now in a stronger position on which to accelerate the pace of change and improvements.

18. The extent of change required affects the whole of the children's social care service. There remains a vulnerability to continuous improvement particularly through the numbers of agency staff. However, the council's workforce strategy and actions being taken to actively recruit staff is proving effective and has resulted in a significant reduction by 50% in the use of agency staff. The council is in the early stages of succession planning within its children's social care workforce.
19. The council's response and that of the Local Safeguarding Children Board (LSCB) to an increase in the numbers of privately fostered children has been slow. The council is challenged by the high numbers of children and young people travelling to the area from abroad to attend language courses, some of whom are at a very vulnerable age. To address this, the council has very recently increased the capacity of the private fostering service. However, only a third of newly notified children received statutory visits on time last year. This, and inconsistencies in the quality and format of privately fostered children and young peoples' records, mean there is potential to miss children and/or not identify emerging risks.
20. The combination of past inspections, external audits and a peer review has resulted in the council having an increased understanding of their responsibility for children's social care services and the need to drive forward improvements. Using the learning from their inspection experiences and a real sense of the need to improve the lives of children and young people, the council has made appropriate decisions to continue to invest in these services, including increasing the numbers of social workers within a climate of challenging financial constraints.
21. Performance management is becoming effective with the council's own unvalidated data showing signs of sustained improvements being evidenced in a number of areas. For example, higher conversion rates of referrals to initial assessments indicating a more consistent understanding and application of thresholds and the number of contacts which proceed to CAFs has increased significantly compared to the previous year. The percentage of re-referrals has reduced and is in line with statistical neighbours. The timeliness of initial and core assessments has improved significantly from a very poor completion rate during 2011/12 with initial assessments currently comparable to statistical neighbours.

22. The council does not yet have a systematic method for gaining the views of children, young people and their carers. Currently, views are obtained on a specific issue or service basis rather than routinely collected views at particular stages of intervention. Children, young people and their families vary in their views about services. Some parents are positive about the help they receive, praising staff for being reliable and helpful, even in complex situations where there had been considerable concern for their children. However, in contrast, the continuity and effectiveness of intervention has been hindered for some children and families by frequent changes of social worker and some parents find the number of professionals involved overwhelming at times.
23. The number of complaints has fallen and most are resolved promptly. Complainants' concerns are regularly discussed by senior managers and lessons for service improvement are identified. There is not yet a systematic mechanism for checking whether learning from complaints has been embedded in sustained improvements to practice.

The effectiveness of the help and protection provided to children, young people, families and carers

24. The effectiveness of help and protection provided to children, young people and their families and carers is **adequate**. Early intervention is a clear priority for the council and its partners and vulnerable children and young people are helped to access a good range of support services. Through the oversight of the Children's Improvement Board (CIB), the council and partners are working towards full implementation of an integrated service delivery model which is the shared vision and plan for improved early identification and intervention and also includes services for children in need. Recent improvements supported by the successful implementation and adoption across the partnership of the 'child's journey' have clarified the referral criteria and established a single point of contact for both early help and children's social care services. As a result, the majority of children now benefit from timely and effective help. Risks and protective factors are assessed and well managed and more families are being offered support, some of whom may not have received a service in the past.
25. The impact of intervention on children's lives is not yet consistent. Where risk is recognised, assessments and child protection plans are focused on the child's experience and are used well to secure parental engagement. In these cases, families respond well to support, resulting in improvements in children's safety, engagement in learning, health and wellbeing.
26. The council is actively addressing the issue of poor social work practice in the past, the consequences of which are still apparent in some cases. For these children, past weaknesses in assessment and poor supervision have

resulted in drift and delay, with social workers failing to intervene with sufficient rigour to engage and challenge parents and carers effectively. Where this has been identified, corrective remedial actions have been put in place.

27. Current practice is proving more successful in identifying risks and intervening at an earlier stage. However, in balancing the legacy impact with current demands, the council will need to maintain their close vigilance on casework and performance to ensure decisions and casework are contributing to effective outcomes for children and young people.
28. Effective information sharing and coordinated early help has resulted in imaginative and flexible solutions and more personalised programmes for some families. A good range of support services commissioned by the council helps to support and safeguard vulnerable children and young people. Services include advocacy, counselling, a one stop shop run by a voluntary agency which includes substance misuse services, homelessness prevention, support for runaways and help for young people at risk of child sexual exploitation (CSE). Commissioned services have clear service specifications setting out their purpose and intended outcomes and they generally achieve positive results.
29. The council commissions a service for children exposed to domestic abuse. However, there is currently a gap in provision for perpetrators of all ages who are not known to the youth offending service or to probation. As a result, opportunities to intervene early to safeguard children who are exposed to domestic abuse can be missed. A draft domestic strategy is currently being written and the council has confirmed that, as result of this inspection, service provision for this group of perpetrators will be made available. The timescale for delivery is yet to be set.
30. Families have given positive feedback about some specific child and family services, including the council's intensive family support and family group conferencing services. There is evidence in some cases that these are improving the engagement of previously resistant families. In general, the involvement of children and parents in helping to assess the impact of the help and protection they receive is limited to ad-hoc examples rather than being embedded more systematically and dynamically within the council's quality assurance processes.
31. A recently developed children's participation strategy sets out clearly the council's commitment to increase children's involvement in shaping services. There is some use of parents' and children's views regarding services, particularly in relation to children with disabilities. However, this approach is not always clearly evidenced in casework with individual children and families.
32. Families are helped to understand the intentions of the help and protection they receive, although this is not achieved consistently. For

example, some parents seen complained of professionals using too much jargon. Overall, parents value openness and honesty and accept challenge, even where there was considerable concern for their children.

33. In some instances, and in particular parenting assessments, social workers are drawing on research and exploring different ways of helping parents develop their understanding of the issues causing difficulties for their children and themselves. Where this participative approach has been taken, it has helped bring about more consistent parenting and improved family relationships.
34. Children engaged in child protection services have access to advocacy support through a service commissioned by the council from a voluntary agency. Examples were seen where children and young people have been helped effectively to contribute to decisions made for them and ensure their views are given serious consideration, for example when deciding whether a child protection plan is appropriate for them.
35. Interpreters, translation and language courses are available to assist communication with children and their families whose first language is not English. Responsiveness to other aspects of diversity, such as ethnicity, culture, religion and disability, is generally weak and variable. For example, a lack of focus on the implications of parents' learning difficulties can be a barrier to a full understanding of safeguarding concerns in some families. Where this is the case, help and protection have been less effective in improving outcomes for children and risks can persist despite involvement with the service over a long period. However, some examples were seen where good attention had been given to disability. For example, a parenting assessment was tailored to meet the needs of a parent with learning difficulties and some very sensitive and appropriate work had been undertaken when a child with severe disabilities was believed to be in need of protection.
36. The number of vulnerable children and families being identified and supported as having additional needs has increased the use of the CAF. Outcomes are generally positive for families. The council is at an early stage of using an outcomes measurement tool, the 'outcomes star'. Early indications of where this is being used show young people and families being actively engaged resulting in improved outcomes. Improved screening by the safeguarding hub and growing clarity on referral criteria and processes has improved the coordination of help once children no longer need social work intervention. This has contributed to reducing the need for high level services in some cases.
37. In most cases, help for children who need protection is ensured by agencies working together effectively. Operation Mansfield, an investigation into CSE, has heightened the awareness of the council and partners to CSE. Peninsula-wide procedures have been developed and a

local multi-agency forum has been established to strengthen joint working to help children in need of protection. However, at the time of the inspection, there was no council specific implementation plan. Multi-agency training has been delayed due to the availability of a designated member of staff from children's services. This has now been addressed with plans in place for the training to start in April.

38. Good attention has been given to reducing the incidents of children and young people who go missing, with children being seen by a voluntary agency after their first missing episode. The council has been effective in raising awareness and broadening the range of agencies involved in identifying children missing from education. As a result, young people missing education are being identified and supported back on roll and attending school more quickly, a large majority of these being within one month.
39. A few children have remained subject to child protection plans for a very long time as a result of a legacy of ineffective practice and poor management oversight. The council acknowledges that improvements in practice are not yet consistent. However, a stronger focus on early intervention, better initial decision making, more focused use of court proceedings where the level of risk is too high combined with a clear process to enable children to step down to a lower level of support where risks are reducing, all help to ensure that most children are now receiving the right level of service and are not subjected unnecessarily to child protection procedures.

The quality of practice

40. The quality of practice is **adequate**. The significant restructuring of children's social care in January 2012 has resulted in an effective safeguarding hub being established where the vast majority of contacts and referrals are received. Decision making for referral to children's social care or integrated services is now more timely and risk is assessed appropriately. Thresholds for access to services are better understood by agencies and supported through the use of the 'child's journey' model.
41. The increase in the percentage of referrals proceeding to initial assessment is further evidence that thresholds are more clearly understood across the partnership and applied consistently and effectively to ensure that the right children are receiving services. The use of the safeguarding hub enquiry form (SHEF) which has been developed to replace the CAF is becoming an effective mechanism for agencies to refer into the hub. The SHEF has been welcomed by agencies and is being used appropriately.
42. Decisions at the point of contact and referral are made by suitably qualified social workers. The location of two decision makers within the safeguarding hub provides a consistent approach to the management

oversight and decision making about referrals into children's social care services. Access to qualified social workers for advice to assist in determining whether to make a referral is readily available and agencies report positively about this accessibility. The out of hours emergency duty service provides an effective and timely response to referrals. Good support is available to families in crisis out of hours through the intensive family support service.

43. Responses to domestic violence referrals are mostly timely and are appropriately risk assessed on an individual referral basis. A few examples were seen where the need for assessment and direct contact with parents and partners would have been more appropriate. However, children were not being placed at risk of significant harm as a result of the decision not to conduct an assessment. The safeguarding hub receives all notifications of domestic violence incidents known to the police where a child is in the family. However, there is no standard baseline criterion to conduct an assessment where, for example, there has been a second or subsequent incident.
44. There is good use of strategy discussions and meetings with examples seen which were well attended by key professionals, outcome focused and had clear decision making and contingency planning in place. However there are too many telephone discussions involving only the police. In a few cases seen, a strategy meeting would have been more appropriate providing an opportunity for wider agency participation and, as a result, more information for consideration.
45. Section 47 child protection enquiries are undertaken by qualified social workers and overseen appropriately by managers. Recording of strategy meetings and section 47 enquiries is too variable. It is not always possible to identify clearly the content of the discussion and actions agreed. In some section 47 enquiries, there was little evidence of all agencies being contacted to inform the outcome of these enquiries. Recent examples confirm an improving picture using this information on which to base a decision. In the majority of cases seen, the outcomes of strategy meetings and section 47 enquiries were appropriate.
46. The responsibility for child protection enquiries within the children with disabilities service (CWDS) had recently been transferred to the safeguarding service with these enquiries being co-worked between the safeguarding and CWDS social workers. However, at the time of the inspection, some social care staff within CWDS remained unclear about responsibility for section 47 child protection enquiries. As a result of the peer review in June 2012, the council had a project plan in place within the Children's Improvement Partnership Plan (CPIP) to reconfigure the CWDS as part of the improvement plan. However, during the course of the inspection, and in direct response to concerns being raised by inspectors, senior managers made an immediate and appropriate decision to move

CWDS social workers and family support workers into the safeguarding service to ensure a robust and consistent approach was applied to child protection enquiries and CWDS social care casework in general.

47. In the majority of cases, assessments are timely. Assessments and plans for children in need are variable with many lacking focus and instances where plans have not been reviewed, particularly in the CWDS where many cases seen did not have a children in need plan. Some social workers report a number of cases where there has been a need to repeat assessments and re-focus work following periods of drift and which have been identified within case file audits as requiring remedial work. However some good examples of assessments have also been seen where effective help has been offered and there have been good outcomes as a result. CAFs evaluated were clear and included the views of parents and children with appropriate consent. They had a clear focus on programmes of work with defined outcomes delivered over a set time period.
48. Good quality parenting assessments are undertaken by staff specifically trained in this area of expertise. Examples were seen which demonstrated appropriate challenge to parents, use of messages from research to inform the assessment leading to good analysis and recommendations appropriate to evidence and findings gathered.
49. Recording is up to date in the majority of cases. However, the quality of recording is variable and in some cases lacks appropriate detail particularly concerning the voice of the child and the outcomes achieved during interventions. There is a prevalent and inappropriate use of acronyms in recording. Within some assessments, evidence was seen where the language used was inappropriate. The quality of recording and the use of recording to share information are enhanced by key professionals other than the allocated social worker, for example occupational therapists and staff within the intensive family support service, being able to record directly onto the electronic case file.
50. The use and quality of chronologies is variable. Chronologies are evident in many cases seen but in some cases have not been used to inform assessments. Some good examples were seen where historical information was used effectively to inform current planning and decisions.
51. The quality of child protection planning is variable with some plans lacking a clear focus and measurable actions, outcomes and timescales. In the better examples, using a more recently introduced format, plans were much improved, with identified risks, associated actions and actions clearly recorded. Some legacy examples were seen of drift including a small number of children on child protection plans for three years. An independent audit of all child protection cases was undertaken in May 2012 where there had been a plan in place for two years or more.

Remedial actions have been taken which have resulted in an increase in care proceedings and a reduction in the numbers of child protection plans.

52. Case conferences observed and case records of conferences demonstrated appropriate attendance by key professionals. However, there is a challenge in attendance by general practitioners partly as a result of the current high number of conferences being held. In a small number of cases seen and conferences observed, the decision for a child to be subject to a child protection plan was questionable with the possibility that a robust child in need plan would have been equally effective. Half of the child protection chairs are permanent employees, the other half being covered by agency staff. This is resulting in a lack of stability and contributing to variable quality in consistency of decision making and quality assurance. A pre-conference scrutiny and quality assurance process is in place which serves to mitigate this and to promote consistency of practice.
53. Child protection core group practice is variable with work seen that included the delivery of support services leading to good outcomes. However, during the observations of a very small number of core groups, the chairing of these was not observed to be consistently effective resulting in meetings that did not cover all the issues fully. Attendance by key professionals at core groups is good. The timeliness and frequency of core group meetings has improved. However, the quality of recording these meetings is variable. Some are recorded poorly making it difficult to identify and track progress and do not evidence sufficient attention being given to the detail of the plan. The template for core group recording it is not being used systematically across the service.
54. The Public Law Outline (PLO) is not being used to best effect. This is an important part of case planning in respect of care proceedings and ensuring that parents are fully informed as early as possible of concerns and the possible implications. The council is aware of this deficit and recently has introduced a framework to clarify PLO processes. The inspection did not identify any cases where the lack of the use of the PLO was resulting in children not being appropriately safeguarded.
55. Historically, some staff have lacked consistent management and guidance. This has resulted in a legacy of poor casework and drift in cases. This legacy is still being worked through and has resulted in a significant increase in child protection plans and care proceedings.
56. Recent work in teams is of an improved standard with evidence of remedial work undertaken in relation particularly to legacy work and adherence to timescales for assessments with evidence of appropriate decision making. In cases seen, no children and young people were inadequately protected or at risk of significant harm.

57. Evidence that children are seen alone and that an effective relationship is built with the social worker is limited. Whilst a small number of examples where seen of children consistently being seen alone, recording in other cases was too brief and assessments did not always provide evidence in this area. In some assessments, good examples were seen of children being listened to and their wishes and feelings being fully explored through direct work by the social worker, the outcomes of which help to inform decisions and assessments.
58. Many staff reported improvements in supervision practice. However, there is a legacy of poor practice in this area particularly in CWDS. In most current examples seen, supervision has been taking place on a regular basis. Case discussion and decision making is recorded on the electronic social care records system. In some examples, supervision entries were brief and showed little evidence of challenge or consideration to the progress being made in relation to child protection plans. In most personal supervision files seen by inspectors, personal and professional development was given an appropriate focus, previous discussions were tracked with actions by staff and the manager clearly recorded along with evidence of identification and work on performance management issues.
59. An advocacy service is available for children who are involved in child protection processes. Examples were seen where this has been effective in supporting their attendance at child protection case conferences. However, the attendance of children and young people at case conferences is an area for development.

Leadership and governance

60. Leadership and governance are **adequate**. Following a number of inspections and service reviews and a formal notice to improve, the council has a clear understanding of its effectiveness, strengths and areas for development. The council, its partners and the relatively new senior leadership team have risen to the challenge to address identified weaknesses in service delivery. The stimulus to advance the progress made has gathered momentum and the need to accelerate the pace has been recognised by the senior leadership team. Through the CPIP, ambitious, essential and necessary strategies in relation to the provision of child protection arrangements and targeted early intervention services for families have been implemented.
61. The children's trust arrangements are in the process of being established within the Health and Wellbeing Board which becomes fully operational from April 2013. As such, the Health and Wellbeing Board is not yet in a position of maturity to provide effective scrutiny and challenge to drive forward the extensive changes and improvements needed within children's social care services. Whilst the children and young people's plan remains in place for the foreseeable future, the predominant plan and partnership

approach used to drive service improvement is the CPIP with oversight by the CIB.

62. The CPIP is wide ranging. It is based upon a simple but complex principle of needing to tackle all service areas. Inevitably this has resulted in a comprehensive plan which is designed to strengthen and build on existing partnership arrangements. It demonstrates the scale of the changes required combined with the Council's aim to reshape services significantly and ensure their sustainability. A robust project management approach and appropriate reporting mechanisms through to the CIB and elected members ensures sufficient rigour and oversight of the plan. The pace of change is gathering momentum and the level of challenge required to support the continued improvements resulted in the appropriate decision to appoint an independent person as chair of the improvement board.
63. The council's corporate plan clearly prioritises the need to improve safeguarding for children. An up to date joint strategic needs assessment (JSNA) has been completed which is now being used to inform the Health and Wellbeing Board's strategy and priorities. The draft health and wellbeing strategy which appropriately includes safeguarding children as a priority, thus reflecting that of the council, has recently been approved by full council. However, specific actions and timescales on which the Health and Wellbeing Board can measure progress across the partnership for achieving the safeguarding priority have yet to be identified.
64. The strategy for preventative services through an integrated model of service delivery is in place and is also embedded within the CPIP. Working in partnership with the council, the public health service is leading on the development of community hubs through which local services and support can be accessed and from which community based commissioning can be informed.
65. The council's chief executive functions are undertaken by a chief operating officer (COO) who maintains a close oversight on progress of the improvement plan through formal line management arrangements with the senior leadership team and by being a member on the CIB. The COO is an interim part time appointment and the current post holder is also the director of adults' services. Whilst there has been no evidence to date, this has the potential to lead to a conflict of interests between the competing demands of adults' and children's services and other council services. Appropriately, during the time of this inspection, full council had approved a new senior leadership structure which includes a dedicated COO post for four days a week.
66. Accountabilities are clear and well established between the Mayor, lead member and the director of children's services. The lead member is well informed on both a formal and informal basis. Learning from the past has heightened the awareness of elected members and increased their

oversight of children's services. Elected members are taking an active interest and oversight including visiting staff in offices to ensure that the improvement programme is maintained and delivered in a purposeful way.

67. Confidence in the senior leadership team is wide spread and significant achievements can be measured in the re-design of the service and the focus on improving social care practice. Staff consistently report positively on the accessibility and visibility of senior managers and demonstrate an understanding in the need for change.
68. Creating a stable workforce with sufficient capacity, skills and experience to support senior managers in implementing the improvement plan has delayed the speed of progress and impeded the development of good quality practice and services to families. The council has increased the number of social workers by 20% and, through the redesign of teams, has reduced significantly the span of responsibility for team managers. There is clear evidence that robust and vigorous recruitment activities are now being effective reducing the dependence on the use of agency staff by half. However, the proportion of agency staff remains too high across the service which may undermine the progress to achieve continuity, consistency and stability.
69. Newly qualified social workers are well supported in their development through an effective induction process, protected caseloads and a mentoring scheme. The allocation of school headteachers acting as individual mentors to managers is a particularly good example of partnership working and collaboration. This innovative approach strengthens the council's desire to provide a learning culture across the partnership on which to build a workforce equipped with the skills to deliver and sustain the improvements.
70. The reconfiguration of services combined with increased staffing has resulted in workloads now being at a manageable level with regular monitoring and oversight of these by the senior leadership team.
71. The TSCB is meeting its statutory responsibility. All statutory agencies are represented and members of the board have sufficient delegated authority to effectively represent their organisation. Attendances rates by some key partners need to improve to support a more strategic collaborative partnership approach to the work of the board. Partnership arrangements with the voluntary sector are being reinforced through the development of a communication strategy to ensure all voluntary organisations are engaging with and fully participating in TSCB activities. The board is actively recruiting two lay members supported by a job description, induction programme and a mentoring scheme where new members will be mentored by experienced participants to support their learning and development.

72. Learning from serious case reviews (SCR) is at an early stage and is a positive contribution to supporting a learning culture and overall improvement in social work practice. The on line e-bulletin is in its infancy. However, its impact in supporting the learning and development framework is evident. Social workers reported that the findings from a recent SCR have challenged their professional assumptions and stereotypes resulting in a greater awareness of vulnerability and the need to be vigilant where children are at risk of CSE. Messages from research and SCRs have informed an effective poster campaign helping to raise awareness of some critical issues which impact on families and social work practice. The TSCB acknowledges that there remains much more to do to ensure it becomes an effective conduit for challenge and learning. A core performance data set informs the TSCB of current practice across the partnership. It supports partner agencies in understanding the work of each agency, strengthening their knowledge and ability to challenge each other.
73. The benefits of multi-agency audits and training are improving working relationships across the partnership, building confidence and a better understanding of the safeguarding agenda. At the time of this inspection, Children Act 2004 section 11 audits to monitor and evaluate compliance of the council and partner agencies with their specific and general duties in respect of safeguarding have been undertaken across the partnership. The findings have yet to be analysed. There is now a growing self-assurance and a stronger focus on safeguarding activities across the partnership further strengthening the prominence of the board and ensuring it plays its full part in driving the improvement agenda.
74. There is some emerging evidence of a potential lack of clarity between the work of the CIB and the TSCB. This was identified within the peer review and some examples were also evident during the inspection. To ensure this does not impede progress, clear lines of responsibility and accountability need to be established so that the CIB does not inadvertently undermine the work of the safeguarding board.
75. A comprehensive suite of performance data includes relevant data from the health service and the police. Improvements in the unvalidated council's performance figures for January 2013 include the percentage of referrals progressing to initial assessments, an increase in CAFs, a reduction in re-referrals, assessments being completed within timescales and initial child protection conferences being held within 15 days. More work is yet to be done to reduce the number of children on child protection plans although this is steadily reducing.
76. The council has been undertaking a systematic programme of case file audits as part of the CPIP and which is reported regularly to the CIB. By December 2012, 500 cases had been audited which has included all those where there was a child protection plan and 200 children in need cases.

This audit activity was established specifically to ensure children were safe and has been effective in identifying a legacy of poor practice and decisions which have led to remedial actions being taken, resulting in an increase in child protection plans and care proceedings.

77. Weekly performance meetings led by the senior leadership team ensure progress against key performance targets is closely tracked and areas of growing concern identified and responded to. Team managers receive weekly performance reports and access to live data to monitor the performance of individual teams and members of staff. However, applying this consistently can prove problematic where agency managers are newly appointed.
78. A quality assurance framework is in place with a phased introduction that is working towards a regular auditing programme across all service provision including weekly audits, monthly overview meetings, auditing of child protection cases both internally and by independent auditors and as standard all managers auditing three cases per month. The need for continuous oversight of practice during the improvement programme is exercised diligently by the senior leadership team which holds a regular 'Friday audit' to sample cases where themes and patterns have been identified through other auditing processes.
79. The phased introduction of the quality assurance framework has been slower than expected and reporting on the findings of those audits undertaken is in its infancy. To support the accelerated learning and development programme senior managers need to ensure findings from audits are firmly embedded within practice. A programme of themed audits and auditing against recently implemented practice standards is in the developmental stage.
80. Throughout the inspection, the senior leadership team demonstrated an open approach and a keenness to learn. This learning culture was evidenced strongly within conversations with individual staff. An example of using this dynamic learning to improve services was seen in the senior leadership's response to inspectors' concerns about the standard of practice within the children with disabilities team. Whilst a project plan was already in place, decisive and immediate action was taken to address these concerns supported by a robust action plan.
81. The voice of children and young people has been used effectively in the preparation of the revised improvement plan to form the priority objectives. Following a series of consultations with children and young people, there is a proposal for a children and young people's sub group working alongside the TSCB to ensure their voice is heard within the safeguarding agenda. However, securing the views of children and families is not sufficiently well embedded on a dynamic basis through regular feedback and evaluation mechanisms, for example, at specific

points during and after interventions to inform service planning and delivery.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate

Agenda Item 13



Title: Torbay Safeguarding Children Board

Wards Affected: All Wards

To: Health and Wellbeing Board **On:** 23 May 2013

Contact: Lisa Jennings – TSCB Business Manager
Telephone: 01803 208583
Email: lisa.jennings@torbay.gov.uk

Purpose

To provide the Health & Wellbeing Board (HWBB) with a brief overview of the role of the Torbay Safeguarding Children Board (TSCB) and consider the inter-relationship between both Boards. Future reports will provide a summary of key areas of TSCB activity.

Background

The TSCB is the key statutory mechanism for agreeing how relevant agencies will cooperate to safeguard and promote the welfare of children in Torbay and for ensuring the effectiveness of agencies' safeguarding activity.

The statutory objectives and functions of the TSCB are set out in Section 14 (1) of the Children Act 2004 as follows:

- a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- b) to ensure the effectiveness of what is done by each such person or body for those purposes

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCB in relation to the above objectives (appendix 1).

The current TSCB structure can be found attached (appendix 2), this is currently under review following a Development Day in March 2013.

Inter-relationship

The HWBB and the TSCB need to carefully consider the nature of their relationship, the governance arrangements that secure effective inter-action and the approaches that will enable robust, inter-active working between the two.

Working Together 2013 (Chapter 3, para 6) states that the LSCB should work with the HWBB, informing and drawing on the Joint Strategic Needs Assessment. The LSCB is also required to submit its annual report to the Chair of the HWBB (Chapter 3, para 16).

It will be important for both the HWBB and the TSCB to develop an effective joint protocol to support their working relationship in the interests of safeguarding children.

The protocol should define how both Boards will work together in the pursuit of safeguarding and promoting the welfare of children and young people and should set out how both Boards will work together to:

- Consult on the refresh of the Joint Strategic Needs Assessment.
- Share information in respect of the health and well-being of children, young people and their parents/carers
- Develop a coordinated approach to performance management and evaluation of success in securing outcomes
- Agree arrangements for the formal presentation of the TSCB annual report to the HWBB and the HWBB providing a formal response to the TSCB
- Ensure that messages and information about keeping children safe are disseminated within partner organisations, including collaborating on stakeholder events
- Ensure action taken by one body does not duplicate that taken by the other

Recommendations

That the Director of Children's Services develop a draft protocol to support the working relation between the Health and Wellbeing Board and the Torbay Safeguarding Children Board in the interests of safeguarding children and seeks the agreement of the Chairmen of the Health and Wellbeing Board and the Torbay Safeguarding Children Board prior to formal ratification by the respective Boards.

APPENDIX 1. LSCB FUNCTIONS

As defined in the Local Safeguarding Children Boards Regulations 2006 (2006 SI No 90)

5. (1) The functions of an LSCB in relation to its objective (as defined in section 14(1) of the Act (4)) are as follows:

- a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
 - i. the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.
 - ii. training of persons who work with children or in services affecting the safety and welfare of children;
 - iii. recruitment and supervision of persons who work with children;
 - iv. investigation of allegations concerning persons who work with children;
 - v. safety and welfare of children who are privately fostered;
 - vi. co-operation with neighbouring children's services authorities and their Board partners;
- b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so;
- c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve;
- d) participating in the planning of services for children in the area of the authority;
- e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1)(e) a serious case is one where:

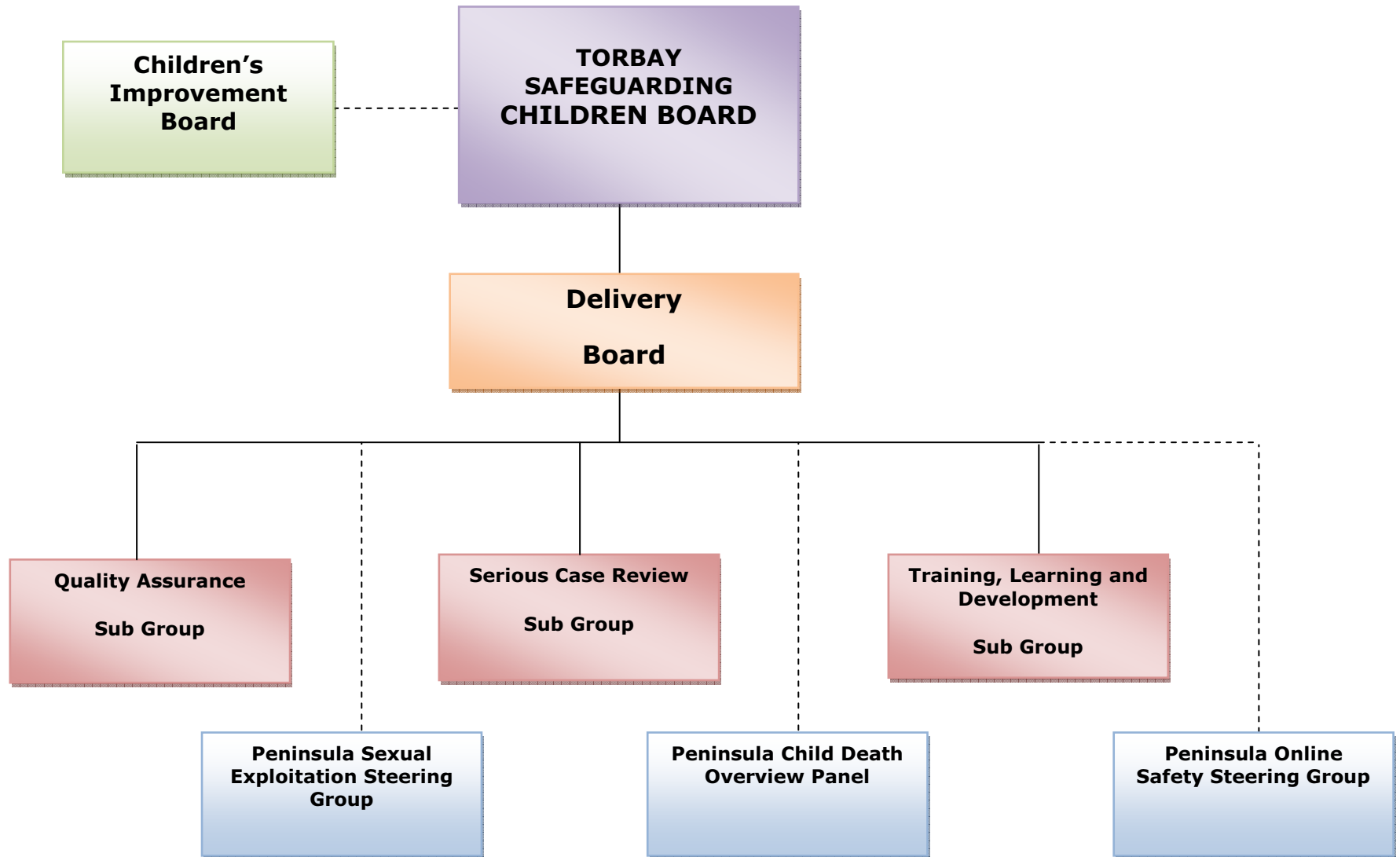
- a) abuse or neglect of a child is known or suspected; and
- b) either:
 - i. the child has died; or
 - ii. the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

(3) An LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objective.

Further functions relating to child deaths

6. (1) From 1st April 2008 each LSCB shall, in addition to the functions referred to in regulation 5, have the following functions in relation to the deaths of children normally resident in the area of the authority—
- a) collecting and analysing information about each death with a view to identifying:
 - i. any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - ii. any matters of concern affecting the safety and welfare of children in the area of the authority; and
 - iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
 - b) putting in place arrangements for a rapid response to each unexpected death of a child, by a group of key professionals who come together for the purpose of enquiring into and evaluating the death.

APPENDIX 2. TSCB STRUCTURE



Title: Performance Framework

Wards Affected: All

To: Health and Wellbeing Board **On:**

Contact: Kate Spencer
Telephone: 01803 207014
Email: Kate.spencer@torbay.gov.uk

1. Purpose

- 1.1 To establish a performance framework for the Joint Health and Wellbeing Strategy.

2. Recommendation

- 2.1 That the Partnership Commissioning Board (or Joint Commissioning Management Group, as appropriate) review the performance framework for the Joint Health and Wellbeing Strategy.

3. Supporting Information

- 3.1 In developing the Health and Wellbeing Board, the Shadow Board agreed that at each meeting an update would be provided on each of the three outcomes identified within the Joint Health and Wellbeing Strategy. This would help enable the Board to determine which priorities would be subject to detailed consideration at future meetings.
- 3.2 It was planned that the first page of these update reports would have an indicator set and the second page a commentary of what has been achieved, what are the challenges and what needs to change in the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy. Draft update reports for each outcome are attached as appendices to this report.
- 3.3 In drafting those reports for this first meeting, it is obvious that there needs to be a wider discussion to determine the indicators to be used to measure the success of the Health and Wellbeing Strategy. There also needs to be a lead person for each outcome in order to:
- Identify the right indicators (ideally ones that are already been collected and reported on)
 - Ensure that the data is available to enable the Council's Performance Team to produce a report

- Provide the commentary on what actions are being taken to meet the outcome
- 3.4 It is recommended that the Partnership Commissioning Board/Joint Commissioning Management Group would be the appropriate place for those discussions to take place.
- 3.5 It is also suggested that it may be more appropriate for the performance report for the three outcomes to be considered by that group (as the members of that are the ones implementing the Strategy on a day-to-day basis) with an update to the Health and Wellbeing Board on which priorities are falling behind schedule, what's being done to address it and which priority/ies should be the focus of debate at future Health and Wellbeing Board meetings. The report would also include the commentary for each outcome of what has happened in the past three months, the challenges ahead and any subsequent changes to the JSNA/JHWS.
- 4. Relationship to Joint Strategic Needs Assessment**
- 4.1 Establishing a light-touch performance/outcomes framework for the Health and Wellbeing Board would help ensure that the Joint Strategic Needs Assessment accurately reflects the needs of the Torbay community.
- 5. Relationship to Joint Health and Wellbeing Strategy**
- 5.1 Establishing a light-touch performance/outcomes framework for the Health and Wellbeing Board would help ensure that the Joint Health and Wellbeing Strategy accurately addresses the needs of the Torbay community.
- 6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy**
- 6.1 No implications at this time.

Appendices

Appendix 1 Draft Update Report – Children have the best start in life

Appendix 2 Draft Update Report – A Healthy Life With a Reduced Gap in Life Expectancy

Appendix 3 Draft Update Report – Improved mental health and wellbeing

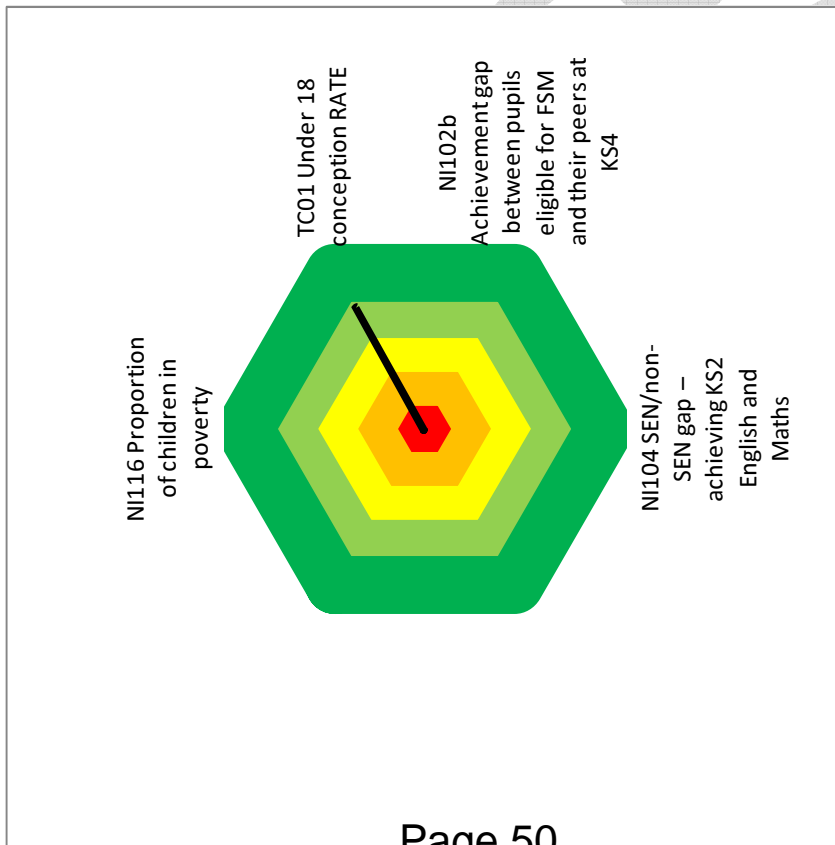
Background Papers:

The following documents/files were used to compile this report:

None

Health and Wellbeing Outcome Report: Children Have the Best Start in Life

Priority	Indicator	Target	Period	Performance	Direction since last period	Polarity
Promote the emotional wellbeing of children and young people	NI116 Proportion of children in poverty	20%	2010/11	23.3%	-	It's best to be low
Provide the full offer of the Healthy Child Programme between 0 and 19 years	No indicator identified as yet	-	-	-	-	-
Reduce teenage pregnancy	TC01 Under 18 conception RATE	50.9	2010	46.6	-	It's best to be low
Increase attainment	NI102b Achievement gap between pupils eligible for free school meals and their peers at Key Stage 4	25%	AY 2010/11	32.9%	+	It's best to be low
	NI104 The Special Educational Needs (SEN)/non-SEN gap – achieving Key Stage 2 English and Maths threshold	No target = not shown on radar	AY 2011/12	53%	-	It's best to be low
Improve employment prospects of working families	No indicator identified as yet	-	-	-	-	-



Achievements since last meeting

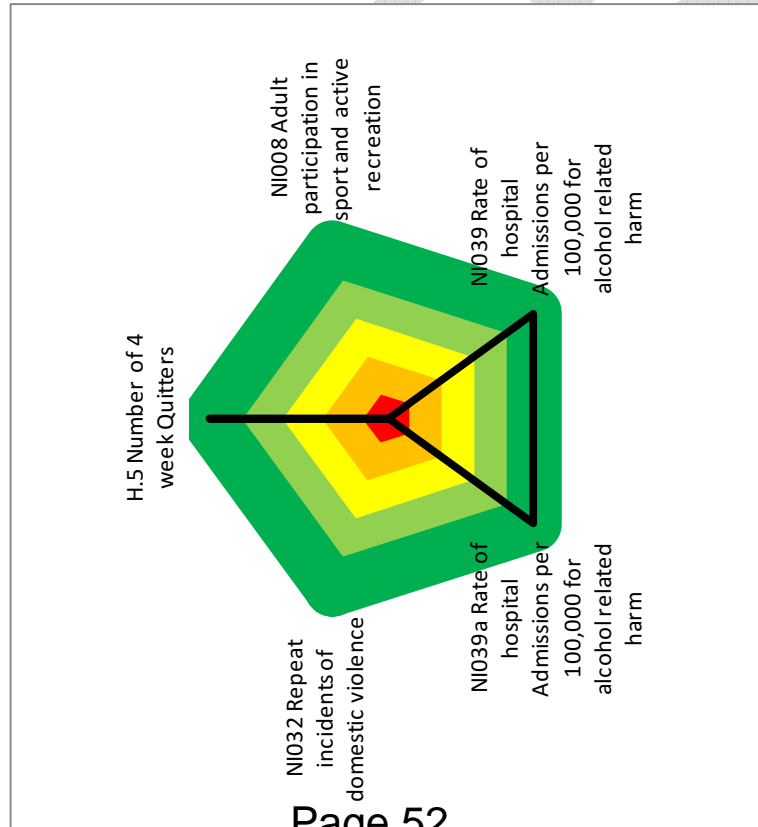
Challenges for the next three months

Action required by partners

Potential amendments required to Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

Health and Wellbeing Outcome Report: A Healthy Life With a Reduced Gap in Life Expectancy

Priority	Indicator	Target	Period	Performance	Direction since last period (Cumulative)	Polarity
Reduce smoking	H.5 Number of 4 week Quitters	471	Q2 2012/13	529	+	It's best to be high
Increase physical activity	NI008 Adult participation in sport and active recreation	25.8%	2011/12	20%	-	It's best to be high
Reduce alcohol consumption	NI039 Rate of hospital Admissions per 100,000 for alcohol related harm	3,559	2011/12	2,169	+	It's best to be low
	NI039a Rate of hospital Admissions per 100,000 for alcohol related harm	1,779	Q2 2012/13	1,110	(Cumulative)	It's best to be low
Increase sexual health screening	NI113a % of population aged 15-24 accepting a test/screening for Chlamydia (Quarterly)	No target = not shown on radar	Q1-4 2011/12	17.8%	(Cumulative) +	It's best to be high
	NI113b No of positive diagnoses for Chlamydia in the screened population aged 15-24	No target = not shown on radar	Q1-4 2011/12	1.5%	(Cumulative) +	It's best to be low
Reduce the risk of cardiovascular disease and cancer	No indicator identified as yet	-	-	-	-	
Support people with Long Term Conditions	No indicator identified as yet	-	-	-	-	
Children and vulnerable adults feel safe and supported in their families and communities	NI032 Repeat incidents of domestic violence	25%	Q4 2012/13	38%	+	It's best to be low



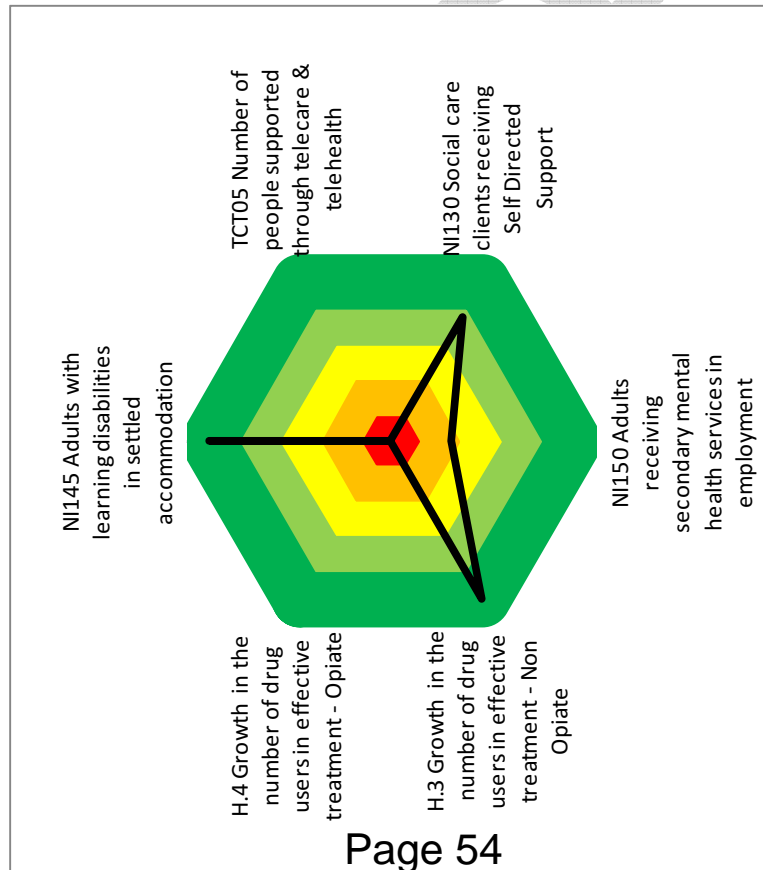
Achievements since last meeting

Challenges for the next three months

Action required by partners

Potential amendments required to Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

Health and Wellbeing Outcome Report: Improved Mental Health and Wellbeing



Priority	Indicator	Target	Period	Performance	Direction since last period	Polarity
Support independent living	NI145 Adults with learning disabilities in settled accommodation (monthly)	60%	April – March 2012/13	69%	+	Its best to be high
	TCT05 Number of people supported through telecare & telehealth (monthly)	1100	March 2012/13	881	-	Its best to be high
	NI130 Social care clients receiving Self Directed Support (Monthly)	55%	April – March 2012/13	58.1%	+	Its best to be high
Support people with mental health needs	NI150 Adults receiving secondary mental health services in employment (Monthly)	6%	March 2012/13	5.5%	+	Its best to be high
Improve care for people living with dementia and their carers	No indicator identified as yet	-	-	-	-	-
Increase the number of problematic drug users in treatment	H.3 Growth in the number of drug users in effective treatment - Non Opiate (Quarterly)	0.7% (Q2)	Quarter 2 2012/13	88%	+	Its best to be high
	H.4 Growth in the number of drug users in effective treatment – Opiate (Quarterly)	-1.9%	Quarter 2 2012/13	3.9%	+	Its best to be high

Achievements since last meeting

Challenges for the next three months

Action required by partners

page 55

Potential amendments required to Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

Title: Integrated Health and Care Initiative

Wards Affected: All wards

To: Health and Wellbeing Board **On:** 23 May 2013

Contact: Kate Spencer
Telephone: 01803 207014
Email: Kate.spencer@torbay.gov.uk

1. Purpose

- 1.1 To outline the commitment from Government to integrate health and social care by 2018 and inviting expressions of interest to become “pioneers” in this area.

2. Recommendation

- 2.1 That the health and care system leaders in Torbay prepare an expression of interest to become health and social care integration pioneers.
- 2.2 That, if successful, further consideration be given to how the Health and Wellbeing Board can work effectively with any other governance arrangements to support the pioneer work.

3. Supporting Information

- 3.1 The Care and Support Minister, Norman Lamb MP, announced, on 14 May 2013, the Government’s ambition to make joined-up and co-ordinated health and care the norm by 2018 with projects in every part of the Country by 2015. A collaborative of national partners (including the Association of Directors of Adult Social Care, Association of Directors of Children’s Services and NHS England) has set out this vision in *Integrated Care and Support: Our Shared Commitment*. The document sets out how the national partnership will work together to enable and encourage local innovation, address barriers and disseminate and promote learning in support of better integration for the benefit of patients, service users and local communities.
- 3.2 Expressions of interest are being sought from local areas to become integration “pioneers” as a means of driving forward change at scale and pace, from which the rest of the Country can benefit.
- 3.3 These pioneers will work across the whole local health, public health and social care systems as well as other local authority departments and the voluntary and community sector. The local area can be that covered by a

local CCG or local authority, or a larger footprint in which different authorities and health bodies work together.

- 3.4 The letter from the Department of Health inviting expressions of interest for health and social care integration “pioneers” is attached as Appendix 1.
- 3.5 It is proposed that, building on the success of integration of health and adult social care in Torbay since the creation of the Care Trust, an expression of interest be put forward. This would take account of the synergies already in place (and being developed) between the CCG, the Torbay and Southern Devon Health and Care NHS Trust, the South Devon Healthcare NHS Foundation Trust and Torbay Council (with its responsibilities for Children’s and Adults’ Services).
- 3.6 The opportunity should also be taken to build on our past success in integration to explore other potential collaborative approaches, in particular with growing pressures on all services due to conduct disorders, behaviour support and wider mental health issues with children and young people.
- 3.7 Expressions of interest need to be submitted by 28 June 2013. Successful pioneers will have access to a jointly (centrally) resourced team of experts who will support and advise on, amongst other things, overcoming barriers and achieving locally and nationally shared ambitions.
- 3.8 The Local Government Association has highlighted that “Health and Wellbeing Boards, as the core local decision makers across health and social care, are crucial to this process and can provide a platform to ensure that public money is used effectively across the NHS and local government to tackle the wider health needs of our communities”. Consideration will, however, need to be given to how, if successful, the Health and Wellbeing Board works effectively with other governance bodies to support the pioneer work.

4. Relationship to Joint Strategic Needs Assessment

- 4.1 Integrating health and social care will be key to meeting the needs of the community as identified within the Joint Strategic Needs Assessment.

5. Relationship to Joint Health and Wellbeing Strategy

- 5.1 The Joint Health and Wellbeing Strategy is predicated on the need to continue the current joined-up approach to health and social care within Torbay and to need to ensure that integration continues to be developed.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

- 6.1 If successful, the pioneer project will help to deliver the outcomes and priorities identified within the Joint Health and Wellbeing Strategy.

Appendices

Appendix 1 – Letter inviting expressions of interest for health and social care integration “pioneers”

Background Papers:

The following documents/files were used to compile this report:

Integrated Care and Support: Our Shared Commitment

<https://www.gov.uk/government/publications/integrated-care>

Agenda Item 15

Appendix 1

Gateway Reference Number: 00079

LETTER INVITING EXPRESSIONS OF INTEREST FOR HEALTH AND SOCIAL CARE INTEGRATION 'PIONEERS'

To:

Local authority chief executives
Chairs of Health and Wellbeing Boards
CCG clinical leads
Provider CEOs across the social care and health system – public, private and voluntary

Dear colleagues,

The Government is encouraging all areas to develop their own reforms to public services. This approach involves all services and builds on experience from the community budget pilots supported by the Department for Communities and Local Government. A collaborative of national partners¹ has now set out an ambitious vision of making person-centred coordinated care and support the norm across the health and social care system in England over the coming years. ***Integrated Care and Support: Our Shared Commitment*** published today, signals how this national partnership will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better integration for the benefit of patients, people who use services, and local communities.

All localities need to develop plans for integration. There is no blueprint. While elements of different models will be transferable, every locality is unique and needs to develop its own model of integration to suit the needs of local people. But we know that delivering better coordinated care and support, centred on the individual, is difficult and that there are barriers at national and local level that are getting in the way.

The national partnership is therefore inviting expressions of interest from local areas to become integration 'pioneers' as a means of driving forward change at scale and pace, from which the rest of the country can benefit. We are looking for pioneers that will work across the whole of their local health, public health and social care systems and alongside other local authority departments and voluntary organisations as necessary, to achieve and demonstrate the scale of change that is required. The local area could comprise of the area covered by a particular CCG or local authority, or a larger footprint in which different authorities and health bodies work together to enable integrated services. What is important is that it would be at a scale at which a real difference can be made.

¹ Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

We will provide tailored support to pioneers. In return, we expect them to be at the forefront of disseminating and promoting lessons learned for wider adoption across the country.

National partner organisations are already working to clarify the scope and extent of the freedoms and flexibilities in the system. These will allow localities to innovate and develop their chosen models for integrated care and support. We will seek to address at local level any additional barriers that emerge as pioneers and other local areas push forward on integrated care and support, and we will assess whether any rules should be changed at the national level, as a result.

The attached annex sets out our vision for pioneers, the criteria and process for selecting them, and the offer of support from national partners, helping us succeed together in meeting our shared aspirations. As we want to enable and encourage local innovation², we would be interested to receive expressions of interest from commissioners and providers. This includes any that might not yet have all of the prerequisites in place but nevertheless have innovative ideas and proposals worthy of further consideration. Any gaps against the criteria could be addressed during the process of pioneer selection for inclusion in the first, or subsequent, cohorts.

If you would like to be considered to become a pioneer, please send an expression of interest, addressing the required criteria on no more than 10 pages, to pioneers@dh.gsi.gov.uk by 28 June 2013. This is the first call for expressions of interest, and we expect there will be further calls in future years as momentum builds and progress is made across England.

We are working closely with the Department for Communities and Local Government and the Public Service Transformation Network – a multi-agency organisation with secondees from across national and local government and local public services - to ensure that the health and social care pioneers programme is closely aligned and integrated with support that the Network will provide to local public services. If you have already submitted an expression of interest to work with the Network and wish also to be considered as a health and social care pioneer, please send an expression of interest. We will work with the Network to ensure that we take account of this as part of the pioneer selection process.

If you have any queries, please contact us at pioneers@dh.gsi.gov.uk.

We look forward to receiving your proposals.

² Innovation: "An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied." **Innovation, Health and Wealth (2011)**

Pioneers in integrated care and support: Selection criteria, process and national support offer

1. Introduction

In our joint publication today, *Integrated Care and Support: Our Shared Commitment*, a collaboration of national partners³ has set out an ambitious vision of making person-centred coordinated care and support the norm across England over the coming years. We have signalled how we will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better person-centred, coordinated care for the benefit of patients and people who use services, their carers and their local communities more generally.

For the most ambitious and visionary localities, we will provide additional bespoke expertise, support and constructive challenge through a range of national and international experts to help such pioneers realise their aspirations on integrated care. This approach builds on the community budget pilots, which provided insights into co-designing integrated health and care at scale and pace. The pioneer programme will link directly with the development of a Public Service Transformation Network extending across government and participating localities.

We want everyone to innovate and we have highlighted in our publication today the freedoms and flexibilities in the system. We will seek to address at local level any additional barriers that emerge as pioneers push forward and we will assess whether any rules should be changed at the national level, as a result.

We aim to stimulate successive cohorts of pioneers, supporting them for up to five years. In return, we expect them to contribute to accelerated learning across the system.

³ Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

2. Our expectations from pioneers

Within five years, we expect pioneers to:

- **be regarded as exemplars:**
 - deliver improved outcomes, including better experiences for patients and people who use services
 - tackle local cultural and organisational barriers
 - realise savings and efficiencies for re-investment

- **have used the Narrative developed for us by National Voices, in association with *Making it Real*, to help shape good, person-centred coordinated care and support for individuals in their area**

- **have demonstrated a range of approaches and models involving whole system transformation across a range of settings**

- **have demonstrated the scope to make rapid progress**

- **have tested radical options, including new reimbursement models and taking the risk of 'failure to integrate' in some cases**

- **have overcome the barriers to delivering coordinated care and support**

- **have accelerated learning across the system to all localities**

- **have improved the robustness of the evidence base to support and build the value case for integrated care and support**

3. Selection criteria

Against this background, we are requesting expressions of interest from areas that wish to become pioneers. We will announce the first of these in late summer 2013.

We will not be prescriptive about the specific models for local adoption; it will be for localities to decide, based on their own judgements and circumstances. However, to be selected as a pioneer, we would expect a locality to satisfy six key criteria:

Primary criterion	Supporting considerations
<p>Articulate a clear vision of its own innovative approaches to integrated care and support</p>	<p>This should include how it will:</p> <ul style="list-style-type: none"> • adopt the Narrative developed by National Voices, aligned with <i>Making it Real</i>; • integrate around, and deliver better outcomes, including experiences for, individuals, families, carers and communities; • align with outcome frameworks; and • identify potential financial efficiencies for reinvestment; and identify potential measures of success.
<p>Plan for <i>whole system</i> integration</p>	<p>This should encompass mental and physical health, social care and public health, as well as other public services, such as education, involving the community and voluntary sectors, as appropriate, across their local areas.</p> <p>The plan should include how the locality will deliver greater prevention of ill health and deterioration of health and personalisation through better integrated care and support.</p> <p>The plan should include those who would benefit most from person-centred, coordinated care and support, such as intensive users of services who repeatedly cross organisational boundaries or who are disproportionately vulnerable.</p> <p>It should also take into account how public services should be integrated with the unpaid contributions of families and communities.</p>

<p>Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area</p>	<p>This should include local executive and political leadership, staff groups, including clinicians, patient groups, people who use the services, carers and families.</p> <p>Areas will also need to demonstrate robust governance structures, including for information sharing, to sustain the approach, as well as a robust plan for engaging local Healthwatch, people who use the services, all staff groups and the public in local service reform.</p> <p><u>The involvement and support of Health and Wellbeing Boards</u> (as a minimum, by the end of the selection process) will be an <u>essential prerequisite</u> for any area to become a pioneer.</p>
<p>Demonstrate the capability and expertise to deliver successfully a public sector transformation project at scale and pace</p>	<p>This might be evidenced by:</p> <ul style="list-style-type: none"> • a proven track record in this area, strong local leadership and accountability; and/or • demonstrable and robust plans to address key local barriers to integrated care and support; and • risk management mitigation strategies, to maximise the likelihood of the area delivering its vision for integrated care and support across its locality.
<p>Commit to sharing lessons on integrated care and support across the system</p>	<p>This would be expected to include involvement in peer to-peer (including clinicians) promotion, dissemination and learning networks.</p>
<p>Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence</p>	<p>This will include:</p> <ul style="list-style-type: none"> • plans that have taken account of the latest available evidence; • understanding of the potential impact on the relevant local

	<p>providers and intended outcomes;</p> <ul style="list-style-type: none">• a commitment to work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support across sectors; and• a commitment to participate actively in a systematic evaluation of progress and impact over time
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4. Selection process

The selection process will be fair and transparent, whilst avoiding unnecessary bureaucracy. It will involve the following steps:

- Potential pioneers have six weeks to develop and return their Expressions of Interest, addressing the selection criteria above and not exceeding 10 pages in length. Expressions of interest can be submitted as joint applications, such as from a CCG and its local authority.
- In early July, the national partnership organisations will undertake an initial review of the Expressions of Interest. We will draw on additional sources of information, including the perspectives of local representatives of people who use services; information provided through the NHS planning round; information from CQC; any relevant information from Monitor and National Trust Development Authority; the recent ADASS/NHS Confederation survey of local authorities; and the selection of the new phase of community budget sites being run by the Department for Communities and Local Government as part of the wider Public Service Transformation Network.
- In mid-July, a Selection Panel made up of representatives from the national partners, three UK and three international experts will consider the Expressions of Interest and any additional information. The Panel will be chaired by Jennifer Dixon, Chief Executive of the Nuffield Trust (other panel members are being confirmed). The Panel will select any areas that meet the evaluation criteria in full or sift in any prospective candidates subject to receiving further information and clarification. National partners will obtain any additional information that might be necessary for the Panel to reach its view.
- The Selection Panel will make final recommendations to the national partners by the end of August, for their approval.

- The first cohort of pioneers will be announced in September 2013.

5. National support for pioneers

During the process of selection, national partners will discuss with pioneers their specific needs and proposed models of integration, and tailor their support accordingly. Based on what the system more generally has told us it needs from national organisations, the support that we envisage providing specifically to pioneers could include some or all of the following:

Capability Need	Support available
Changing the strategic/executive level culture	Organisational development Priority setting Action Learning sets Workshops, including peer-to-peer and champion support
Developing local payment systems	Payment design Contract design and models Cost collection Risk underwriting
Understanding the framework of rules on choice, competition and procurement	Clarification of rules and how integrated solutions can comply with them
Workforce flexibility	Employment law advice Workforce development
Public and professional opinion and engagement	Implementation of the Narrative National political support Engagement expertise
Analysis and evidence	Data and service audits Analytical support Financial modelling and health economics expertise to build the value case Evaluation expertise

In addition, we will:

- provide a dedicated 'account manager' as the main day-to-day point of contact with each pioneer to help them access the specialist support they need;

Gateway Reference Number: 00079

- draw together the current learning from literature and sites where integrated care has already been successfully adopted and other related initiatives, such as Year of Care implementer sites; and
- connect the pioneer sites through a strong community of practitioners to enable rapid and real time sharing of best and emerging practice across the pioneers, as well as more generally across the rest of the country.

Please submit your applications to pioneers@dh.gsi.gov.uk by 28th June 2013
If you have any queries or questions about the process these can also be submitted to pioneers@dh.gsi.gov.uk

Title: Development of Mapping and Consultation Work in Torbay:
Organisational Audit

Wards Affected: All

To: Health and Wellbeing Board **On:** 23 May 2013

Contact: Gerry Cadogan
Telephone: 07825 861780
Email: Gerry.cadogan@torbay.gcsx.gov.uk

1. Purpose

- 1.1 In order for the Torbay Health and Wellbeing Board to involve all the organisations in the statutory, voluntary, community and private sector, it is necessary to have a clear picture of the variety and nature of such organisations in the Bay.
- 1.2 This paper provides an update on work that has been undertaken on developing this picture to date, and recommends a process to develop and ensure accuracy on an ongoing basis.

2. Recommendation

- 2.1 That available information relating to contacts and links for all relevant organisations in Torbay be cross-referenced to ensure accuracy;
- 2.2 That, once completed, the Torbay Health and Wellbeing Board adopt a single resource which will be used as the focus for consultation and communication with health and social care organisations in Torbay; and
- 2.3 That the Torbay Health and Wellbeing Board support the upkeep and maintenance of the resource.

3. Supporting Information

- 3.1 A LINK/Healthwatch Pathfinder conference was held at the English Riviera Centre in April 2012, chaired by Councillor Lewis.

Preparatory work was undertaken by the then Torbay LINK, facilitated by Gerry Cadogan, to undertake a basic 'mapping' exercise, which involved identifying the known organisations and partnerships in Torbay, and asking conference delegates to provide additional information to update this. A mapping exercise had been discussed at great length at the Torbay Together Involvement Group, a subgroup of the Torbay Strategic Partnership (TSP), but until then was seen as a resource intensive exercise. Torbay LINK felt that

a basic 'snapshot' would be a simple and cost-effective start to the process. Annexes 1 and 2 were circulated for comment to those attending on 8 May 2012.

3.2 The TSP, for a variety of reasons, was not in a position to progress this work. On behalf of the Health and Wellbeing Board, the Annexes were circulated again for comment in early May 2013, but this time the circulation list developed by Healthwatch Torbay was used.

3.3 At the same time, Torbay Council and Torbay and Southern Devon Health and Care NHS Trust published their joint Torbay Directory (<http://www.torbaydirectory.com/>) which provides the contact details for organisations in Torbay which are grouped into 'Your Wellbeing', 'Your Family', and other groups of interest.

4. Relationship to Joint Strategic Needs Assessment (JSNA)

4.1 Mapping and identifying the organisations in Torbay will provide a dissemination point for the JSNA information, and provide a route for input to its ongoing development.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 The work complements the strategy priorities, by ensuring that there is potential for involving appropriate groups and communities for involvement and consultation.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 This would enhance the current and future work of both the JSNA and the Joint Health and Wellbeing Strategy.

Appendices

Annex 1 Torbay Healthwatch Mapping Exercise (2012)

Annex 2 Provider Engagement Network (2012)

Background Papers:

None

THE TORBAY HEALTHWATCH MAPPING EXERCISE

Why have a community engagement mapping exercise?

- For a long time, Torbay LINK members have been involved in meetings and groups from statutory, community, voluntary, private and user-led services;
- Nobody felt that they had an understanding of the number or nature of the groups or organisations involved in health and social care in Torbay;
- Department of Health guidance says that any Healthwatch will be;
 - ✓ A community organisation
 - ✓ Open to all
 - ✓ Using the voices and experiences of local people
 - ✓ Encouraging high quality health and social care
 - ✓ Challenging poor health and social care services
- Healthwatch must also;
 - ✓ Promote the voice of local services
 - ✓ Increase the voice of users and carers of health and social care services

Both these statements mean that the best quality health and social care services should be available to those people who need them, wherever they live in the Torbay area.

We have decided to define 'ENGAGEMENT' as the ongoing process of actively involving and supplying information and help to health and social care services, users and carers. Information that we receive from this, we will feed into the design and delivery of health and social care services in Torbay.

We will be able to feed directly into:

- The GP Clinical Commissioning Group
- The Care Quality Commission
- Local health and social care service providers in Torbay

This is important because, if health and social care services do *not* meet the needs of patients, users, carers and families in Torbay, then continuing to provide them is unethical and expensive.

WARNING!

1. We know that this is not scientific, complete, or the best way to do a mapping exercise, but it was simple, inexpensive, and we know more now than we did when we started!
2. This is a snapshot of the organisations based in Torbay (health and social care) based on feedback that we got from these people and organisations.
3. All this means that it will probably not be accurate today which is why we are asking you to comment!

HOW HAVE WE DONE THIS MAPPING?

1. A piece of work had been undertaken by Torbay Care Trust, and we used that as the starting point for this exercise
2. In early November 2011, we sent an e-mail to all the people on the lists and databases that we could bring together.
3. When we received responses, we developed the map again. We sent the new map to all those that we had originally e-mailed, asking for further comments.
4. We updated the information at the end of February 2012, so what you see today is a snapshot of the map at that time.

WHAT ARE WE ASKING YOU TO DO?

1. Look at the sheets
2. Use the post-it notes to add your comments under each sheet (signed or unsigned, but please make them polite!)
3. All comments will be welcomed and included in the feedback and map.
4. Please give us any advice on how we can develop this exercise, which will be ongoing.
5. Any further thoughts? Contact Gerry Cadogan on gerry.cadogan@nhs.net

PEOPLE/ORGANISATIONS WHO WE CONTACTED

Lesley Roddick-Harris – Action for Blind People
Rebecca Garside - South Devon Healthcare Foundation NHS Trust (SDHFT)
Brent Attenborough -Torbay Care Trust (TCT)
Catherine Hill – TCT
Rebekah Redshaw – Children’s Society
Chris Forster – Sanctuary Housing
Margie Goffney – COOL Recovery
Janette Oxley- CVA Torbay
Deanna Cranston
D.William
Torbay Disability
Emily Willebore – Torbay Council
Pat Harris – LINK
Marisa Cockfield – GP Clinical Commissioning Group
Tracey Cabache – Torbay Council
Gerry Cadogan -TCT
Debbie Stark – TCT
Iain Reid – TCT
Ian Tyson – TCT
Siobhan Grady – TCT
Tim Nand-Lal – TCT
Sarlett Curtis – TCT
Hannah Hurrell – TCT
Jonathon Brook – TCT
Mark Richards – TCT
Fran Mason – Torbay Council
Jess Sneddon – Torbay Council
Mandy Riley – Torbay Council
Kevin Mason – Devon and Cornwall Police
Geoff King – Parkinsons’ UK South West
Jennie Hack – Westcountry Housing Association (Deaf Community)
J.Harriman - Brixham College
Kristy Cooper – Living Options
Julie Backholer – SDHFT
Michael – Intercom Trust
A.Kemp – MS Society
James Drummond – Carers’, TCT
Kelly Ebdon – SDHFT

Carol Pearson – SDHFT
LINK members
Sevil Fertinger – TCT BME worker
Julia Melluish – Parent’s Participation Forum
Jacqui Bamford – TCT (Mental Health Department)

Comments made on day:

Housing is important for patients’ wellbeing- the standard that people live in affects their health! Pity that there was no one present to address their concerns (Cllr Ian Doggett)

Shared Lives South Wes ;PLEASE CONTACT US!; we are social care providers of 24 hour accommodation, and support in family settings for adults aged 18 plus.

Contact Helen Duff (Co-ordinator for Torbay):

hduff@sharedlivessw.org.uk

Tel: 01626 360170

www.sharedlivessw.org.uk

Ramsay Healthcare UK, Mount Stuart Hospital, acute surgical/medical hospital in Torquay since 1984.

Contact Jenny Stevens, Hospital Matron, Mount Stuart Hospital, St Vincents Road, Torquay TQ1 4UP

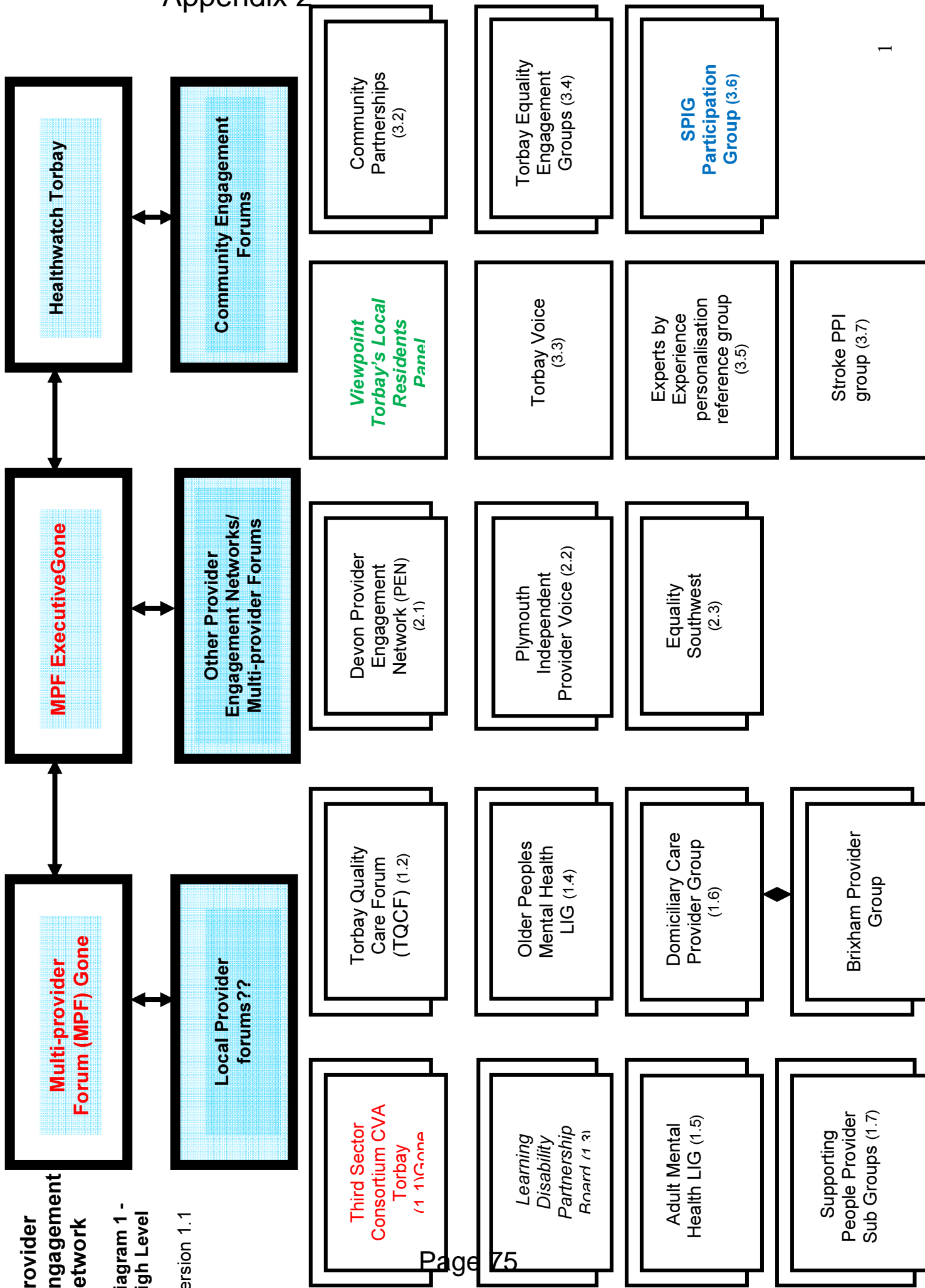
E-mail: jenny.stevens@Ramsayhealth.co.uk

Gerry Cadogan

8 May 2012

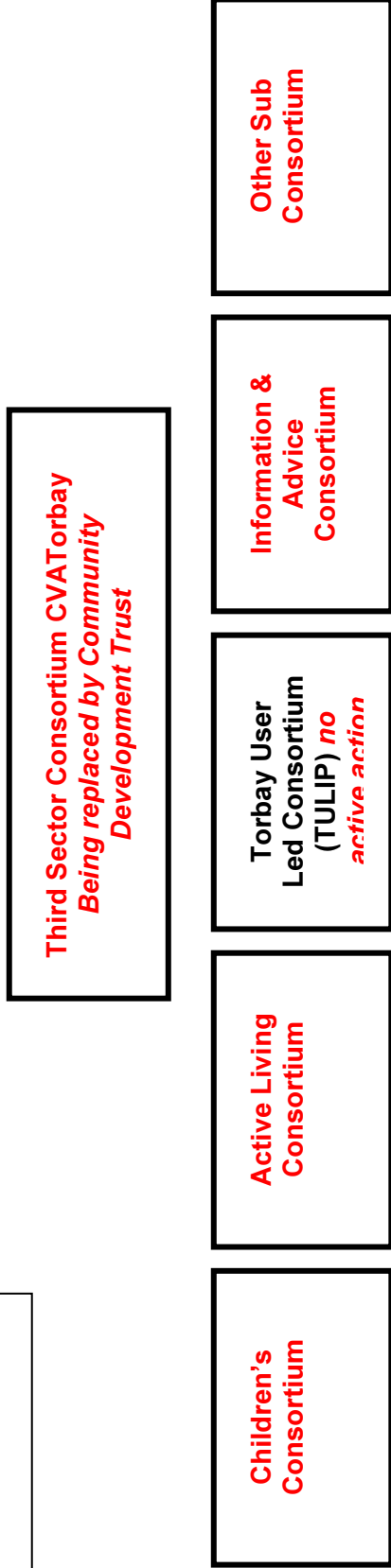
Agenda Item 16

Appendix 2



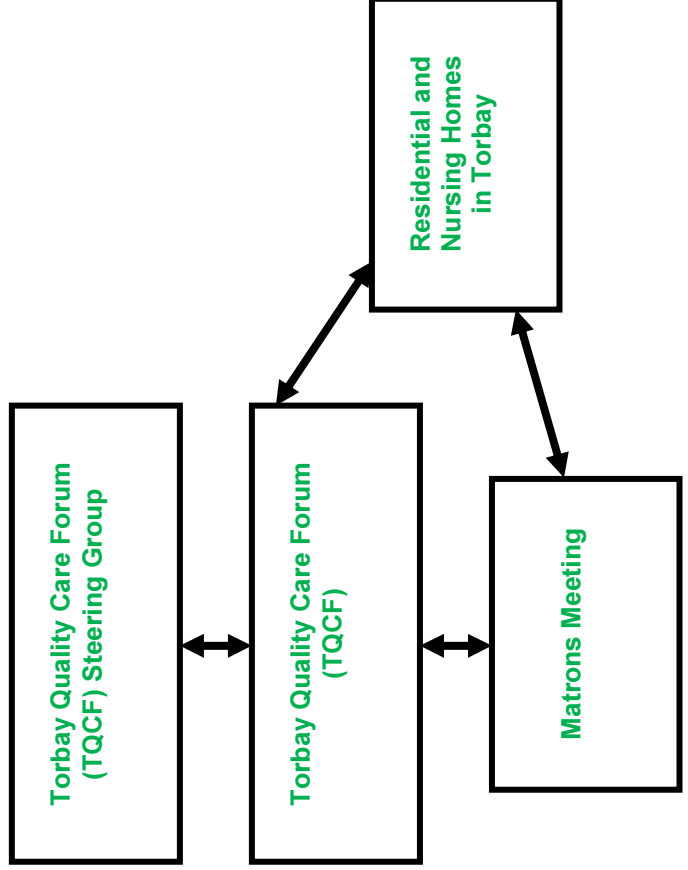
Provider Engagement Network

Diagram 1.1 – Third Sector Consortium

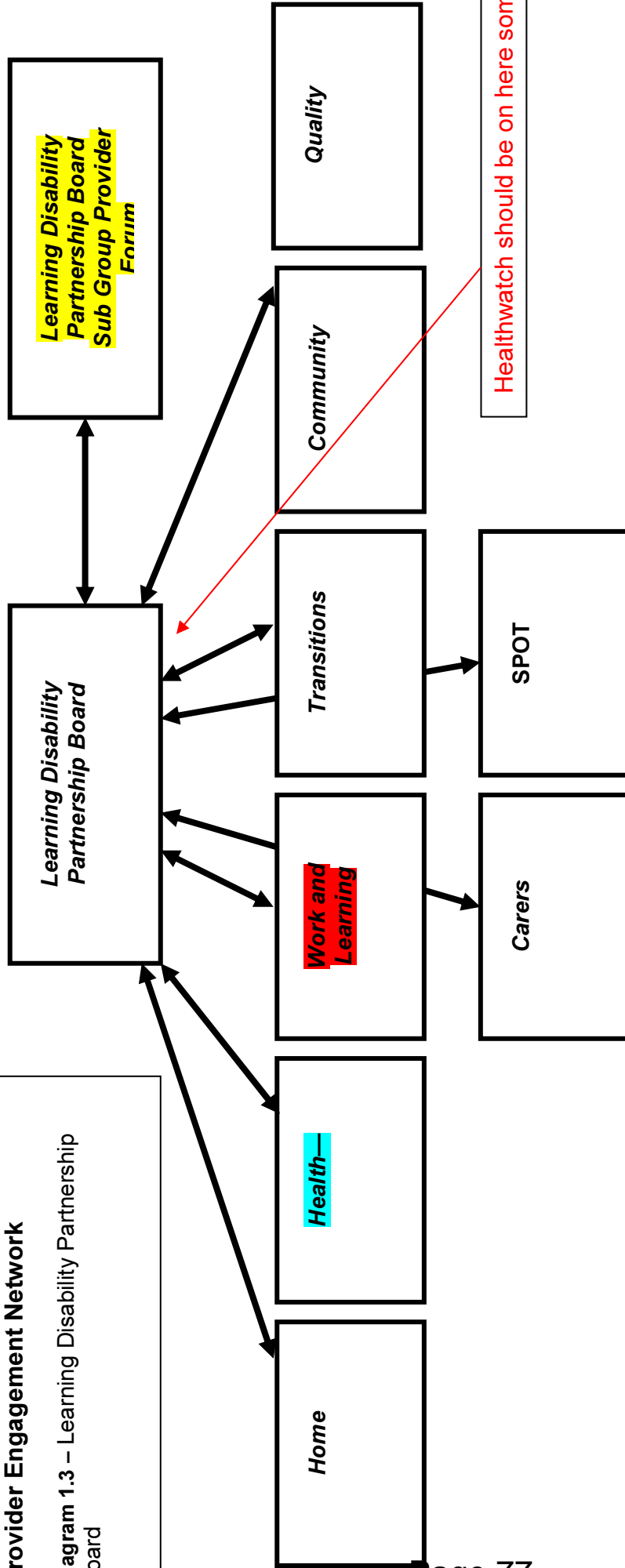


Provider Engagement Network

Diagram 1.2 – Torbay Quality Care Forum (TQCF)



Provider Engagement Network
 Diagram 1.3 – Learning Disability Partnership Board



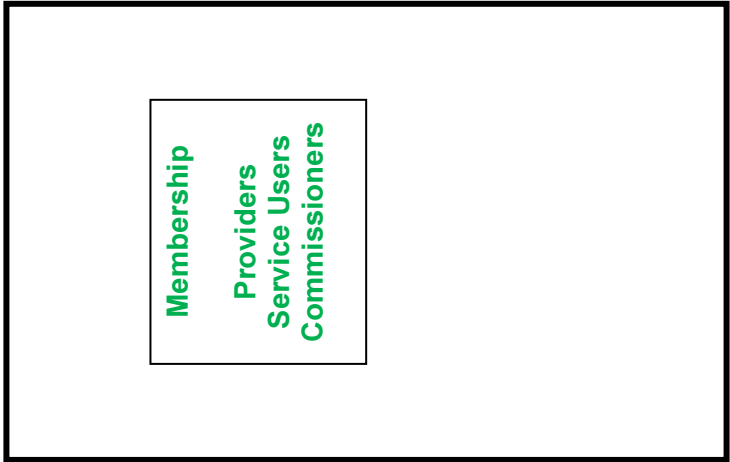
This is likely to be the new commissioner in future I would expect

LD provider forum not running at present been absorbed by larger provider forum but under debate about how this works

Work and learning forms a sub group of the worklessness forum too and is being redeveloped as the Disability employment action group

Provider Engagement Network
Diagram 1.4 – Older Peoples Mental Health
LIG

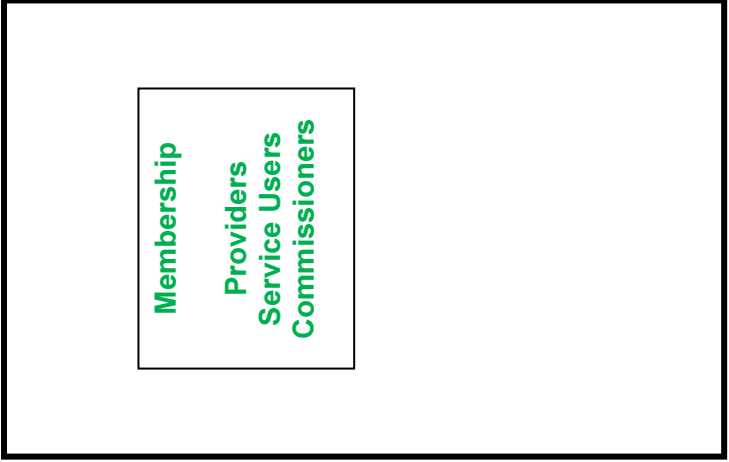
**Older Peoples Mental
Health
LIG**



**Membership
Providers
Service Users
Commissioners**

Provider Engagement Network
Diagram 1.5 – Adult Mental Health LIG

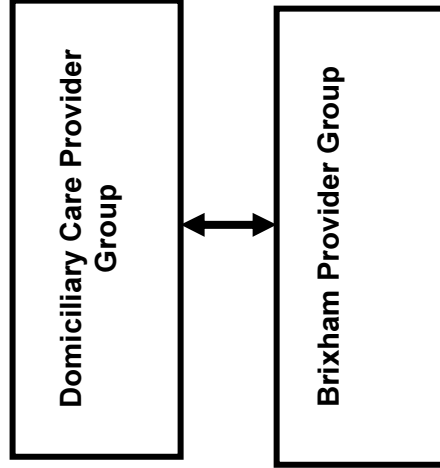
Adult Mental Health LIG



**Membership
Providers
Service Users
Commissioners**

Provider Engagement Network

**Diagram 1.6 – Domiciliary Care Provider Group
Brixham Provider Group**



Unsure if this has now changed under the umbrella of the Business Support Unit given that commissioning and provider has split form the trust

Provider Engagement Network
Diagram 1.7 – Supporting People Provider Sub Groups

Supporting People

Older Peoples strategy Sub group

Physical disability Strategy Sub group

Learning disability Strategy Sub group

Mental Health Strategy Sub group

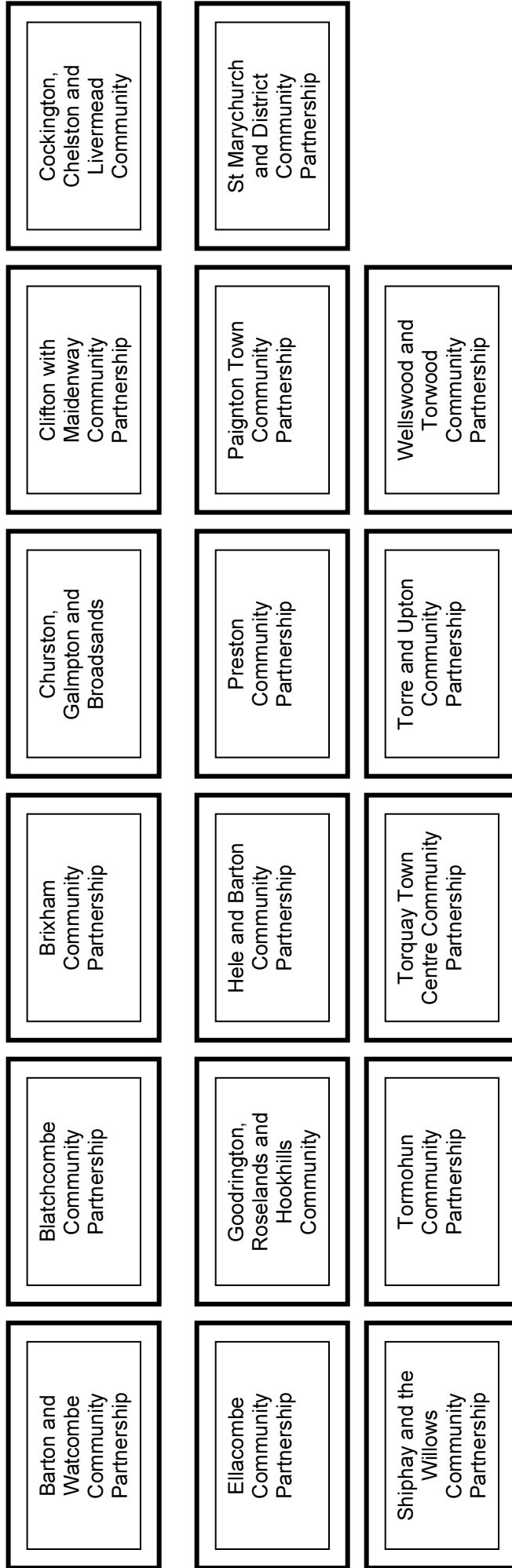
Children families and Young people Strategy Sub group

Homelessness, criminal justice and substance misuse Strategy Sub group

As far as I am aware these groups are no-longer functioning - The LD one is a repeat of the home group – it became the same group we have been restarting it as the Home group after the changes to the way SP works

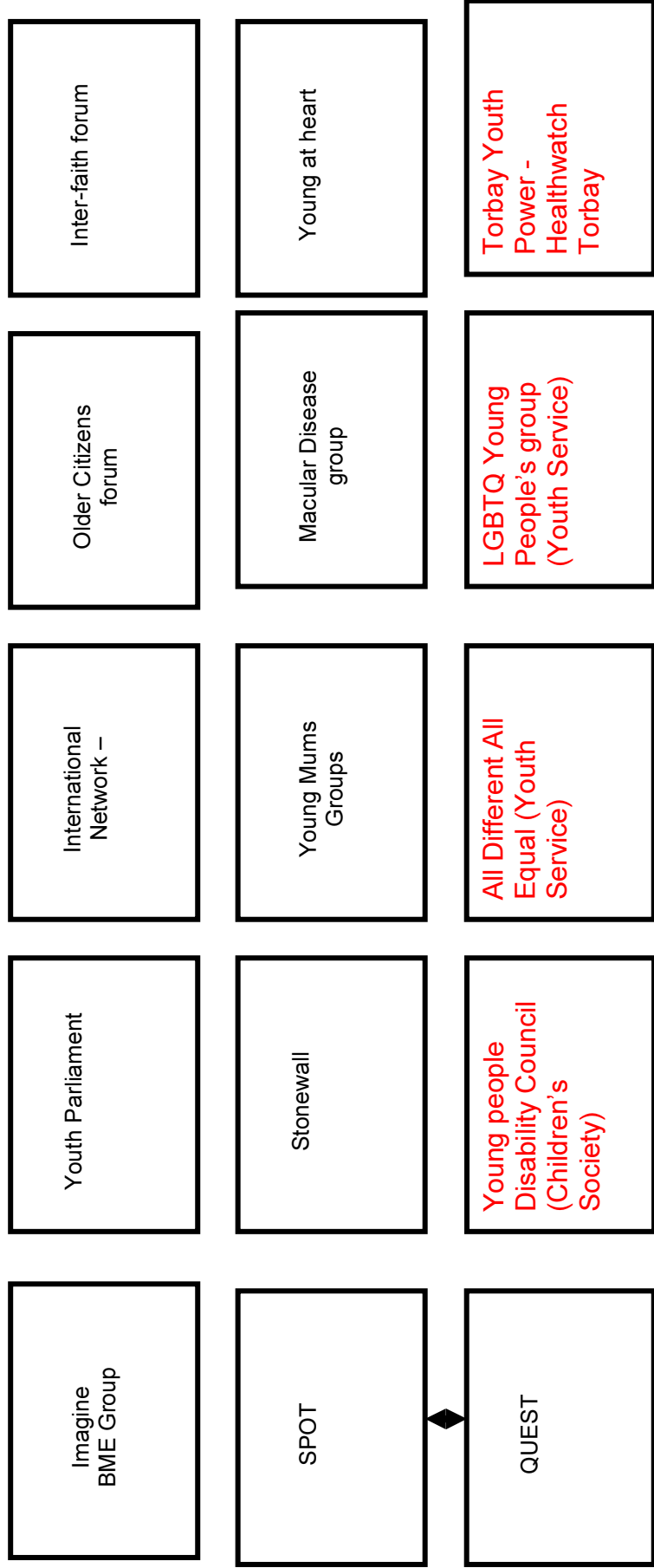
Provider Engagement Network
Diagram 3.2 Community Partnerships

Community Partnerships

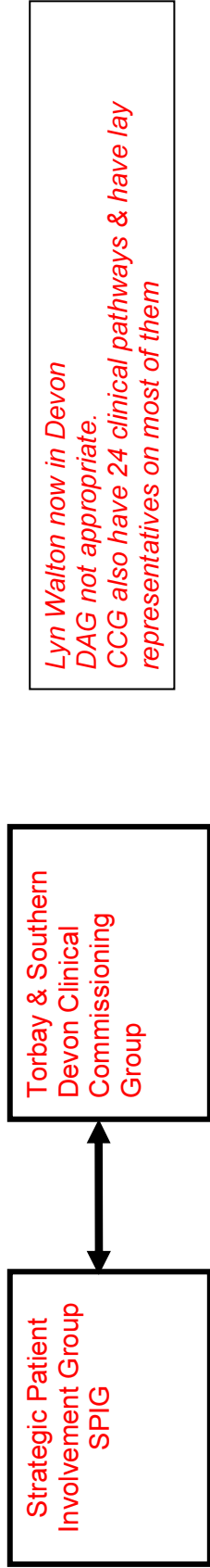


Provider Engagement Network
 Diagram 3.4 Torbay Equality Engagement
 Groups

Torbay Equality
 Engagement
 Groups (3.4)



Provider Engagement Network
Diagram 3.6 SPIG



*Not sure if DAAG should be included somewhere- Hospital Disability engagement group
ACE aren't mentioned but maybe hidden in one of the other groups
I funded some work via Living options but this work has been ended – at the moment*

Provider Engagement Network
Diagram 1.7 – Supporting People Provider Sub Groups

Supporting People

Older Peoples strategy Sub group

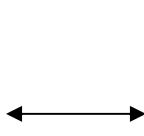
Physical disability Strategy Sub group

Learning disability Strategy Sub group

Mental Health Strategy Sub group

Children families and Young people Strategy Sub group

Homelessness, criminal justice and substance misuse Strategy Sub group



Stroke Support Group

Action for Blind People

Coalition of Disabled People



SPO T Speaking Out in Torbay

BID Be Involved Devon

Epilepsy Action Group

Cool Recovery Group

Safeguarding structure

-

Torbay Strategic Partnership –
GONE not sure what replaced
with

Economy and Environment
Board

Health and Wellbeing
Board

Safer and Stronger
Communities Board

CHILDREN

Children's Trust

Young People's Substance Misuse Group

Be Healthy Operational Board

Positive Contribution now POSITIVE FOR YOUTH

Children's Improvement Board

Poverty Action Group

Health & Being Bo

- Young Inspectors
- School Councils
- In-Care Council
- Disability Council
- Young Carers
- FUNK
- UKYP
- FUNK/Play Torbay
- LGBTQI
- Youth Projects
- BME
- Healthwatch
- One-off groups/consultations

Also:

Early Years Forum

Maternity Services Liaison Committee

Other Groups: please note for accuracy and decide which section you would wish to be associated with:

Action for
Blind People

New Redvers

Torbay Deaf
Group

Cool
Recovery

Stroke Support
Group

Parkinsons'
Support
Group

Sensory
Disability
Group

Intercom
Trust

Coalition of
Disabled People

Epilepsy
Action Group

Macular
Degeneration

Disability Service

Eddystone
Trust
(HIV and
sexual
health)

Living
Options

Multiple Sclerosis
Society

HOUSING ASSOCIATION

Westcountry
Housing
Society

Sanctuary
Housing

Think there are more HA in Torbay now – not sure
who

Agenda Item 17

Outcome 3 Improved Mental Health and Wellbeing

Mental health is everyone's business. As *No Health Without Mental Health* states, 'good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.'

At any one time, roughly one in six of us is experiencing a mental health problem. We need to build resilience, promote mental health and wellbeing, and challenge stigma and discrimination. We need to prevent mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families

We want all residents in Torbay to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

Priority 15

Improve care for people living with dementia and their carers

- Provide education and awareness programmes which will improve earlier diagnosis rates
- Commission a dementia advisor service to enable easy access to care, support and advise following diagnosis
- Ensure appropriate use of antipsychotics, by continuing to audit and monitor local prescribing
- Continue to commission the third sectors in delivery of peer support services
- Improve care in care homes by considering the benefits of a specialist liaison service to work proactively with residential and nursing homes by providing advice, support and an awareness and education programme

This paper provides a brief overview of dementia and carers in Torbay.

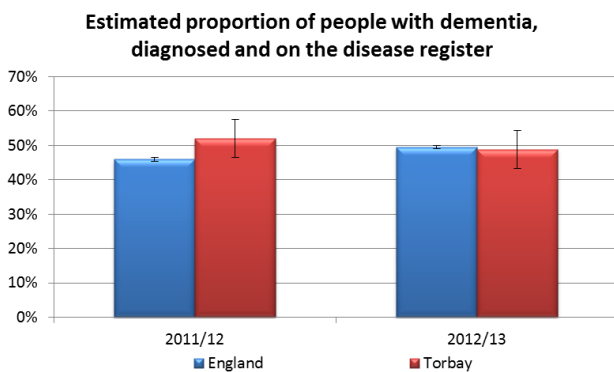
Dementia is a syndrome (a group of related symptoms) that is associated with an on-going decline of the brain and its abilities. While it is not possible to prevent all cases of dementia, there are some measures that can help prevent vascular dementia.

The number of people with dementia is increasing. In Torbay there are around **1,250** registered patients on the dementia disease register (just under 4% of the over 65 population). However, population level prevalence estimates suggests the number of persons with dementia is nearer **2,500** (around 7.5% of the over 65 population).

This difference represents a potential level of unmet need within the population in the order of **1,250** (around 3.7% of the over 65 population).

Around half of those that are estimated to have dementia are known to their GP. This is a similar to the national proportion.

Figure 1: Estimated dementia diagnosis



Source: QOF, POPPI and Torbay Council

There are different forms of dementia

- Alzheimer's disease (AD): 62%
- Vascular dementia (VaD): 17%
- Mixed dementia (AD and VaD): 10%
- Dementia with Lewy bodies: 4%
- Fronto-temporal dementia: 2%
- Parkinson's dementia: 2%
- Other dementias: 3%

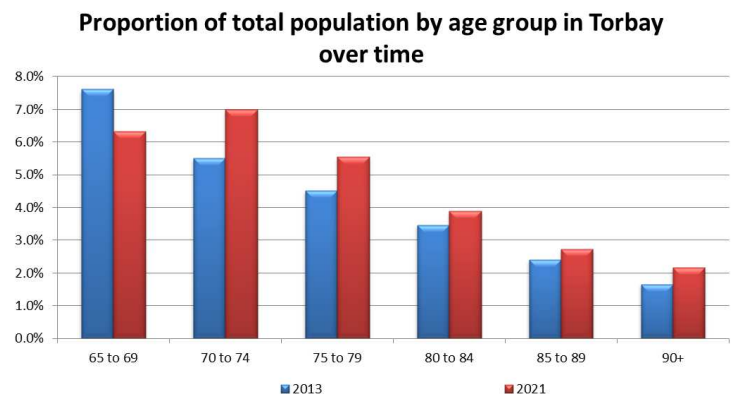
Alzheimer's disease:

The two main risk factors for Alzheimer's disease are **age** and **family history**. These risk factors also feature for the other forms of dementia.

Vascular dementia:

Risk factors associated with vascular dementia include, **age, high blood pressure, stroke, diabetes** and **smoking**.

Figure 2: Torbay's aging population



Source: ONS 2011 based population projections

The proportion of unpaid carers in Torbay is amongst the highest in England, and has increased considerably between censuses. Around 16,100 (12.3%) of all people (of all ages) provide some degree of unpaid care in Torbay. We do not know how many carers care for someone with dementia.

Census - provision of unpaid care (1 or more hours)		2001 census	2011 census	Change
England		9.9%	10.2%	3.2%
South West	% of all people	10.1%	10.8%	7.3%
Torbay	Count	13,881	16,107	16.0%

The table below shows the outcomes, overarching indicators and improvement areas from the adult social care, NHS and public health outcome frameworks that could contribute to this priority.

Adult Social Care Outcomes Framework 2013–14	
Domain 1: Enhancing quality of life for people with care and support needs	<p>Overarching measure 1A. Social care related quality of life</p> <p>Outcome measures <i>People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.</i></p> <p>1B. Proportion of people who use services who have control over their daily life <i>Carers can balance their caring roles and maintain their desired quality of life.</i></p> <p>1D. Carer-reported quality of life <i>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.</i></p> <p>1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.</p>
Domain 3: Ensuring people have a positive experience of care and support	<p>Overarching measure <i>People who use social care and their carers are satisfied with their experience of care and support services.</i></p> <p>3A. Overall satisfaction of people who use services with their care and support 3B. Overall satisfaction of carers with social services 3E: Improving people's experience of integrated care</p> <p>Outcome measures <i>Carers feel that they are respected as equal partners throughout the care process.</i></p> <p>3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for <i>People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.</i></p> <p>3D. The proportion of people who use services and carers who find it easy to find information about support <i>People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.</i></p> <p>This information can be taken from the Adult Social Care Survey and used for analysis at the local level.</p>
NHS Outcomes Framework 2013–14	
Domain 2: Enhancing quality of life for people with long term conditions	<p>Overarching indicator 2 Health-related quality of life for people with long-term conditions</p> <p>Improvement area <i>Ensuring people feel supported to manage their condition</i></p> <p>2.1 Proportion of people feeling supported to manage their condition <i>Enhancing quality of life for carers</i></p> <p>2.4 Health-related quality of life for carers <i>Enhancing quality of life for people with dementia</i></p> <p>2.6 i Estimated diagnosis rate for people with dementia 2.6 ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life</p>
Domain 4: Ensuring that people have a positive experience of care	<p>Improvement area <i>Improving people's experience of integrated care</i></p> <p>4.9 Indicator in development</p>
Public Health Outcomes Framework 2013–16	
Domain 4: Healthcare public health and preventing premature mortality	<p>Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.</p> <p>4.16 Estimated diagnosis rate for people with dementia</p>

REPORT TO: Health and Wellbeing board			
TITLE OF REPORT:	Living Well with dementia – Torbay Update		
PREPARED BY:	Ann Redmayne		
	Mental Health Commissioning Manager		
CONTRIBUTORS:	Dr Nick Cartmell		
DATE PREPARED:	May 2013	DATE OF MEETING:	May 23 rd 2013
Please indicate below to show which Quality issue this report covers and for which period:			
MONTH OR PERIOD COVERED	Position statement as at May 2013		
QUALITY DOMAIN (please tick all that apply)	PATIENT SAFETY	<input checked="" type="checkbox"/>	PATIENT EXPERIENCE <input checked="" type="checkbox"/>
	EFFECTIVENESS/OUTCOMES	<input checked="" type="checkbox"/>	
<p>1. <u>Introduction</u></p> <p>1.1 The prevalence of dementia doubles with every 5 year increase in age. Dementia is therefore essentially an illness of old age. It is estimated that currently there are 700,000 people with dementia living in the United Kingdom. The cost to the economy is estimated as £17- £18 billion. The population is aging and over the next 30 years the number of people is expected double.</p> <p>1.2 The improvement of dementia services has received increasing attention over the past 10 years, starting with the inclusion of a standard relating to mental health services in the <i>National Service Framework for Older People, DH, 2000</i>, the development of a set of clinical guidelines for effective and efficient dementia care produced by The National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE), <i>Dementia, Supporting people with dementia and their carers, NICE/SCIE, 2006</i> and culminating in the publications of the National Dementia Strategy, <i>Living Well with Dementia: A National Dementia Strategy, DH, 2009</i> and 'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy' (DoH 2010). This document will play a central role in ensuring that the needs of people with dementia become and remain a priority.</p> <p>1.3 Living Well with Dementia, the first ever National Dementia Strategy was published in February 2009. It provides a clear pathway for improving the support available to people living with dementia, their families and their carers. As its title suggest, the emphasis is on living well with dementia throughout the course of the illness, at whatever stage people receive a diagnosis and in whatever setting they are living or receiving care.</p> <p>1.4 The National Dementia Strategy has identified 17 key objectives (see appendix 1), which when implemented will result in significant improvements in the quality of services provided to people living with dementia and should promote a greater understanding of the consequences of dementia .</p> <p>1.5 Further to the National Dementia Strategy 2009 the Prime Minister David Cameron announced a personal challenge for dementia on Friday 25th May 2012. In that announcement he reiterated the National Dementia Strategy and aims to build a focus in three areas:</p>			

- Driving improvement in health and care – by going further and faster on implementing the National Dementia Strategy
- Increasing awareness – by creating dementia friendly communities
- Accelerating research into dementia

1.6 Strategic direction is set and monitored through the Mental Health and Learning Disability Redesign Board, linking with the Devon-wide Joint Dementia Steering Group, chaired by Dr Nick Cartmell (Ashburton GP and SHA/ South Devon CCG GP Dementia Lead) and implementation at a local level through the Local Older People's Mental Health Implementation Group (OPMH LIG) chaired by Dr Richard Montgomery (Torbay's GP Dementia Lead)

1.7 This report aims to illustrate progress continues to be made against the strategy and to communicate the South Devon and Torbay CCG's dementia commissioning intentions for 2013-14.

2. National Strategic priorities

2.1 2012-13 operating framework requires PCT's to publish their dementia implementation plan

- Good quality early diagnosis and interventions for all
- Improved quality of care in General Hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic drugs

2.2 2013-14 NHS Outcomes framework

Domain 2: Enhancing quality of life for people with long term conditions

- Estimated diagnosis rate or people with dementia
- A measure of effectiveness of post-diagnosis care in sustaining independence and improving quality of life

3. South Devon and Torbay Dementia Commissioning intentions

3.1 Key outcomes to be achieved:

- Timely (early) diagnosis and intervention – more than 55% of prevalence will have a formal diagnosis of dementia (GP QOF register) by 2015. Current rates – Torbay 47%, Devon 35.7% (*Source: Alzheimer's Society: Mapping the Dementia Gap 2012 – Progress on improving diagnosis of dementia 2011-2012*). Agreed post diagnosis intervention pathway to ensure people living with dementia are able to access timely and effective support to sustain independence and improve quality of life for the individual and their carer/family
- Improved quality of care in acute and community hospitals for people living with dementia and their carers by the implementation of the SHA dementia hospital standards, leading to improved user and carer experience. Improved accessed to specialist psychiatric liaison.
- Enabling people with dementia to live well in care homes. Reducing acute admissions from care homes, improved quality of life outcomes, advance directives, appropriate antipsychotic medication prescribing and improved staff satisfaction
- Improved awareness, reduced discrimination and stigma (dementia friendly community)

3.2 Key pieces of work in the next year to achieve outcomes:

We will continue to implement the dementia strategy and the Prime Minister Dementia Challenge:

Key work areas:

- Early diagnosis and interventions, including:
 - Publish dementia care pathway (Map of Medicine). Agree care pathway for at risk groups e.g. people with learning disabilities, BME background
 - Primary care role in the diagnostic pathway
 - Agree the model and implement high quality memory clinics across the CCG, based on a “one stop” model where possible. Capital improvement – through a successful dementia environmental challenge fund bid
 - Agree and develop interventions and support following diagnosis
 - Ensure access to anti-dementia drugs
 - Acute care screening of all acute admissions over 75 (National CQUIN)
 - Raising awareness through the development of dementia friendly communities
 - Establish locality sensitive dementia prevalence data to inform future commissioning intentions
 - Support other professions to identify and promote the benefits of early diagnosis e.g. pharmacist, district nurses
- Support the development of dementia friendly communities (Norms Mc Namara, Torbay Dementia Alliance)
- Appropriate prescribing of anti-psychotic prescribing for people living with dementia
- We will work with the independent sector to ensure Individuals with dementia live well in care homes by developing a Torbay and South Devon Dementia Care Home Learning Community.
- Improving quality of care for people living with dementia and their carer’s in acute and community hospitals by continuing to implement the dementia hospital standards developed by the SHA Expert Reference Group. We will continue to embed and evaluate the Liaison Psychiatry Service at Torbay Hospital. High quality liaison psychiatry services such as Rapid Assessment interface and Discharge (RAID) have been shown to save money for the NHS by reducing hospital admissions and length of stay. Collaborative care arrangements outside hospital can also improve people’s ability to manage their own health and offer a cost-effective way of joining up mental and physical healthcare for people with Long Term Conditions. We will review the RAID model and work with key stakeholders to develop services to meet local needs.
- Building voluntary and community sector capacity to provide an appropriate level of services are available to support people living with dementia and their carers e.g. memory cafés, orientation programmes post diagnosis, dementia advisors, peer support services, with the aim to prevent crisis, acute admissions and delay in the need for residential care.
- Addressing carer’s needs – develop an innovative range of services to need the needs of those who care for people with dementia
- Keeping people safe – by the use of GPS tracking for those with dementia who are at risk of wandering

Assurances:

Please outline in this section any targets or performance measures that the provider is expected to meet and the evidence that gives assurance. Please include charts, tables or any other visual aid that

would demonstrate the findings/assurances. Please keep your text concise,

The South Devon and Torbay Mental Health Redesign group will continue to monitor progress.

Issues arising:

Please outline in this section any issues that have been identified – e.g. is the provider failing to meet expected quality requirements or standards? How has the issue been addressed? What is the timeframe for getting back on track?

No major issues identified – all key stakeholders are committed to improving care for people living with dementia and their carers; however some of the planned improvements are reliant on securing additional resources particularly to address inequities across South Devon and Torbay.

Risks:

Please outline in this section if there is an indication of risk to patient safety, patient experience or clinical effectiveness or expected outcomes. Please rate the risk – high, medium, low and outline the actions that have been put in place to mitigate the risk. Does this risk need to be escalated?

Identified risks includes:

Sustainability of services funded through charitable funding. (Peer support services). (South Devon issue only)

Further action

APPENDIX 1**NATIONAL DEMENTIA STRATEGY OBJECTIVES**

- Objective 1: Improving public and professional awareness and understanding of dementia.
- Objective 2: Good-quality early diagnosis and intervention for all.
- Objective 3: Good-quality information for those with diagnosed dementia and their carers.
- Objective 4: Enabling easy access to care, support and advice following diagnosis
- Objective 5: Development of structured peer support and learning networks.
- Objective 6: Improved community personal support services.
- Objective 7: Implementing the Carers' Strategy.
- Objective 8: Improved quality of care for people with dementia in general hospitals.
- Objective 9: Improved intermediate care for people with dementia.
- Objective 10: Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers.
- Objective 11: Living well with dementia in care homes.
- Objective 12: Improved end of life care for people with dementia.
- Objective 13: An informed and effective workforce for people with dementia.
- Objective 14: A joint commissioning strategy for dementia.
- Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.
- Objective 16: A clear picture of research evidence and needs.
- Objective 17: Effective national and regional support for implementation of the Strategy.

Agenda Item 17

Appendix 3

To: Chairs of Health and Wellbeing Boards

Dear Colleagues

As you may know, the Prime Minister launched a 'Challenge on Dementia' in March 2012 to deliver major improvements in dementia care and research by 2015.

The National Dementia Strategy Programme Board, chaired by the Minister for Care Services Norman Lamb MP, has been tasked with going further and faster to deliver for people with dementia and their family carers. Three sub-groups have been formed to lead on: creating dementia-friendly communities, better research, and driving improvements in health and care.

We are the co-chairs of the Health and Care Sub-Group and we, with the support of the Local Government Association, are writing to ask for your commitment to the Dementia Challenge and your assistance in taking this important agenda forward.

A number of key commitments were made by the Prime Minister as part of the March 2012 launch. I'd therefore like to ask that your local health and wellbeing board considers:

- Reviewing your local Dementia Strategy with particular emphasis on enablement and intermediate care access for people with dementia, accommodation solutions, end of life support and health and social care workforce development
- Ensuring the needs of people with dementia and their carers are part of the Joint Strategic Needs Assessment process
- Whether you need to make dementia a priority in your Joint Health and Wellbeing Strategies.
- Signing up to the National Dementia Declaration and joining your Local Dementia Action Alliance to work with local partners to drive forward improvements for people with dementia in your area (link below).

We are also asking health and wellbeing boards nationally to sign up to the *Dementia Care and Support Compact* – found in Annex B of the challenge document. Please consider publicising this on your websites, stating how you will fulfil this commitment and asking your local Health Trusts to do the same.

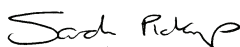
We would also encourage you to ask your Acute Hospital Trusts to sign up to the call to action – the Right Care: creating dementia friendly hospitals (link below). This will allow hospitals in your area to gain access to support and advice on becoming more dementia friendly including supporting people with dementia to be discharged back home.

The Prime Minister has asked the National Dementia Strategy Board to provide a formal update on progress by March 2013. We would encourage

you to share your progress through the Dementia Challenge 'Get Involved' website. Some useful online resources are listed below.

For more information or to send in best practice, please use the Dementia Challenge email address: dementiachallenge@dh.gsi.gov.uk

Yours sincerely



Sarah Pickup,
President, Association
of Directors of Social
Services



Sir Ian Carruthers OBE, Chief
Executive,
NHS South of England



and Councillor David
Rogers OBE
Chair, LGA Community
Wellbeing Board

Online resources:

Number 10 Press Launch

<http://www.number10.gov.uk/news/a-day-to-remember-dementia-campaign-launches/>

Dementia Challenge Documents

<http://www.dh.gov.uk/health/2012/03/pm-dementia-challenge/>

Dementia Challenge – Get Involved

www.dementiachallenge.dh.gov.uk

Local Government Association – Adult Social Care resources

<http://www.local.gov.uk/adult-social-care>

National Dementia Declaration and Dementia Action Alliance

http://www.dementiaaction.org.uk/info/5/join_the_alliance

Right Care: creating dementia friendly hospitals

http://www.dementiaaction.org.uk/info/2/action_plans/165/the_right_care_creating_dementia_friendly_hospitals

Prime Minister's challenge on dementia

Delivering major improvements in
dementia care and research by 2015



DH INFORMATION READER BOX

Policy HR / Workforce Management Planning / Clinical	Estates Commissioning IM & T Finance Social Care / Partnership
Document Purpose	For Information
Gateway Reference	17392
Title	Prime Minister's Challenge on Dementia - Delivering major improvements in dementia care and research by 2015
Author	Older People & Dementia Team
Publication Date	26 March 2012
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Emergency Care Leads
Circulation List	Directors of Finance, Voluntary Organisations/NDPBs, Council of Deans of Health, Medical Royal Colleges
Description	This document sets out the Prime Minister's challenge on dementia, an ambitious programme of work to push further and faster to deliver major improvements in dementia care and research by 2015, building on the achievements of the existing National Dementia Strategy.
Cross Ref	Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	James Davison Social Care Policy - Older People & Dementia Room 8E13, Quarry House Quarry Hill, Leeds LS2 7UE 0113 2547377 www.dh.gov.uk/dementia
For Recipient's Use	

PRIME MINISTER'S CHALLENGE ON DEMENTIA

*Delivering major improvements in dementia care
and research by 2015*

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Prime Minister's foreword

Imagine feeling confused and afraid because close friends and relatives seem like strangers; being unable to leave the house alone because you might not be able to find your way back; or seeing the fear in your loved one's face, as they struggle to make sense of familiar surroundings.

For many people in this country, this is the reality of everyday life. 670,000 people in England are living with dementia. An estimated twenty one million people in our country know a close friend or family member with dementia – that's 42% of the population. One in three people aged over 65 will have dementia by the time they die. And as life expectancy increases, more and more people will be affected.

Dementia is one of the biggest challenges we face today – and it is one that we as a society simply cannot afford to ignore any longer. We have made some good progress over the last few years, but there's still a long way to go.

Our research knowledge on dementia lags behind other major diseases such as cancer or heart disease. People with dementia and their carers still face a lack of understanding from public services, businesses and society as a whole. And as many as half of all dementia sufferers in this country are unaware that they have the condition, meaning that they cannot get the help that they and their families need.

So I am determined that we will go further and faster on dementia – making life better for people with dementia and their carers, and supporting the research that will ultimately help us slow, stop and even prevent the condition. Of course the Government doesn't have all the answers, and we can't fix everything overnight. But with a sustained and concerted effort from all parts of society, I believe we can make a real difference – and we are determined to do so.



Introduction

After a century of advances in medical science, sanitation and nutrition, people today are living longer than ever before. This is an extraordinary success story, but one that presents challenges as well as opportunities.

One in three people over the age of 65 will develop dementia. In England in 2012, 670,000 people have dementia – equivalent to the combined populations of Bristol and Leicester. This number will double in the next 30 years.

Among the over-55s, dementia is feared more than any other illness. And at an estimated £19 billion a year, the cost to our economy is huge. It is estimated that this is higher than the costs of cancer, heart disease or stroke. We have not only a moral imperative to improve dementia care – there is a strong financial one too.

Living Well with Dementia – A National Dementia Strategy (2009), was one of the first strategies of its kind in the world. It set the standard for improving the lives of people with dementia, for their families and their carers, through raising awareness, encouraging earlier diagnosis and providing high-quality treatment and care.

Three years on, and we've made progress (see Box 1). But we need to do more. We need to push further and faster to improve radically the quality of life for people living with dementia, their families and carers by 2015.

Box 1: Progress on improving dementia care

- **94% of primary care trusts (PCTs) now have a dedicated memory service for dementia**, and a further 4% are planning to set up a memory service in the future, according to the first national audit of memory services published in September 2011. The average number of people using memory services per PCT increased by 57% between 2008/9 and 2010/11 (from 605 to 951).
- **The NHS and Social Care, working together with wider partners, have taken forward initiatives to reduce the prescribing of antipsychotic drugs for people with dementia to improve quality of life** with a view to achieving overall a two thirds reduction in the use of antipsychotic medicines. However, more needs to be done.
- **More than 90 leading organisations have joined the Dementia Action Alliance (DAA) since October 2010**. Organisations from health, social care, and the voluntary and commercial sectors are working together to help improve the quality of life for people with dementia, their carers and families.
- **A Dementia Commissioning Pack was launched in July 2011**, to guide NHS commissioners in getting the best possible outcomes for people with dementia and the best value for money.

The ambition

We want to make a real difference to the lives of people with dementia. Building on the National Dementia Strategy, we believe that the UK can be a world leader in dementia care and research.

People with dementia, their families and carers have told us what is important to them and what will help them to live well with dementia. They say they want to receive an early diagnosis and timely, good-quality information that will help them make informed choices about their care. They want the treatment and support they receive to be the best for their dementia and life, regardless of whether they are cared for at home, in hospital or in a care home.

The Health and Social Care Bill will improve quality and choice of care for people with dementia and their carers. GPs and other clinicians who come into regular contact with people with dementia and their carers will have the primary responsibility for commissioning health and care services, which should ensure that they get the care that they need and want.

The forthcoming Care and Support White Paper will benefit people with dementia and their carers too, giving them more choice and control over their care, better information, and better-quality care.

But we will need to do more. The PM's Challenge on Dementia is a challenge to the whole of society as well as government. It will focus on three key areas:

- **Driving improvements in health and care**
- **Creating dementia friendly communities that understand how to help**
- **Better research**

As well as driving up the quality of care, work in these three areas should help to reduce future pressures on the NHS and social care.

Annex A sets out the full list of the actions being taken forward across the three areas.

Key commitments

Driving Improvements in health and care

- 1. Increased diagnosis rates through regular checks for over-65s.** We will ensure that GPs and other health professionals will make patients aged 65 and older aware of memory clinics and refer those in need of assessment. From April 2013, there will be a quantified ambition for diagnosis rates across the country, underpinned by robust and affordable local plans.
- 2. Financial rewards for hospitals offering quality dementia care** From April 2012, £54m will be available through the Dementia Commissioning for Quality and Innovation (CQUIN) to hospitals offering dementia risk assessments to all over-75s admitted to their care. From April 2013, this will be extended to the quality of dementia care delivered. Also for April 2013, access to all CQUIN rewards will be dependent on delivering support for carers in line with the National Institute for Health and Clinical Excellence (NICE)/Social Care Institute for Clinical Excellence (SCIE) guidelines.
- 3. An Innovation Challenge Prize of £1m** NHS staff can win up to £1m for innovative ideas for transforming dementia care.
- 4. A Dementia Care and Support Compact signed by leading care home and home care providers** Ten leading organisations have set out their commitment to deliver high-quality relationship-based care and support for people with dementia, and to engage and involve the wider community in this work.
- 5. Promoting local information on dementia services** We will promote the information offer pioneered by NHS South West, which will be launched on 28 March 2012 and rolled out across the south by the end of 2012. From April 2013, similar information will be available in all other parts of the country. We will also be setting out in the Care and Support White Paper further steps to ensure that all people receiving care and support get better information to support their care choices.

Creating dementia friendly communities that understand how to help

- 6. Dementia-friendly communities across the country** By 2015, up to 20 cities, towns and villages will have signed up to become more dementia-friendly.
- 7. Support from leading businesses for the PM's Challenge on Dementia** Leading national organisations have already pledged to look at how they and others can play a part in creating a more dementia friendly society and raising awareness of dementia.
- 8. Awareness-raising campaign** From autumn 2012, we will invest in a nationwide campaign to raise awareness of dementia, to be sustained to 2015. This will build on lessons learned from previous campaigns and will inform future investment.
- 9. A major event over the summer, bringing together UK leaders from industry, academia and the public sector,** to take forward the PM's Challenge on Dementia.

Better research

- 10. More than doubling overall funding for dementia research to over £66m by 2015**
The combined value of the National Institute for Health Research (NIHR), Medical Research Council (MRC) and Economic and Social Research Council (ESRC) funding

for research into dementia will increase from £26.6m in 2009/10 to an estimated £66.3m in 2014/15.

- 11. Major investment in brain scanning.** MRC will make a major additional investment in dementia research using the BioBank. MRC anticipates piloting the brain scanning of a subset of this national cohort, with a view to rolling out to 50,000–100,000 participants.
- 12. £13m funding for social science research on dementia (NIHR/ESRC).**
- 13. £36m funding over 5 years for a new NIHR dementia translational research collaboration to pull discoveries into real benefits for patients. Four new NIHR biomedical research units in dementia and biomedical research centres which include dementia-themed research will share their considerable resources and world-leading expertise to improve treatment and care.**
- 14. Participation in high-quality research** Offering people the opportunity to participate in research will be one of the conditions for accreditation of memory services.

Driving improvements in health and care

The implementation of the National Dementia Strategy is beginning to improve the lives of people with dementia, but we need to do more to improve the quality of care. Failure to act will mean our health and social care services will struggle under the pressure of increasing numbers of people with dementia. **We must ensure that every person gets the treatment and support which meets their needs and their life.**

The NHS reforms will improve quality and choice of care for people with dementia and their carers. GPs and other clinicians who come into regular contact with people with dementia and their carers will have the primary responsibility for commissioning health care, which should ensure that they get the care that they need and want. The forthcoming Care and Support White Paper will set out a range of proposals that will benefit people with dementia and their carers, giving them more choice and control over their care, better information, and a greater assurance of quality. Our reforms will enable a much more integrated approach with health and social care services centred around people's needs.

Better diagnosis

Currently only 42% of people with dementia in England have a formal diagnosis. The diagnosis rate varies – from 27% in the worst-performing areas to 59% in the best. Too often, diagnosis comes too late – during a crisis or beyond the point where people can plan for the future and make informed choices about how they would like to be cared for. This is not good enough.

Surveys show us that people with dementia would like early diagnosis. And we know that with early intervention, and access to the right services and support, people with dementia can continue to live well for many years.

The people most at risk of developing dementia (the over-75s) see their GP at least once, if not several times, a year. Around 97% of people aged over 75 go to their GP surgery at least once a year, and around 87% at least once every six months.

Key commitment 1

Increased diagnosis rates through regular checks for over-65s We will ensure GPs and other health professionals make patients aged 65 and older aware of memory clinics and refer those in need of assessment. From April 2013, there will be a quantified ambition for diagnosis rates across the country, underpinned by robust and affordable local plans.

Clinical commissioning groups and local health and wellbeing boards will be encouraged to work with wider local partners to improve diagnosis rates. We will incentivise improved diagnosis rates by including a new indicator in the NHS Outcomes Framework 2013/14.

Improving care in hospitals

A quarter of all hospital beds are occupied by someone with dementia, and many hospitals struggle to provide the high-quality care that meets the needs of people with dementia. But others get it right. There are examples of excellent and innovative practice across care settings. We need to support this good practice and encourage it to develop and spread.

Key commitment 2

Financial rewards for hospitals offering quality dementia care From April 2012, £54m will be available through the Dementia CQUIN to hospitals offering dementia risk assessments to all over-75s admitted to their care. From April 2013, this will be extended to the quality of dementia care delivered. Also for April 2013, access to CQUIN rewards will be dependent on delivering support for carers in line with NICE/SCIE guidelines.

Key commitment 3

An Innovation Challenge Prize of £1m NHS staff can win up to £1m for innovative ideas for transforming dementia care.

Improving standards in care homes and domiciliary care

While many care homes and care-at-home services offer excellent support for people with dementia, some are not doing enough. We need to make sure that whether people are being cared for in their own home, or in care homes, the staff who work with them have the knowledge and skills to help them lead as fulfilling a life as possible.

Key commitment 4

A Dementia Care and Support Compact signed by leading care home and home care providers. Ten leading organisations have set out their commitment to deliver high-quality relationship-based care and support for people with dementia, and to engage and involve the wider community in this work.

Better information for people with dementia and their carers

People with dementia and their families and friends would like better information about health and care services. They want to know what they are entitled to, so that they can be sure they are getting all the support they need. Greater transparency in health and care services can also drive up quality and empower people with dementia and their carers.

But currently, the quality of advice and information which people receive is variable. In all too many areas, it is extremely difficult for people with dementia to find out what support is available and to what they are entitled to.

In 2011/12, primary care trusts were asked to work with their local authorities to publish dementia plans which set out the progress they were making locally towards implementing the National Dementia Strategy. We will do preparatory work that will mean that clinical commissioning groups, working with health and wellbeing boards, are able to go further and provide a transparent local information offer to support people with dementia and, crucially, their carers.

Key commitment 5

Promoting local information on dementia services We will promote the information offer pioneered by the NHS South West, which will be launched on 28 March 2012 and rolled out across the south by the end of 2012. From April 2013, similar information will be available in all other parts of the country. We will also be setting out in the Care and Support White Paper further steps to ensure that all people receiving care and support get better information to support their care choices.

In the South West, the local NHS, local authorities and the Alzheimer's Society have produced a web-based information service called Our Health. This uses the NICE quality standards and other evidence to provide information on the support people with dementia should expect to receive. Our Health describes the different services available across the South West, how they can be accessed, and the quality of care they are likely to receive. People also have the opportunity to give feedback on their experience.

Better support for carers

There are around 550,000 people in England acting as the primary carers for people with dementia. Carers for people with dementia save the nation nearly £7 billion every year. Research shows that carers of people with dementia experience greater strain and distress than carers of other older people.

We want to see better support for carers. The NHS is now required to work closer than ever before with local carers' organisations and councils to agree plans, pool their resources and make sure that carers get the support and break they deserve. We have provided an additional £400m to the NHS between 2011 and 2015 to provide carers with breaks from their caring responsibilities to sustain them in their role. The NHS should also ensure that a range of psychological therapies and support is available to carers of people with dementia in line with NICE/SCIE dementia guidelines.

The NHS and Social Care working together with wider partners should continue to reduce inappropriate prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medication.

CHAIR OF THE CHAMPION GROUP

Co-chair: Sir Ian Carruthers

Co-chair: Sarah Pickup

Case study: A personal experience of early diagnosis

I was diagnosed with dementia six years ago at the age of 50. Although I struggled for three years to get my diagnosis because of my young age, I was still able to receive my diagnosis while in the early stages. I first noticed symptoms 10 years ago when I started to struggle in my job as a teacher – I was forgetting things and struggling to organise classes. I also lost my mathematical ability. I was put on Aricept straight after my diagnosis, which made a huge positive difference to my quality of life. Life doesn't have to end after receiving a diagnosis; you just have to start making choices. I have a very positive outlook and think it is extremely beneficial to have an early diagnosis as it enables you to make important choices and decisions that can help you live life well. I still enjoy playing tennis and regularly go on holiday.

Person with dementia

Creating dementia-friendly communities that understand how to help

The health and care system has a vital role to play in improving support for people with dementia. But alone it cannot combat the stigma attached to dementia. Lack of awareness among the public and poor understanding in communities has a major impact on the experience of people with dementia. This is a call to action across the whole of society. **We would like people living with dementia to be able to say that they know what they can do to help themselves and who else can help them, and that their community is working to help them to live well with dementia.**

Dementia-friendly communities

People living with dementia want to remain independent for as long as possible, and they want to have choice and control over their lives through all stages of their dementia. With an early diagnosis and the right support they can achieve this.

But this is not the experience of the vast majority of people living with dementia. Not only do they frequently have to battle for diagnosis and support, but everyday things we all take for granted – getting to the shops, spending time with friends and family, getting money from the bank, and going on holiday – are made difficult because of the limited understanding of dementia in their communities.

People with dementia talk about stigma and social isolation. They report losing friends following their diagnosis, seeing people cross the street to avoid them, feeling lonely, and struggling to use local services. Research with the general public has shown that this is often down to the fear, misunderstanding and helplessness people feel in the face of dementia. They simply do not understand enough to support someone to live well with dementia.

The common misunderstandings about dementia – that it's an inevitable part of ageing and that nothing can be done to improve people's lives – prevents our communities and society from becoming more dementia-friendly and meeting the needs of people with dementia and their families. As a society, we must make sure that people with dementia, their carers and families can be active citizens with the potential to live well with dementia at every stage of the condition.

Building more dementia-friendly communities will take time. The Alzheimer's Society will take the lead, working with members of the Dementia Action Alliance to create a formal dementia-friendly recognition process that will make villages, towns and cities accountable to people with dementia and their carers through local Dementia Action Alliances. They will identify what villages, towns and cities need to do to be recognised as dementia-friendly. Only villages, towns and cities that meet their criteria will be granted dementia-friendly community status.

Key commitment 6

Dementia-friendly communities across the country By 2015, up to 20 cities, towns and villages will have signed up to become more dementia-friendly.

Key commitment 7

Support from leading businesses for the PM's Challenge on Dementia. Leading national organisations have already pledged to look at how they and others can play a part in creating a more dementia-friendly society and raising awareness of dementia.

Public understanding

Despite the rising numbers of people living with dementia, public understanding of the condition is limited and populated with misconceptions. Poor understanding of dementia has a fundamental impact on the health and well-being of people with dementia. It can lead to their rights not being recognised and families and the economy being put under serious strain. People with dementia, their carers and families struggle to remain independent in a society that does not understand dementia or how to support those affected by dementia to live well with it.

Key commitment 8

Awareness-raising campaign From autumn 2012, we will invest in a nationwide campaign to raise awareness of dementia, to be sustained to 2015. This will build on lessons learned from previous campaigns and will inform future investment.

Key commitment 9

A major event over the summer, bringing together UK leaders from industry, academia and the public sector, to take forward the PM's Challenge on Dementia.

CHAIR OF THE CHAMPION GROUP

Co-chair: Angela Rippon

Co-chair: Jeremy Hughes

Case study: A dementia-friendly city – York

In York, the Joseph Rowntree Foundation is funding a year-long project exploring how local partners, including people who are living with dementia and their families, can make the city of York a better place for those affected by the condition. The Dementia Without Walls project will use the experiences of people with dementia, and those who support and care for them, to consider how life can be lived to the full. Also, drawing on examples of current best practice locally, nationally and internationally, the project will challenge people to think afresh, not only about health and social care services, but housing, shopping, leisure and transport. In other words, the everyday amenities that most people take for granted, but which can create enormous challenges for people with dementia. A core aim will be creating opportunities for people with dementia to experience different kinds of services. This will be done through ‘seeing is believing’ visits (to see different places and services where innovative approaches are being tried) and by sharing their experiences with other service users.

Better research

While the UK is considered one of the top five countries for dementia research, there are still major challenges, including significantly increasing dementia research capacity and capability; understanding better the mechanisms of the disease and likely targets for intervention; and translating research into practice that affects quality of life. **We would like people to feel confident that we are making significant progress towards prevention, treatment and cure in the UK, and to be able to say that they wanted to take part in research and were able to do so.**

Funding more high-quality research into care, cause and cure

Delivering on the commitment to enable people with dementia and their carers to participate in research will involve work to raise the volume of high-quality studies in the system – across the fields of care, cause and cure.

While it is important to ensure that all areas of scientific work are covered, consultation with experts in the field indicates that some of the greatest opportunities for further scientific progress – for finding the causes and cures for this devastating condition – lie at the early stage 'discovery' end of the scientific spectrum. There are also opportunities for social science research focused on living well with dementia and on the delivery of dementia care services.

Key commitment 10

More than doubling overall funding for dementia research to over £66m by 2015. The combined value of the NIHR, MRC and ESRC funding for research into dementia will increase from £26.6m in 2009/10 to an estimated £66.3m in 2014/15.

Key commitment 11

Major investment in brain scanning MRC will make a major additional investment in dementia research using the BioBank. MRC anticipates piloting the brain scanning of a subset of this national cohort, with a view to rolling out to 50,000–100,000 participants.

Note: The UK Biobank is the largest study in the world to determine the environmental and genetic factors that influence how we age, including the risks of developing dementia. This long-term programme has already recruited 500,000 people between the ages of 40 and 69.

Key commitment 12

£13m funding for social science research on dementia (NIHR/ESRC)

Key commitment 13

£36m funding over 5 years for a new NIHR dementia translational research collaboration to pull discoveries into real benefits for patients. Four new NIHR biomedical research units in dementia and biomedical research centres which

include dementia-themed research will share their considerable resources and world leading expertise to improve treatment and care.

Participation in research

Compared with other conditions such as cancer, the level of public engagement in research, by donation or by direct participation in studies, is low. When people are offered the opportunity to take part in the research, they are often keen to do so. However, people with dementia and their carers are not routinely offered the opportunity to participate in high-quality research and there is no nationally consistent system to enable them to do so, should they wish.

Key commitment 14

Participation in high-quality research *Offering people the opportunity to participate in research will be one of the conditions of accreditation for memory services.*

CHAIR OF THE CHAMPION GROUP

This work will continue to be led by the Ministerial Advisory Group on Dementia Research (MAGDR) on behalf of Paul Burstow MP, Minister of State for Care Services. The group itself will be co-chaired by Dame Sally C Davies and Sir Mark Walport.

Case study: Living Well with Dementia research

Topic: Living Well with Dementia: the contribution of dementia advisers and peer support networks

Funded by: DH Policy Research Programme: £650,000

Research team: School of Health in Social Science, University of Edinburgh

Background

The National Dementia Strategy (NDS) stresses the importance of promoting the quality of life and well-being of those living with dementia and their carers. As part of the implementation of the NDS, dementia advisers and peer support networks were established in 40 demonstrator sites across England. These have developed a range of different methods and approaches for enhancing the well-being and increasing the resilience of those living with the disease. Evaluation was built into the developments of the new service models from the beginning, both at a local level and nationally.

The study

The study's aims are threefold:

- to describe the range of dementia adviser and peer support organisational models developed; and their evolution, management and governance;
- to evaluate the impact of the new service models in terms of:
 - the well-being of patients and carers;
 - their contribution to the objectives of the NDS;
 - the integration, sustainability and transferability of the organisational models involved.
- to examine in depth the patient/carer experience of the new service models, in respect of increasing accessibility, improving involvement and information, enhancing support for making choices, and increasing independence.

Progress

The study began on 1 April 2010 and is due to complete in September 2012. Interim findings indicate:

- strengthened partnership working;
- increased awareness of dementia on the part of providers;
- support provided being seen to fill a 'gap' in existing provision;
- a perceived reduction in carer stress;
- appreciation from other providers of the value of the new services;
- a reduction in demand for statutory services; and
- a network built on the commonality of experience.

Next steps

The commitments set out in the Prime Minister's Challenge on Dementia will be taken forward by a range of partners across health and social care, the research and industry sector, and broader society. Three **champion groups** will bring together leading organisations and groups with an interest, to support the delivery of the commitments and to mobilise wider engagement. The champion groups will report on progress to the Prime Minister through Department of Health (DH) ministers. Each will comprise co-chairs and 10–15 members drawn from key sectors, including health and social care, industry and the third sector.

Champion groups

Driving improvements in health and care

Co-chairs: Sir Ian Carruthers (NHS South West) and Sarah Pickup (ADASS)

Creating dementia-friendly communities that understand how to help

Co-chairs: Jeremy Hughes (Alzheimer's Society) and Angela Rippon

Better research

Led by the existing Ministerial Advisory Group on Dementia Research (MAGDR), with the work co-chaired by Dame Sally C Davies and Sir Mark Walport (Wellcome Trust)

Measuring progress

Progress will be reported to the Prime Minister in September 2012. Thereafter progress will be reported to the Prime Minister in March 2013 and the Department of Health will review future reporting arrangements.

Conclusion

Dementia is undoubtedly one of the major health and social care issues of our time. Until recently it was also one of the most ignored. The National Dementia Strategy has made a good start in addressing the needs of people with dementia, but we need to make more rapid progress. The wide range of new measures in this document demonstrate the Government's commitment on tackling dementia. By 2015, we intend that every person with dementia will be able to say the following:

"I get the treatment and support which are best for my dementia and my life."

"I know what I can do to help myself and who else can help me. My community is working to help me to live well with dementia."

"I wanted to take part in research and was able to do so."

Through research, we will in time find a cure. But until we do, every effort must and will be made to improve the lives of people with dementia and their families and carers.

Annex A: List of actions

Driving improvements in health and care

- **Increased diagnosis rates through existing checks for over-65s** We will ensure that GPs and other health professionals make patients aged 65 and older aware of memory clinics and refer those in need of assessment. From April 2013, there will be a quantified ambition for diagnosis rates across the country, underpinned by robust and affordable local plans.
- **Financial rewards for hospitals offering quality dementia care** From April 2012, £54m will be available through the Dementia CQUIN payment framework to hospitals offering dementia risk assessments to all over-75s admitted to their care. From April 2013, this will be extended to the quality of dementia care delivered. Also, for April 2013 access to all CQUIN rewards will be dependent on delivering support for carers in line with the NICE/SCIE guidelines.
- **An Innovation Challenge Prize of £1m** NHS staff can win up to £1m for innovative ideas for transforming dementia care.
- **A Dementia Care and Support Compact signed by leading care home and home care providers** Ten leading organisations have set out their commitment to deliver high-quality relationship-based care and support for people with dementia, and to engage, involve the wider community in this work.
- **We will promote the information offer pioneered by the NHS South West, which will be launched on 28 March 2012 and rolled out across the south by the end of 2012** From April 2013, information will be available in all other parts of the country. We will also be setting out in the Care and Support White Paper further steps to ensure all people receiving care and support get better information to support their care choices.
- **We will work with the profession to identify how best to improve early diagnosis of dementia through improvements in awareness, education and training and through potential improvements to the GP contract.**
- **We will ask NICE to consider ways of improving the dementia indicators in the Quality and Outcomes Framework.**
- **We will call on the Royal Colleges to respond to the challenge of dementia by bringing forward plans to ensure that all their members are capable and competent in dementia care.** The Royal Colleges have committed to driving this forward.
- **We will ensure that memory clinics are established in all parts of the country, and will work with the Royal College of Psychiatrists to drive up the proportion of memory services that are accredited, through publication of their national Memory Services Accreditation Programme, so that individual organisations can benchmark and report their own performance to drive improvement.**

- **The NHS will guarantee a written integrated personalised care plan to people with dementia.**
- **There will be better support for carers** The NHS is required to work closer than ever before with local carers' organisations and councils to agree plans, pool their resources, and make sure that carers get the support and break they deserve and that young carers do not take on excessive or inappropriate caring roles. We have made available an additional £400m to the NHS between 2011 and 2015 to provide carers with breaks from their caring responsibilities to sustain them in their role.
- **Carers have the right to be assessed and their needs met** In addition we know carers can take their support as a personal budget and they are encouraged to do so. The NHS should also ensure that a range of psychological therapies are commissioned and made available to carers of people with dementia in line with NICE/SCIE guidelines, as well as ensuring services are made available to support the couple relationship where one person is caring for a partner with dementia.
- **By September 2012 we will launch pilots of dementia clinical networks aimed at spreading clinical expertise.**
- **We welcome the Nursing and Care Quality Forum's forthcoming views on what should be done to address the needs of people with dementia as part of its work to spread best practice in nursing and care in all care settings.**

Creating dementia friendly communities that understand how to help

- **Dementia-friendly communities across the country** By 2015, up to 20 cities, towns and villages will have signed up to become more dementia-friendly.
- **Support from leading businesses for the PM's Challenge on Dementia** Leading national organisations have already pledged to look at how they and others can play a part in creating a more dementia-friendly society and raising awareness of dementia.
- **Awareness-raising campaign** From autumn 2012, we will invest in a nationwide campaign to raise awareness of dementia, to be sustained to 2015. This will build on lessons learned from previous pilot campaigns and will inform future investment.
- **A major event over the summer, bringing together UK leaders from industry, academia and the public sector, to take forward the PM's Challenge on Dementia.**
- **We will work with the Alzheimer's Society to develop local Dementia Action Alliances to bring together people with dementia, their carers and key organisations, funded by £537,000 from the Department of Health over three years.**
- **We will make sure that people with dementia and carers on diagnosis have an information pack about dementia produced in conjunction with the Alzheimer's Society.**

- **The Dementia-friendly Communities Programme working in partnership with the Dementia Action Alliance will develop evidence on what a dementia-friendly community is.**

Better research

- **More than doubling overall funding for dementia research to over £66m by 2015.** The combined value of the NIHR, MRC and ESRC funding for research into dementia will increase from £26.6m in 2009/10 to an estimated £66.3m in 2014/15.
- **Major investment in brain scanning** MRC will make a major additional investment in dementia research using the BioBank. MRC anticipates piloting the brain scanning of a subset of this national cohort, with a view to rolling out to 50–100,000 participants.
- **£13m funding for social science research on dementia (NIHR/ESRC)** including £3m for public health research.
- **£36m funding over 5 years for a new NIHR dementia translational research collaboration to pull discoveries into real benefits for patients. Four new NIHR biomedical research units in dementia and biomedical research centres which include dementia themed research will share their considerable resources and world leading expertise to improve treatment and care.**
- **Participation in high-quality research** Consent to participate in research will be one of the conditions of accreditation for memory services.
- **The MRC will spend over £3m in supporting the UK brain bank network, which connects all the UK brain banks for the benefit of donors, researchers and future patients** This includes £500k a year to improve the process for donation of brain tissue by meeting the costs of collecting brain tissue through the NHS, so smoothing the pathway to donation.
- **A major event will be staged for pharmaceutical and biotech companies to showcase the benefits of conducting dementia research in the UK, and to assess how best to remove the barriers to doing so.**
- **We will work towards recruiting 10% of patients into clinical trials.**
- **Up to £9m of DH funding will be made available for research into ‘living well with dementia’ and the delivery of dementia care.**
- **The DH will increase its support for capacity-building in dementia research, focusing on nurses as well as doctors.**
- **The MRC is a leading partner in two international initiatives in the area of neurodegeneration research: the European ‘Joint Programming’ initiative which aims to coordinate national efforts in this area; and the Centres of Excellence Network in Neurodegeneration (CoEN) which seeks to add value to existing investments in excellence.**

- **The world-leading MRC Laboratory of Molecular Biology (LMB) is moving to its new £200m facilities in Cambridge in the autumn** Within this, the Neuroscience Research Division has been provided with an expanded budget of £29m over the next three years, with a major part of its research dedicated to dementia/neurodegeneration.
- **The NIHR has also just completed a first-ever themed call for proposals in dementia research** Some £17m will be committed to new research projects through this call, exceeding original expectations. The 18 projects to be funded range from work on better diagnosis to improving care in a wide range of settings, from individual's own homes, through residential care to specialist hospitals.

Annex B: Dementia Care and Support Compact

Introduction

This Dementia Care and Support Compact is our response to the Prime Minister's Challenge on Dementia. It sets out our commitment to supporting the delivery of the National Dementia Strategy and improving care and support for people with dementia, their carers and families.

Our challenge

We challenge the perceptions surrounding social care services for people with dementia. Our services will provide the right care, in the right place, at the right time.

People with dementia using our services will be able to say:

- I am respected as an individual.
- I get the care and support which enables me to live well with my dementia.
- Those around me and looking after me are well supported and understand how to maximise my independence.
- I am treated with dignity and respect.
- I know what I can do to help myself and who else can help me.
- I can enjoy life.
- I feel part of a community and I am inspired to participate in community life.
- I am confident that my end-of-life wishes will be respected. I can expect a good death.

Our commitment

We will:

- focus on quality of life for people with dementia, as well as quality of care. By knowing the person, their life history and their personal culture, our staff will deliver a personalised package of care and support;
- set a benchmark for high-quality relationship-based care and support for people with dementia. We will inspire and encourage our sector to take responsibility for delivering this, building on existing good practice;
- engage and involve the wider community to improve their support for people with dementia, including GPs and healthcare professionals;
- play our part in supporting the wider community, sharing the knowledge and skills of our staff, and inviting people into our care settings;
- work with commissioners of care for people with dementia to ensure they commission quality care services appropriately; and
- clearly set out how we have delivered on this Compact to make a difference for people with dementia, their carers and families. This will link into the work on quality and transparency being taken forward as part of the Care and Support White Paper.

Signatories

Martin Green, Chief Executive, English Community Care Association and DH Independent Sector Dementia Champion

Jane Ashcroft, Chief Executive, Anchor

Mike Parsons, Chief Executive, Barchester Healthcare

Stuart Fletcher, Chief Executive, BUPA

Mike Parish, Chief Executive, Care UK

Miranda Wixon, Executive Committee Member, CERETAS

Ted Smith, Chief Executive, European Care

Dr Peter Calverley, Chief Executive, Four Seasons Healthcare

Fiona Lowry, Chief Executive, Good Care Group

Dr Bridget Warr, Chief Executive, United Kingdom Home Care Association



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TORBAY CARE TRUST
DEMENTIA STRATEGY

2009-2012

"We can no longer ignore dementia, or pretend that is an inevitable part of the aging process. A strategic, cross-cutting approach is vital if we are to deal with the challenges and consequences of dementia as a society"

(Department of Health, 2008)"

Torbay Dementia Strategy

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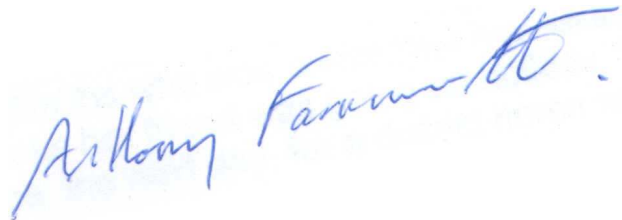
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1.0 FORWARD

"We can no longer ignore dementia, or pretend that is an inevitable part of the aging process. A strategic, cross-cutting approach is vital if we are to deal with the challenges and consequences of dementia as a society" (Department of Health, 2008)"

"Dementia is a condition that imposes a good deal of distress on those who are living with it and for their families. It is especially important for us here in Torbay because we have a large and growing population of older people. Much can be done. Early assessment followed by support and care for carers, care in hospital settings and care in residential and nursing homes all requires development.

We are fortunate in Torbay in having good local services and some fantastic commitment from the voluntary sector. We have a large task ahead, but the National Strategy clearly sets out the direction we should take. We welcome this and are committed to improving our local services. Some of our first steps are set out in this strategy; the task will take effort and resources over a sustained period to provide to the standards which vulnerable people and their carers have every right to expect."

A handwritten signature in blue ink, reading "Anthony Farnworth". The signature is written in a cursive style and is positioned above the printed name and title.

Acting Chief Executive,
Torbay Care Trust

2.0 Executive Summary

- 2.1 Recent reports and research have highlighted the shortcomings in the current provision of dementia services in the UK. Dementia presents a huge challenge for Torbay now and even more so in the future due to our higher than the national average elderly population. It is anticipated that the local incidence of dementia will increase from 2,929 in 2010 to 4,930 in 2030. Torbay Care Trust currently spends £10,312,000 on mental health services for older people. Research suggest that costs will treble over the next 30 years
- 2.2 Whilst the numbers and costs are daunting, the impact on those with the illness and their families is overwhelming. Dementia is a progressive disease, resulting in a decline in memory and reasoning functioning, communication skills and skills need to carry out activities of daily living. The needs of such individuals are complex and often can not be provided by one agency alone.
- 2.3 The National Dementia Strategy has identified 17 key objectives which when implemented will result in significant improvements in the quality of services provided to people living with dementia and should promote a greater understanding of the consequences of dementia.
- 2.4 This strategy has been developed following extensive consultation with users, carers and other key stakeholders. The strategy builds on the National Dementia Strategy: Living Well with dementia (DoH 2009) and the findings of the Strategic Health Authority Peer Review (summer 09).
- 2.5 The Torbay Dementia Strategy aims to provide a framework to implement improved responsiveness and quality services for people living with dementia and their carers across Torbay and improved health outcomes. The implementation of this strategy will be phased over the next 3 years as it is recognised that within Torbay, dementia is a key priority for improvement.
- 2.6 The focus of the Torbay Dementia Strategy is:
 - To raise awareness and understanding of dementia within the general public
 - To ensure there is early diagnosis, support and intervention for people living with dementia and their carers
 - To provide a higher quality of care to enable people to live well with dementia at all stages of the illness.
- 2.7 This strategy will be a catalyst for change in the way people living with dementia are viewed and cared for within Torbay. The implementation of this strategy will ensure that people with dementia and their carers are supported throughout and receive the highest possible standard of care

3.0 INTRODUCTION

Impact of dementia

- 3.1 It is estimated that currently there are 700,000 people living with dementia in England with this figure likely to double over the next 30 years in the absence of any medical breakthrough in treatment. Dementia costs the UK economy £17 billion per year, with the costs in the next 30 years rising to £50 billion a year. In cost of illness studies, the direct costs of Alzheimer's disease alone exceed the combined cost of stroke, cancer and heart disease. In addition the prevalence of dementia is linked to increasing age (Everybody's Business). The number of people aged over 65 will increase by 15% and the number of people over the age of 85 will increase by 27% hence, as the number of older people in the population continues to rise, it is likely that the future costs of dementia care will increase considerably.
- 3.2 All types of dementia are progressive, involving physical and mental deterioration, usually over the course of several years, and culminate in the person's death, either directly or indirectly.
- 3.3 Few would dispute that any form of dementia can be deeply distressing for both the person living with the condition as well as their family and friends. However, it is also clear that there is a vast amount that can be done to improve and maintain quality of life in dementia.

Definition of dementia

- 3.4 The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses in which there is a progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop Behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness.
- 3.5 The causes of these illnesses are not well understood to date but they all result in structural and chemical changes in the brain leading to the death of brain tissue. The main sub-types of dementia are: Alzheimer's disease, vascular dementia, mixtures of these two pathologies ('mixed dementia') and rarer types such as Lewy body dementia, dementia in Parkinson's disease and fronto-temporal dementia. The term 'Alzheimer's disease' is used sometimes as a shorthand term to cover all forms of dementia.
- 3.6 The dementias all share the same devastating impact on those affected and their family carers. Dementias affect all in society irrespective of gender, ethnicity and class. They can affect adults of working age as well as older adults. People with learning disabilities are a group at particular risk
- 3.7 The dementias all share the same devastating impact on those affected and their family carers. Dementias affect all in society irrespective of gender,

ethnicity and class. They can affect adults of working age as well as older adults. People with learning disabilities are a group at particular risk

- 3.8 Dementia is a terminal disorder, although people may live with their dementia for 7 – 12 years after diagnosis.

The National Dementia Strategy – Living well with dementia

- 3.9 The first national dementia strategy was published in February 2009 – Living well with dementia – A National Dementia Strategy, (Department of Health). The National Dementia Strategy identified 17 key objectives (Appendix 1) which when implemented will result in significant improvements in the quality of services provided to people living with dementia and their carers and should promote a greater understanding of the consequences of dementia.
- 3.10 The National Dementia Strategy builds on three key steps to improve the quality of life for people with dementia and their carers:
- To ensure better knowledge about dementia and to remove the stigma that still surrounds it as well as improving education and training for professionals
 - To ensure that people with dementia are properly diagnosed
 - To develop a range of services for people with dementia and their carers which fully meets their changing needs over time

Torbay Dementia Strategy

- 3.11 The Torbay Dementia Strategy aims to provide a framework to implement the Nation Dementia Strategy and to implement improved, responsive and quality service, improved health and well being related outcomes, for people living with dementia and their carers across Torbay. The strategy has been developed following extensive consultation with people living with dementia, carers and other key stakeholders (Torbay care trust, Devon Partnership Trust, Aged Concern, Alzheimer's Society, Independent Providers) and been informed by the Strategic Health Authority Peer review which took place on the 30th June and 1st July 2009.
- 3.12 The focus of the Torbay Dementia Strategy is:
- To raise awareness and understanding of dementia with the general public
 - To ensure there is early diagnosis, support and intervention for people living with dementia and their carers
 - To provide a higher quality of care to enable people to live well with dementia
 - To ensure appropriate support is available for carers
 - To implement the National Dementia Strategy

Purpose of the Torbay Dementia Strategy

- 3.13 The purpose of the strategy is to provide a framework for local services to deliver quality improvements to dementia services, addressing health inequalities relating to dementia and ensuring delivery on key ambitions and performance indicators.

- 3.14 This strategy will be a catalyst for change in the way that people living with dementia are viewed and cared for within Torbay. The implementation of this strategy will ensure that people living with dementia and their carers are supported throughout and receive the highest possible standard of care resulting in improved health outcomes and quality of life. We acknowledge this can only be achieved by transcending existing boundaries and partnership working between statutory providers, commissioners, the third sector and users and carers.

The Torbay vision

- 3.15 The vision in Torbay is for people with dementia and their family carers to be helped to live well and improve the quality of their life, no matter what the stage of their illness or where they are in the health and social care system. Transformation of dementia services will ensure that in the future all people with dementia have access to the appropriate care and support. In order to achieve this vision, the following needs to take place:
- the public and professionals are well informed about dementia and the fear and stigma associated with the illness has been dispelled by changing public and professional attitudes, understanding and behaviour
 - families affected by dementia will know where to go for help and what services are available, and where the quality of care is exceptional
 - make early diagnosis and treatment the rule rather than the exception
 - enable people with dementia and their carers to live well with their condition by the provision of good quality care for all from diagnosis to the end of life, in the community, in hospitals and in care homes
- 3.16 Full implementation of the Torbay Dementia Strategy will ensure that all people with dementia and those that care for them will have the best possible healthcare and support. Improving health and social care outcomes in dementia in the short and medium term can have significant benefits for society both now and in the future.
- 3.17 The Torbay Dementia Strategy follows the National Dementia Strategy in taking an outcome focused approach and therefore is divided into three broad themes and this is replicated in this strategy:
- raising awareness and understanding
 - early diagnosis and support
 - living well with dementia

4.0 Key Drivers

4.1 With the publication of Forget me not, the Audit Commission's report on older people's mental health services (Audit Commission, 2000) and the National Service Framework for Older People (Department of Health, 2001) dementia began to become a priority for public policy in the UK. More recently the profile has risen significantly in both media and policy terms, particularly as a result of the publication of several key reports and guidance, including:

- Everybody's Business, (DoH 2005)
- Forget me not (Audit Commission 2002)
- Sainsbury Centre for Mental Health reviewed older people's mental health services in Devon and Torbay (2005)
- Twilight period (J. Delves 2002)
- Death by Indifference (DoH 2007)
- Supporting people with dementia and their carers (National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence, 2006)
- NICE guidance
- Dementia UK (Alzheimer's Society, 2007a)
- Improving services and support for people with dementia (National Audit Office, 2007)
- Home from home (Alzheimer's Society, 2007b)
- See me, not just the dementia (Commission for Social Care Inspection, 2008)
- Always a last resort (All Party Group on Dementia, 2008)
- Dementia – Out of the shadows (Alzheimer's Society, 2008)
- Living well with dementia: A national Dementia Strategy (DH 2009)

4.2 Messages from the above give consistent messages which includes the increasing challenge that dementia poses to health and social services because of the rising number of people affected, the importance of overcoming existing obstacles to early diagnosis and intervention, and the need to improve the consistency and quality of care and support for people with dementia and their carers.

4.3 In February 2009 the DoH published the first National strategy – Living well with dementia: A National Dementia Strategy. The strategy contains three key themes:

- Improving public and professional awareness of dementia
- Better early diagnosis and intervention
- Ensuring high care and support.

4.4 Few people who are involved in the field of dementia would challenge the importance of these objectives. Torbay Care Trust's dementia strategy build on these aims and expand how they will be implemented in such a way at a local level to ensure we really make a difference to those with dementia and their families who live in Torbay.

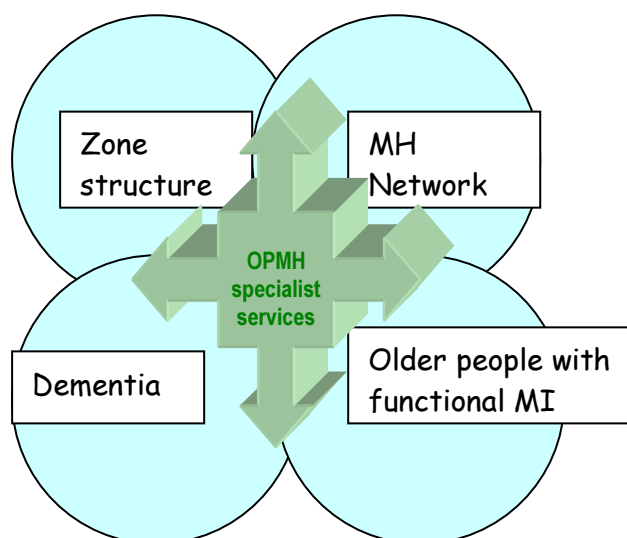
- 4.5 The NDS sets out a wide range of services that should be available to every person with dementia and their carers. The recommended services are based on:
- Evidence-based interventions
 - Services that people living with dementia and their carers told us during the NDS consultation
 - Recommendations from the SHA Peer review

5.0 National and Local Context

Background information

- 5.1 Torbay is a seaside resort area in a beautiful part of Devon. It has a population of approximately 140,000 which is growing due to inward migration. The forecasts are that the growth will continue at a rate of 1,200 each year. Torbay is made up of three towns; Torquay, Paignton and Brixham, Torquay is the largest with a population of around 64,000, Paignton has a population of around 49,000 and Brixham is far smaller with just under 18,000. Torbay is a popular place for retirement therefore accelerating the rate of increase of the older population constantly. There is also a high incidence of "fragmented families" – i.e. following the loss of a partner the individual is left living alone with family members living out of the area.
- 5.2 According to the 2001 census figures, Torbay has 28.6% of its population over the age of 60yrs, this compares with a national average for England and Wales of 20.9%. This means that there are approximately 37,900 people over the age of 60 yrs living in Torbay.
- 5.3 Torbay Key Facts:
- Torbay covers an area of just 64 square Kilometers (25 square miles)
 - Torbay has approximately 45 Kilometers (27 miles) of coast line with 20 public beaches
 - The average age of residents in Torbay is 43.7 years; higher than the England & Wales average of 39.2
 - Over 15,000 of Torbay's resident population live with an area in the top 10% most deprived in England
 - Torbay resident population has a higher prevalence of alcohol related deaths compared to the England & Wales. This may suggest a higher rate of people with alcohol-related dementia in the future.
 - Torbay is the 10th most populated authority in the South West while at the same time being the 8th smallest in area.
- 5.4 Torbay Care Trust delivers both social care and health services across a geographic area that is divided into 5 zoned area teams. The teams are multi-disciplinary and are based on GP surgeries in Torquay (north and south), Paignton (north and south) and Brixham.
- 5.5 Adult mental health services are provided by MH Networks: mental health networks have been developed and provide services with three component functions:
- Wellbeing and access
 - Urgent care
 - Recovery and independent living
- 5.6 OPMH specialist services (integrated health and social care team), deliver and support services for two main categories of older people and their carers, dementia (organic) & functional mental health problems, recognising that people do not necessarily fit these categories neatly and that flexibility (an aim for both networks & zones) will be required to meet individuals' needs.

- 5.7 Older people with mental health problems have complex needs which can only be met by Specialist Older people's mental health teams and generic health and social care teams. TCT aims to develop stronger links between generic zone teams by co-locating OPMH team members, the zone teams and primary care. A specialist hub will be retained at Chadwell.



National context

- 5.8 Dementia is one of the most severe and devastating disorder we can face. It is also very common. Key data illustrate the impact of dementia as follows:
- There are approximately 700,000 people with dementia in England
 - In just 30 years, the number of people with dementia is expected to double to 1.4 million
 - The national cost of dementia is about £17 billion per year
 - In the same 30 years, the cost will treble to over £50 billion per year
 - Dementia is predominantly a disorder of later life, but there are at least 15,000 people under the age of 65 who have the illness
 - Its incidence and prevalence rise exponentially with age
 - It affects men and women in all social groups
 - People from all ethnic groups are affected by dementia
 - The level of UK diagnosis and treatment of people with dementia is generally low, with a 24-fold variation in activity between highest and lowest activity by PCT
 - Care home placements for people with dementia costs the UK £8 billion per year with two-thirds paid by social services and one-third by older people and their families
 - Nationally there are over 500,00 family members who care for people with dementia which constitutes over £6 billion a year of unpaid care.

- International comparisons suggest that the UK is in the bottom third of European performance in terms of diagnosis and treatment, with less than half the activity of France, Sweden, Ireland and Spain

Local context

5.9 The Torbay GP registered population for Torbay, as at October 08, was 145,686. As incidence of dementia is directly related to the age profile of the population it is vital we consider the age profile of the zone in order to ensure services are developed to meet the need of the local zone population

5.10 The table below demonstrates the projected number of people aged 65+ with dementia in 2008 geographically across Torbay. The table illustrates that 26.3% of the population in Brixham is over 65 where as in South Torquay 16.7% of the population is over 65.

Zone	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
Total Pop	21,796	25,386	26,341	25,975	46,188	145,686
Pop aged 65+	5,732	5,678	5,874	5,580	7,709	30,573
Pop aged 40 to 64	8,039	8,820	9,118	9,148	15,807	50,932
Pop aged 65 to 69	1,615	1,470	1,398	1,444	2,155	8,082
Pop aged 70 to 74	1,358	1,255	1,308	1,324	1,788	7,033
Pop aged 75 to 79	1,067	1,121	1,138	1,114	1,408	5,848
Pop aged 80 to 84	866	897	1,012	832	1,177	4,784
Pop aged 85+	826	935	1,018	866	1,181	4,826

Zone	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
Total Pop	21,796	25,386	26,341	25,975	46,188	145,686
Pop aged 65+	26.3%	22.4%	22.3%	21.5%	16.7%	21.0%
Pop aged 40 to 64	36.9%	34.7%	34.6%	35.2%	34.2%	35.0%
Pop aged 65 to 69	7.4%	5.8%	5.3%	5.6%	4.7%	5.5%
Pop aged 70 to 74	6.2%	4.9%	5.0%	5.1%	3.9%	4.8%
Pop aged 75 to 79	4.9%	4.4%	4.3%	4.3%	3.0%	4.0%
Pop aged 80 to 84	4.0%	3.5%	3.8%	3.2%	2.5%	3.3%
Pop aged 85+	3.8%	3.7%	3.9%	3.3%	2.6%	3.3%

5.11 Zone population – April 2008

FEMALES	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
65 to 69	799	754	727	748	1,092	4,120
70 to 74	714	675	695	691	927	3,702
75 to 79	556	637	633	599	795	3,220
80 to 84	537	569	616	526	703	2,951
85+	567	651	716	612	821	3,367

MALES	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
65 to 69	816	716	671	696	1,063	3,962
70 to 74	644	580	613	633	861	3,331
75 to 79	511	484	505	515	613	2,628
80 to 84	329	328	396	306	474	1,833
85+	259	284	302	254	360	1,459

5.12 Estimated local prevalence

The following prevalence rates have been applied to estimate local prevalence data (source: POPPI):

Estimated Prevalence (%)	Female	Male
65-69	1	1.5
70-74	2.4	3.1
75-79	6.5	5.1
80-84	13.3	10.2
85+	25.2	19.7

5.13 The table below was produced by applying ONS sub national population by Sex and quinary age groups for 20008

Estimated Zonal Prevalence

FEMALES	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
65 to 69	8	8	7	7	11	41
70 to 74	17	16	17	17	22	89
75 to 79	36	41	41	39	52	209
80 to 84	71	76	82	70	93	392
85+	143	164	180	154	207	848
TOTAL	276	305	327	287	385	1,580

MALES	Brixham	North Paignton	North Torquay	South Paignton	South Torquay	Grand Total
65 to 69	12	11	10	10	16	59
70 to 74	20	18	19	20	27	103
75 to 79	26	25	26	26	31	134
80 to 84	34	33	40	31	48	187
85+	51	56	59	50	71	287

TOTAL	143	143	155	138	193	771
Overall Total	418	448	482	425	578	2,351

5.14 The above table suggests that as at April 2008 we should have expected there to be **2351** people living in Torbay with a diagnosis of dementia. However data from Torbay GP Dementia register identified **853** people with dementia (Quality Outcome Framework 06/07).

5.15 It is estimated that within Torbay only 36% of "true" dementia cases are recorded on practice registers. This means that approximately two thirds of dementia cases are undiagnosed.

5.16 Expected incidence of dementia in Torbay over the next 30 years:

Age Group	Prevalence	2008 Practice based profile of need	2007 MYE based profile of need	2010	2015	2020	2030
				2006 Based, 2008 Sub National Population Projections			
40 to 64	1 in 1,000	51	46	48	48	48	50
65 to 69	1 in 50	162	157	176	208	192	240
70 to 74	1 in 20	352	338	370	420	500	505
75 to 79	1 in 20	292	293	295	340	390	435
80 to 84	1 in 5	957	959	960	1,000	1,180	1,680
85+	1 in 5	965	1,036	1,080	1,180	1,340	2,020
TOTAL				2,929	3,196	3,650	4,930

The table above show the incidence of dementia is anticipated to more than double by 2030.

The table was produced by applying projected increases form ONS sub national population projections by sex and quinary age groups for 2010, 2015, 2020, 2030 (source: POPPI) to Mid-2007 Population Estimates for 2007 zones in England and Wales (Source ONS). Prevalence rates have been applied as described in 5.12

5.16 These zone level projections do not include projections for people with early onset dementia and people with a learning disability.

5.17 It has been reported that the learning disability community can experience a prevalence of approximately 4% above the general population. (Cooper 1997) with those who have Down 's syndrome at particular risk of developing dementia:

- 30-39 years 2%
- 40-49 years 9.4%
- 50-59 years 36.1%
- 60-69 years 54.5%

(Currently there are approximately 570 people with a known learning disability in Torbay)

6.0 Existing services, resources and benchmarking data

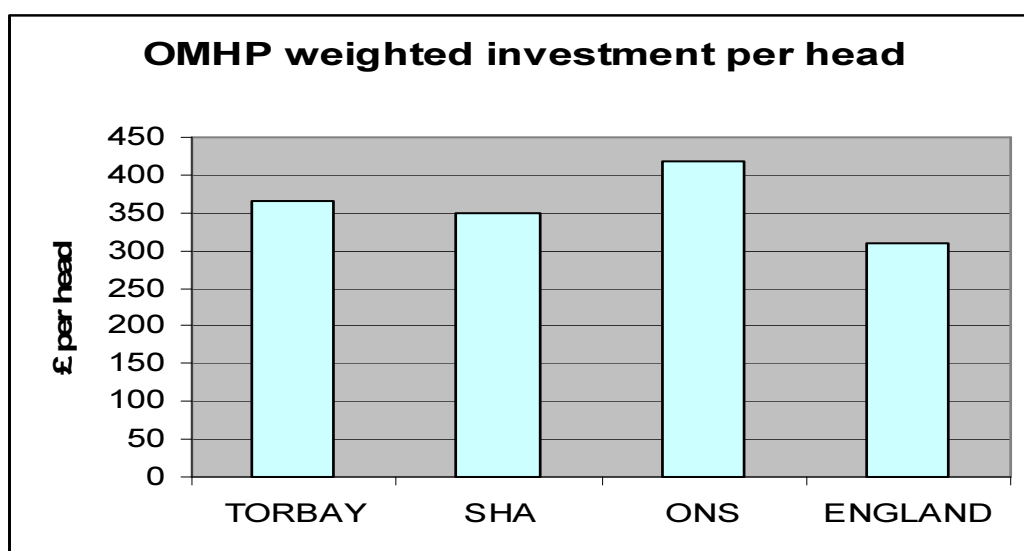
Financial data

6.1 For the first time in 2005, the Department of Health supported service financial mapping for specialist older people's mental health services. It has proved invaluable for local providers and commissioners to benchmark local services against national provision.

6.2 The 07/08 service and financial mapping information, along with local data, will be used to map current services and to ascertain current spend. However the data shown is for the spend on OPMH services and not just dementia services.

6.3 Overview of OPMHS investment

SERVICE CATEGORY	TORBAY	TORBAY	This SHA	THIS ONS	ENGLISH LITs
Direct Costs	£9,597	93%	85%	86%	83%
Indirect costs	£450	4%	6%	6%	7%
Overheads	£71	1%	7%	6%	8%
Capital Charge	£194	2%	3%	2%	3%
Total OPMHS	£10,312,000				

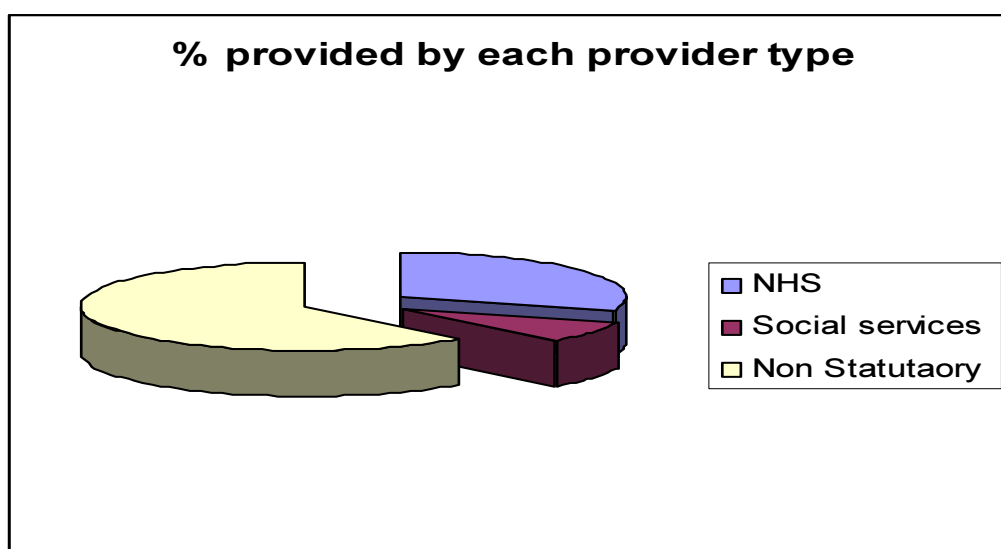


Torbay weighted investment in OPMH services per head - £365 (£15 per than the SHA average)

6.4 Torbay Investment in older people mental health services 07-08 (health and social care)

Breakdown of spend (direct costs):

SPECIALIST SERVICE	EXPENDITURE
Specialist OPMH (health and social care)	£5,264,000
Day care services	£229,000
Home care	£94,000
Residential care	£3,727,000
Special housing	£141,000
Special groups (e.g. LD)	£142,000
TOTAL SPEND	£9,597,000



- 6.5 Of the total annual spend 30% within the NHS, 8% social services and 62% within the independent/third sector.

Existing services

- 6.6 Health and social care services for people with dementia and their carers are commissioned by Torbay Care Trust.
- 6.6 **Specialist Older Mental Health Team.** Torbay has a community health and a social care team for Older People with mental health problems (CMHT) which are currently co-located under a single integrated manager. The "team" includes community psychiatric nurses, occupational therapists, consultant psychiatrists, administration staff, community support workers, psychologists (all employed by DPT) and social workers, admin staff,

community support staff (employed by TCT) and AMHP's (employed by TCT). CMHT provide information and advice to people using services, support to other agencies (including the third sector), carry out initial assessments, establish treatment plans and arrange appropriate care packages for those with severe mental health problems as well as care management/care coordination, which includes ongoing complex casework and review. The total staffing is 11.47 wte per 10,000 populations.

6.7 Acute inpatient facilities
(Fernworthy closed for refurbishment)

AREA	NAME	LOCATION	TYPE	SITE	OWNER	BEDS	BEDS PER 1000 65+ POP
Torbay	Harbourne	Totnes	Organic	Totnes	DPCT	10	0.62 (Devon 1.11)

6.8 Statistics below are for 06/07 rather than 07/08 as Fernworthy is currently suspended due to refurbishment.

- Admissions per 1000 population over 65yrs for Fernworthy = 4.2 (Compared to a DPT average of 6.9)(05-06)
- 18% were admitted as formal patients (detained under the Mental health Act) and 82% as informal patients (Compared to DPT average of 7% patients admitted as formal patients)
- Inpatient budget per 1000 population over 65years = £27,903 (Compared with Devon average of £44,513)
- Average bed occupancy of Fernworthy = 70% (DPT average = 78%)
- Average length of stay 39 days (DPT average = 42)
- Fernworthy audit on a weekly basis delayed discharges – the most common reason for delay, currently, is “awaiting a nursing home placement”
- Fernworthy is a mixed unit for older people with functional and organic mental health problems

6.9 Older People’s mental health inpatient services are currently under review. The review is taking place under the auspices of the OPMH PEG (Professional Expert Group). This strategy will incorporate and implement the findings of the review. However the strategic context recommended in this strategy includes:

- Rebalancing OPMH service resources from hospital to integrated community based services, with more comprehensive service provision across the whole pathway, improving home based supports and services for carers.
- Needs led and not age determined services
- Providing separate inpatient facilities for older people with organic and functional mental health needs
- Average bed occupancies of 85%
- Ensuring sound governance, training and support for inpatient staff

- Appropriate facilities to ensure privacy and dignity for male and female patients
- Given age related physical facilities, sufficient staff for assistance with personal care.

Memory Clinic Services/early intervention

- 6.10 The CMHT has been offering a Memory clinic service in Torbay for nearly 20 years. However having recognized that it does not have the capacity to see and diagnose all Torbay clients TCT invested an extra £44,000 in 2009/2010 to double the capacity of the current service. This will be rolled out from the January 2010.

Residential care/nursing home

- 6.11 There is a higher than average number of residential and Nursing home beds in Torbay. There are three Nursing homes which specialize in complex mental health and dementia, and many dementia specialist residential homes. In addition to these it is recognized that most physical Nursing homes and residential care homes care for a significant number of residents who have a dementia

Intermediate Care unit

- 6.12 This compliments other community based intermediate care resources in Torbay. It is currently able to provide 8 residential beds. The service provides assessment and intensive reablement.

Carer support workers

- 6.13 The CMHT has a part time carer's support worker, offering carers assessments and support groups.

Memory Café

- 6.14 Established 5 years ago, and after a slow start, the memory café, run in Paignton by the Alzheimer's Society has gone from strength to strength. It currently meets weekly and welcomes up to about 50 people each time. TCT is very pleased to be working with the Department of Health and the Alzheimer's Society as a National Dementia Strategy Demonstrator site to extend the current provision over the next two years.

Community Team for Adults with Learning Disabilities

- 6.15 The Community Team for Adults with Learning Disabilities works closely with the CMHT for older people to support individuals with learning difficulties who are suffering from dementia

Zone health and social care teams

- 6.16 In Torbay the district nurses, generic adult care social workers, occupational therapists and physiotherapists sit together in 'zone teams'. These teams are

geographically based across the bay and are linked with particular GP practices. It is recognized that the vast majority of people with dementia and their carers will not be directly in touch with specialist services for most of the time they have the illness. These people are supported by their GP's and by the zone teams if required.

World Class Commissioning

6.17 World Class Commissioning is about delivering better health and well being for the population: "adding years to life and life to years". The outcomes element of the World Class Commissioning Assurance process required Primary Care Trusts to select eight priority outcomes that will be assessed as part of the assurance process; these outcomes reflect local strategic priorities and the selected outcomes are consistent with the Primary Care Trust's longer term ambitions and aspiration for Torbay i.e.:

- To improve health and reduce health inequalities
- To eliminate waiting
- To improve health services

7.0 Development of Torbay's dementia strategy

- 7.1 This strategy has been developed following extensive consultation on local services and the draft national Strategy, during the summer of 08 (see appendix 3). It has been based on the World Class Commissioning guidance.
- 7.2 The information gathered during the local consultation has been used to underpin this strategy and has informed our priorities for development 2009-10.
- 7.3 Local consultation identified there were already areas of good practice undertaken in Torbay, but there were areas for further development.
- 7.4 The Torbay Older People's Mental Health Local Implementation Group has become a time limited dementia implementation task and finish group. The group is chaired by TCT Acting Chief Executive. Representation includes Primary Care, Independent providers, voluntary sector, mental health professionals, zone manager, users and carers, acute trust and commissioners. (See appendix 2)
- 7.5 The OPMH LIG has systematically worked through the recommendations in the National Dementia Strategy (2009 DoH) and the SHA peer review (summer 09) and have mapped current provision against the recommendations. Areas for development have been identified.
- 7.6 This strategy highlights areas for development and investment for 09/10. Resources were secured for developments 09/10 and the improvements are being implemented.
- 7.7 Specific work regarding support for people who have a learning disability and dementia is planned, implemented and monitored via the Learning Disability Programme Board at Devon Partnership trust. This forms part of the Health plan monitored via Torbay's Learning Disability Partnership Board.

8.0 Raising Awareness and Understanding

Objective 1: Improving public and professional awareness and understanding of dementia

(Living well with dementia: A National Dementia Strategy (DoH 2009))

- 8.1 There is generally a low level of public and non-specialist professional understanding of dementia. There is also a widespread stigma attached to dementia where both the public and non-specialist professionals find it hard to talk about dementia, and seek to avoid addressing the possibility of an individual being affected. For professional groups, this can result in low priority being accorded to the development of the skills needed to identify and care for people with dementia.
- 8.2 There is also a widespread mis-attribution of symptoms of "old age", resulting in an unwillingness to seek or offer help. There is also the false view that there is little or nothing that can be done to assist people with dementia and their carers. These factors act together to delay diagnosis and access to good quality care.

Local examples of good practice

- 8.3 Some examples of good practice in Torbay include:

Raising awareness and understanding

- **Integration of OPMHT with in zone teams**, will bring expertise on dementia to influence and support primary care and generic services at a local level
- **Dementia consultation process**, variety of public events and post card survey
- **Memory Cafes** introduced to raise awareness, open to the public and offering initial support, advice, information and signposting for people who are concerned with memory problems and their carers. Professional expertise available. Café currently runs on a weekly basis, demand is high for this service. The memory café also facilitates peer support.
- **Older people's board** – dementia awareness raising through involvement in the consultation phase of the National Dementia Strategy
- **Open dementia consultation** events led by CSIP, and support for the SW CSIP OPMH Collaborative
- **Whole Systems Training initiatives** across statutory, independent and voluntary sectors – i.e., for the Mental Capacity Act, and Safeguarding Adults as two examples.
- **Dementia information packs** - production and distribution of a comprehensive information pack produced by the Local Alzheimer's Society with statutory sector support. (Launched March 09)

Achieving Improved Awareness amongst the Public, Service Users and Carers

8.4 To achieve improved awareness amongst the public, Service Users and Carers the following will be delivered:

- We will develop and implement a local campaign to raise awareness, involving all partners and make full use of variety of media
- We will involve public health/health promotion expertise on an alcohol/dementia campaign
- We will continue to support the Dementia Care Pathways booklet and ensure the distribution of packs to a wide range of locations including GP practices, pharmacies, libraries, community centers, zone teams, memory clinic and memory cafes. The information will be updated on a regular basis
- We will ensure information is accessible for those living with a learning disability, sensory loss, physical disability or from a Black and Minority Ethnic group.

Achieving Improved Awareness amongst Professionals

8.5 To achieve improved awareness amongst professionals the following actions will be delivered across Torbay:

- OPMH staff will work with GP practices to increase the awareness and knowledge of dementia within primary care
- We will use existing communication channels to raise awareness e.g. TCT newsletter, Local Medical Council newsletters.
- We will identify a local GP who will act as dementia Champion.
- We will develop raising awareness initiatives using emerging integrated team and zones as hub for local activities to promote and implement the national strategy.
- Ensure an appropriate assessment tool is used to identify those with a learning disability and dementia at the Annual Health check for those with a learning disability.

Key Priorities to achieve objective 1

Areas for development	Actions	Lead	Timescale
- Develop and implement local campaign to raise awareness. Involve all partners and make full use of variety of media.	OPMH staff to work with surgeries to increase awareness	Joanna Wildgoose	12 months
- Involvement of public health/health promotion expertise on an alcohol/dementia prevention campaign.	Develop public awareness and staff training strategy	Ann Redmayne	12 months
- Finalise local dementia commissioning strategy and formal validation process	Present to SMT, TCT Board, PEC, OSC	Ann Redmayne	Dec 09
- Ensure information is available in accessible formats	Ensure information is available in accessible formats	Ann Redmayne	Feb 10

9.0 Early Diagnosis and Support

Good-quality early diagnosis and intervention for all

Objective 2: Good-quality early diagnosis and intervention for all

(Living well with dementia: A National Dementia Strategy (DoH 2009))

- 9.1 Nationally only one third of people with dementia receive a formal diagnosis at any time in their illness. For some people diagnosis is often made too late for them to make any choices about their care. For others the diagnosis can come at a time of crisis which may have been avoided if the diagnosis had been made earlier
- 9.2 Early diagnosis and intervention can improve quality of life and delay or prevent unnecessary admissions into care homes
- 9.3 The diagnosis of dementia, and in particular mild dementia and people with learning disabilities where the diagnosis is more complex, should be carried out by a clinician with specialist skills. This will include:
- improving how the diagnosis is made
 - giving the diagnosis in a sensitive and informative way to the person with dementia and their family, and
 - providing directly appropriate treatment, information, care and support after diagnosis
- 9.4 Evidence suggests that a local memory café service can provide a point of contact for people with dementia and their carers; they can provide information and advice about dementia and help to signpost them to specialist help and support. A memory café service can complement existing health and social care supports that people with dementia already receive and facilitate peer support.
- 9.5 People with dementia and their carers can obtain continuity of care and support not only from statutory services, but also in the form of peer support. Structured models of support can incorporate advice and support from health and social care professionals and enable people living with dementia and their carers, to exchange practical advice and emotional support

Local examples of good practice

- 9.6 Some examples of good practice in Torbay include:

Examples of local good practice:

- **Integrated zones teams**, with the inclusion of Older People's Mental Health teams into the generic health and social care zone structure, will bring improvements through case finding, promoting independence and care pathways with operational arrangements for effective interfaces between primary care, specialist and generic services for right interventions through the progression of need.

- **Links** –there are currently good established links and relationships with the OPMH team and primary care.
- **Liaison** – established links with community hospitals
- **Memory Clinics** (with EDI functions) already in operation in Torbay, but needs to be reviewed in light national guidelines
- **Memory Service functions** delivered across Torbay by CMHS(OP)s, with other specialist staff (Psychiatrists and Clinical Psychologists)
- **'Fast Track Re-entry'** systems in CMHS(OP)s were thought to be good, however the dementia strategy consultation have brought the effectiveness into question and carers have indicated there is a lack of 'continuity of care'
- **Information** – Comprehensive information pack has been developed in partnership with the third sector. (Launched March 09)
- **Carer support worker** - DPT employ a dedicated carer support worker for carers of older people with mental health problems
- **Care Pathway** – Care pathway has been agreed (See appendix 1)

Achieving Improved Early Diagnosis and Support Services

9.7 To achieve improved early diagnosis and support services for people with Dementia the following will be delivered:

- *Early diagnosis and case-finding:*
 - monitor actively the % of general practitioner registered patients with dementia diagnosis (Quality outcomes Framework).
 - Promote and monitor general practitioner uptake of awareness training offered
 - Improve case finding within Community Learning Disability Service and identify services to meet the needs of ensuring linkage to an integrated dementia pathway
- *Memory and assessment services:*
 - Commissioners to lead work to establish a clear service specification for memory service, with defined outcomes and capacity to meet the need

Key priorities to achieve objective 2

Areas for development	Actions	Lead	Timescale
- Need to monitor actively the % of general practitioner registered patients with dementia diagnosis.	OPMH team to work closely with surgeries to ensure registers are accurate	Jane Batstone	12 months
- Promote and monitor general practitioner uptake of awareness training offered.	Link to training plan in Objective 1	Ann Redmayne	12 months
- Commissioners to lead work to	Write service spec based on	AR,DS,CW,JH	By Feb10

<p>establish clear service specification for memory service, with defined outcomes and capacity.</p> <p>- Improve case finding within the Community Learning Disability Service and identify services to meet needs ensuring linkage to an integrated dementia pathway.</p>	<p>EDI PIG and local need data. Commission expanded EDI service</p> <p>LIG to seek input from LD service and request they nominate a dementia champion (letter from AR to consultant & service manager).</p>	<p>AR/Nikki Henderson</p>	<p>By Feb 10</p>
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9.10 **Good quality information for those with diagnosed dementia and their carer**

Objective 3: Good-quality information for those with diagnosed dementia and their carer

(Living well with dementia: A National Dementia Strategy (DoH 2009))

9.11 The importance of good quality information for patients and carers to enable them to direct their own care is essential. Every person diagnosed with dementia and their carers need to be provided with good quality, relevant, information on the illness and the local services that are available to them. Whilst different information may be required for different types of dementia or as the dementia progresses, every person diagnosed should receive a standard information pack at or soon after diagnosis, depending on when they are ready to receive it

Local examples of good practice

- **Dementia Care pathway booklet** for carers
- Devon Partnership Trust run **post-diagnosis groups** from the memory clinic
- **"One Stop Shop"**
- **Carer's education group**

Achieving good-quality information for those with diagnosed dementia and their carer

9.12 To achieved improved good-quality information for those with diagnosed dementia and their carer will be delivered:

- Commissioners will work with partners in health and Social Care and the third sector to monitor information available with view of improving access for *all* including those living with a learning disability, sensory difficulties or those from a Black and Ethnic Minority (BME) group
- We will commission a programme of audits to evaluate effectiveness of the information accessed by people with dementia

Key Priorities to achieve objective 3

Areas for development	Actions	Lead	Timescale
- Commissioners to work with partners in Health & Social Care and third sector to monitor information available with view to improving access	Review what is available	SLL & David Mannion	6 months
- Undertake programme of audits to evaluate effectiveness of the information accessed by people with dementia.	Audit department	AR	6 months

9.13 Enabling easy access to care, support and advice following diagnosis

Objective 4: Enabling easy access to care, support and advice following diagnosis

(Living well with dementia: A National Dementia Strategy (DoH 2009))

9.14 One of the most clear and consistent messages emerging from discussions with people with dementia and their carers has been the desire for there to be someone who they can approach for help and advice at *any* stage of the illness. Currently health and social care services normally discharge individuals once the case is stable.

9.15 The National Dementia Strategy suggests that this support needs to be provided without removing health and social care professionals from the front line. However there is a lack of good-quality evidence to support the range of models that exist nationally. The Department of Health demonstrator sites have been established to identify best practice. Torbay Care Trust will use the learning to commission a Dementia Advisor Service for people living with dementia and their carers in Torbay.

9.16 Local examples of good practice

Local examples of good practice:

- “Days out” service.
- Carers Support Groups.
- Carers Support Workers.
- OT post diagnosis group.
- Sensory memory stimulation group.
- Need to access follow on resources possibility outside mental health expertise base.
- Memory cafe in Paignton all that is available but is appreciated and valued.
- Comprehensive cohesive working in zonal teams.
- Joint working at CMHT level – good relationships between health and social care.

Achieving easy access to care, support and advice following diagnosis

9.17 To achieve easy access to care, support and advice following diagnosis Torbay will:

- We need to use the learning to commission a Dementia Advisor Service for people living with dementia and their carers in Torbay.
- We pilot a dementia advisor service in Brixham (2010/11)
- Commission a dementia advisor service across Torbay (2011/12)

Key priorities to achieve objective 4

Areas for development	Actions	Lead	Timescale
- Learn the lessons from the Department of Health Dementia Advisors' Demonstrator sites and apply to local practice.	Apply learning, develop service specification, business case, consider pilot in one area	AR	12 months
- Memory Clinic needs to be developed to provide a variety of support and education options.	Review Clinic and medication protocol	JW, SLL	3 months
- Also needs to link with a dementia pathway.	Develop a fully commissioned comprehensive dementia pathway	AR	12 months

9.18 **Peer support and learning networks for people with dementia and their carers**

Objective 5: Development of structured peer support and learning networks
(Living Well with dementia: A National Dementia Strategy)

9.19 One clear message we have received from people living with dementia and their carers, who have used the memory café, is that they draw significant benefit from being able to talk to others in similar situations.

9.20 The value of peer support is that this can empower people to make choices and assist them to plan their own lives

9.21 Torbay is a Department of Health Demonstrator Site for Peer Support. The support and learning will enable us to commission an evidence based peer support service for *all* who require it across Torbay.

9.22 Local areas of good practice

- Host carer scheme open to people with early dementia.
- Plans to commission a Memory Café network.
- CMHT input into Memory Café.
- Dementia Café runs every week.
- Plans to develop Memory Cafés in Torquay & Brixham (Demonstrator site).
- Carer's Education Group.
- Carers' Support Group.

Achieving structured peer support and learning networks for people with dementia and their carers.

9.23 To achieve an improvement in structured peer support and learning networks for people with dementia and their carers, the following will be delivered:

- *Peer support*
 - We will fully implement the DOH peer support demonstrator project implementation plan.
 - We will work with the Department of Health to establish best practice (09-11)
 - We will develop and commission a model based on the findings of the DOH demonstrator site evaluation

Key Priorities to achieve objective 5

Areas for development	Actions	Lead	Timescale
Low intensity support (dementia adviser and peer support networks) are consistently cited by carers of people with dementia as their top priority. Support networks are generally inexpensive, and hence offer a potential early on. Opportunity to review coverage and funding arrangements and learn from national demonstrator sites	Commissioners to develop a comprehensive pathway and commission it. This may involve transfer of resources.	AR	12 months
	Fully Implementation of DOH peer support demonstrator project implementation plan. Ensure sustainability (commissioning strategy)	AR, SO, DM	18 months

10 Living well with dementia

Objective 6: Improved community personal support services
Objective 7: Implementing the Carers' Strategy for people with dementia
Objective 8: Improved quality of care for people with dementia in general Hospitals
Objective 9: Improved intermediate care which is accessible to people living with Dementia
Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers
Objective 11: Living well with dementia in care homes
Objective 12: Improved end of life care for people with dementia
(Living well with dementia: A national Dementia Strategy 2009)

- 10.1 Nationally two-thirds of all people with dementia live in their own homes in the community. Some of these people will be in the early stages of their dementia and some nearing the end of their lives. The right support at the right time and in the right place is especially important to give them choice and control over the decisions that affect them. Whilst the majority of care and support for people is provided by family members and friends, home care is probably the single most important service involved in supporting people with dementia in their own homes.
- 10.2 Specialist dementia home care can provide considerable benefits to both people with dementia and their carers with improved outcomes including reduced stress and risk of crises for the carers, and extended capacity for independent living for people with dementia. Within Torbay there is a need to ensure the market place delivers quality services. We currently do not commission a specialist dementia domiciliary care provider.
- 10.3 People with dementia are known to be an 'at risk' group in terms of abuse through financial exploitation, fraud and theft with some individuals who are unable to complain. Torbay safeguarding protocols provide clear information on how to complain about poor standards of care, or report concerns about possible abuse to safeguard people with dementia and their carers, ensuring their human rights are protected. Staff in all settings should be familiar with these arrangements.
- 10.4 Most family carers want to be able to provide the support to enable the person with dementia to stay at home, although they often require more assistance than is routinely available. Residential care may be the most appropriate and effective way of meeting someone's needs and providing a service of choice. However, it should always be a choice. Often older people with dementia are admitted to long-term residential care because it appears that there are no other alternatives available, especially if the person has been admitted to hospital as the result of a crisis. This is partly due to a lack of knowledge and understanding from professionals. It is also due to home care staff and family carers not receiving adequate training and advice in dementia, so not having the skills and competencies to provide appropriate care.

- 10.5 Flexible and responsive breaks and day services are vitally important to support families in their caring role and people with dementia. These services should provide valued and enjoyable experiences for people with dementia and their carers. They can play an important role in preventing institutionalization and keeping people with dementia in the community. Breaks can be provided in a variety of settings, including the home of the person with dementia. They also need to be on an emergency, urgent and planned basis. Torbay Care Trust is a Department of Health Demonstrator site to develop innovative breaks for carers.
- 10.6 Up to 70% of acute hospital beds are occupied by older people and up to a half of these may be people with cognitive impairment, including those with dementia and delirium. The majority of these patients is not known to specialist mental health services and is undiagnosed. People living with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalization
- 10.7 Admission to hospital can be a confusing and challenging time for people with dementia and family members who may be excluded from care planning within the hospital setting and the discharge planning. There can also be a lack of co-ordination between hospitals and care providers at the point of discharge, with delay in access to care packages such as home care and intermediate care that might enable successful discharge. Further improvements to hospital care include:
- the development of an explicit care pathway for the management and care of people with dementia in hospital, led by a senior clinician
 - to ensure carers are actively involved in care planning and the discharge process
 - commissioning a liaison psychiatry service, which includes specialist liaison older people's mental health service to work at Torbay Hospital
- 10.8 Intermediate care is not widely available for people with dementia. There is good clinical evidence that people with mild or moderate dementia with physical rehabilitation needs do well if given the opportunity. People with severe dementia may need more specialist services to deliver their mental health needs as well as those providing general physical rehabilitation.
- 10.9 In order to enable people with dementia to live well with their condition, much is being done that is positive in terms of housing options and assistive technology that are part of mainstream care for people with dementia and that contribute to their independence and safety.
- 10.10 Improving the quality of care for people with dementia in care homes is an objective of the National Dementia Strategy with a number of recommendations being made:
- identification of a senior staff member within the care home to take the lead for quality improvement in the care of dementia in the care home

- development of a local strategy for the management and care of people with dementia in the care home, led by that senior staff member
- only appropriate use of anti-psychotic medication for people with dementia
- the commissioning of specialist in-reach services from older people's community mental health teams to work in care homes
- the specification and commissioning of other in-reach services such as primary care, pharmacy, dentistry, etc
- Readily available guidance for care home staff on best practice in dementia care

10.11 For people with dementia, end of life planning needs to take place early while they still have the sufficient mental capacity and where decisions and preferences can be recorded consistent with the principles set out in the Mental Capacity Act. This could include the use of lasting powers of attorney, advance decisions and advance statements

10.12 **Local areas of good practice**

Local areas of good practice (as identified by the SHA Peer review process)

Objective 6:

- Host carer scheme
- Well managed, with dynamic leadership generic zonal teams
- St Edmunds Intermediate care and community support team
- Currently review of day care services
- Residential, visited by the SHA peer review were able to demonstrate they were able to provide high quality services to meet the needs of people living with dementia

Objective 7:

- Dementia Care Pathway information booklet for carers
- Carer assessment process
- Patient held record - Yellow folder system for people with complex needs
- Carers support workers in GP surgeries
- "safely Home scheme"

Objective 8:

- Commissioning of a liaison psychiatric service at Torbay Hospital
- Specialist Dementia Nurse within the DGH
- Extensive educational package
- Excellent links with Plymouth University
- Innovative work to improve care for people with dementia with in the district general hospital – lead by the Assistant Director of Nursing

Objective 9:

- Existence of intermediate care services
- St Edmunds – excellent outcomes for people living with dementia.

Objective 10:

- Telecare show flat
- Plans for extra care housing – on track for October 2010

Objective 11:

- Specialist support into residential homes
 - Specialist dementia residential home
- Objective 12:
- Joint advance statements which include sign up by the Local Ambulance Trust
 - Non-malignancy end of life pathway being considers
 - Strategy for End of Life care being developed but not yet implemented
 - Gold standard framework in place but not for people living with dementia

Key priorities to achieve objective 6

10.13

Areas for development	Actions	Lead	Timescale
- Review capacity of domiciliary care to meet actual and predicted demand.	Consider specialist dom. Care service	AR	12 months
- Range and quality of day care	Review day care provision	Hannah Horrocks	18 months
- Improved choice and control for people living with dementia and their carers	Encourage individual budgets	SS, CW & Nicola Barker	

Key priorities to achieve objective 7

10.14

Areas for development	Actions	Lead	Timescale
- Promote Carers Strategy and link to programme of training amongst staff to raise awareness.	SW to link with training programme	Linda Hammett /AR	12 months
- Review systems for collecting data about carers and identify improvements.	Systems review	LH/Katie Heard	12 months
- Consider an out of hours' helpline for carers.	To be commissioned	AR	12 months
- Promote the work of the Carers Support Worker in each GP practice.	SW to work with practices to increase awareness	LH	6 months
- Range and quality of day care	Review day care provision and develop community hubs	Hannah Horrocks	By April 10
	Fully implement DOH demonstrator carer programme (dementia)	James Drummond	18 months

Key priorities to achieve objective 8

10.15

Areas for development	Actions	Lead	Timescale
- Raise profile of, and training for, DOLs and MCA to improve safeguarding.	Prioritise training for key staff ~ plan to be developed for all staff	Liz Childs/ Maggie Dunbar	6 months
- Dementia awareness training to be comprehensively rolled out.	As above	MD	6 months
- Environmental issues need attention using the Alzheimer's Society reference tool.	Staff to work with University of Stirling to review environments	MD	12 months
- Liaison service and also care/intermediate care need to be properly commissioned and service specification formalised with provider input.	Commissioner to develop service spec with DPT	AR	Fully operational by April 09

Key priorities to achieve objective 9

10.16

Areas for development	Actions	Lead	Timescale
- Undertake a training needs analysis.	Undertake analysis	David Jones & Sally Pritchard	6 months
- Regularly monitor effectiveness of intermediate care for people with dementia.	Audit care	DJ & SP	6 months

Key priorities to achieve objective 10

10.17

Areas for development	Actions	Lead	Timescale
- Telecare in St. Edmunds needs development	Sally to discuss options	SP	6 months
- Further extra care housing for people with dementia + their carers planned (e.g. Guineas Trust 65 flats ECH re-modeled from sheltered). Ensure plans linked with the local Dementia Strategy.	Strategies for housing and dementia need to link closely	AR, John Bryant, Barbara Alexander	6 months

Key priorities to achieve objective 11

10.18

Areas for development	Actions	Lead	Timescale
<ul style="list-style-type: none"> - Consider expanding current support to allow for training and education within care homes. - CPN and multi professional in-reach to care homes. - Consider and develop further preferred providers. - Need specialist pathway for dementia and roll out yellow folder. - Preferred provider lists or specific homes that are contracted with. - Contract specifications to focus on qualitative aspects and to be taken into account alongside CQC rating. - Stimulate the role of dementia champions in care homes. 	Commission care home support team	AR	6 months
	As above		
	Tender to preferred providers	AR	6 months
	Develop pathway	AR & DS	6 months
	Develop contract	Ray Hodgson	6 months
	Care home link CPN	Bob Bartrum	6 months

Key priorities to achieve objective 12

10.19

Areas for development	Actions	Lead	Timescale
<ul style="list-style-type: none"> - Consider expanding current support to allow for training and education within care homes. - Develop pathway in EOL strategy that is dementia specific. 	Extend current developments	AR & Maggie Clough	6 months
	End of Life strategy to link directly with DS	DS, AR & Reine	6 months

11.0 Framework for delivering the National Dementia Strategy

Objective 13: An informed and effective workforce for people with dementia

(Living well with dementia: a national Strategy)

Workforce

- 11.1 People with dementia and their carers need to be supported and cared for by a trained workforce, with the right knowledge, skills and understanding of dementia to offer the best quality care and support. Awareness and skills are therefore needed in all sections of the workforce and society, not just those involved with dementia care.
- 11.2 Training should also cover the principles of the Mental Capacity Act 2005 to ensure that all decisions made on behalf of people with dementia, where they lack capacity, are in the best interests and take their wishes and desires into account.
- 11.3 Torbay Care Trust and Devon Partnership trust have both developed workforce strategies to ensure that high quality and relevant workforce developments are provided to support organisational commissioning and provider functions.
- 11.4 In order to ensure effective plans for the delivery of dementia services in the community and in line with the current workforce strategies, a review of future workforce requirements will be taken forward jointly by NHS Torbay Care Trust and Devon Partnership Trust.

Key priorities to achieve objective 13

Areas for development	Actions	Lead	Timescale
- Workforce development strategy required to address training needs across all partners in relation to dementia.	Develop training strategy and implementation plan	AR	6 months
- Extend dementia awareness training within the SDHFT to wider range of staff.	Increase training in hospitals	Maggi Dunbar & community hospital matrons	12 months
- Improve awareness within zonal teams and with general practitioners and build confidence of staff to respond appropriately to needs of people with dementia and their carers.	Increase specialist team presence in the zones	CW	12 months
	GP communication and education programme	JW	12 months

Joint Commissioning Strategy for Dementia

Objective 14: A joint commissioning strategy for dementia
(Living well with dementia: the National Dementia Strategy)

- 11.5 This strategy has been developed following extensive consultation on local services and the draft national Strategy, during the summer of 08 (see appendix 3). It has been based on the World Class Commissioning guidance.
- 11.6 The information gathered during the local consultation has been used to underpin this strategy and has informed our priorities for development 2009-10.
- 11.7 Local consultation identified there were already areas of good practice undertaken in Torbay, but there were areas for further development.
- 11.8 The Torbay Older People's Mental Health Local Implementation Group has become a time limited dementia implementation task and finish group. The group is chaired by TCT Acting Chief Executive. Representation includes Primary Care, Independent providers, voluntary sector, mental health professionals, zone manager, users and carers, acute trust and commissioners. (See appendix 2)
- 11.9 The OPMH LIG has systematically worked through the recommendations in the National Dementia Strategy (2009 DoH) and the SHA peer review (summer 09) and have mapped current provision against the recommendations. Areas for development have been identified.
- 11.10 This strategy highlights areas for development and investment for 09/10. Resources were secured for developments 09/10 and the improvements are being implemented.

Key priorities to achieve objective 14

Areas for development	Actions	Lead	Timescale
<ul style="list-style-type: none"> - Approve and publish the local Dementia Strategy. - Include milestones, target dates, lead individuals and clearly identified short and medium term priorities and investment in action plan. 	Publish local strategy redraft <ul style="list-style-type: none"> - Present to January LIG - Communication plan 	AR CW Jim Delves	6 months
<ul style="list-style-type: none"> - Consider how core messages from local Dementia Strategy can be reinforced to relevant staff whose main focus is not 	Link with training strategy	AR	12 months

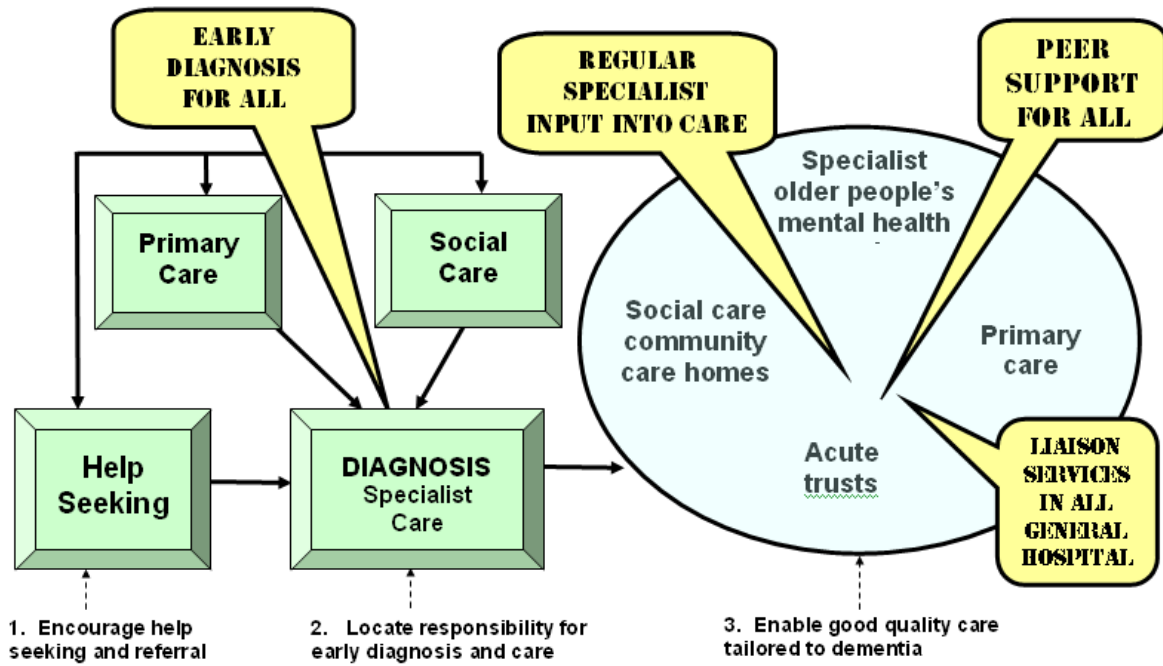
dementia. - Develop capacity planning, looking at quantifying supply of services at different points of an agreed commissioner determined dementia pathway, as well as demand in the JSNA. - Re-clarify the lead general practitioner role for dementia. - Seek opportunities to involve clinicians and practitioners in a leadership role for certain work-streams. - Begin work to define outcomes for objectives in the local Dementia Strategy and commissioned services for monitoring and evaluation	Clear plan to increase capacity over 5 & 10 years	AR	12 months
	AR to discuss and clarify with LT	AR	12 months
	AR & CW to identify key individuals	AR	
	Local strategy to include a review and evaluation process bi-annually	AR	

Governance and implementation plan

11.11 The Torbay Dementia Strategy will be monitored through the Local Implementation Group. (See appendix 1 for membership). This group will report progress to Torbay Care Trust Board and the Older People's Partnership Board

11.12 The Torbay Implementation Group will be responsible for implementing and monitoring the strategy, reviewing the quality of data for specific service areas. Task and finish Sub-groups of the LIG will be established to implement specific objectives. Performance management arrangements will be put in place to ensure the strategy is achieving the planned actions specified.

DEMENTIA CARE PATHWAY



(Based on the Sube Banerjee model 2008)

Dementia Local Implementation Group – Membership

NAME	REPRESENTAION
Anthony Farnsworth	Chair Acting Chief Executive (TCT)
Chris Whitehead	Integrated Service Manager (DPT/TCT)
Dr David Sommerfield	Consultant Psychiatrist DPT Medical Director
Dr Liz Thomas	GP
Mike Vango	Carer
Jim Delves	Alzheimer's Society
Ann Redmayne	Mental Health Commissioner
Robin Causley	Aged Concern
Sally Pritchard	St Edmunds (intermediate care)
James Drummond	Carers Lead TCT
Liz Feller	Independent Sector (Residential Care)
Maggie Dunbar	Specialist Nurse (SDHCT)
Julie Hickie	Zone Manager (TCT)
Sue Smith	Social Worker
Cindy Stocks	Non Executive Director (TCT) Torbay Council Member
Dr Joanna Wildgoose	Consultant Psychiatrist

NATIONAL DEMENTIA STRATEGY OBJECTIVES

Objective 1: Improving public and professional awareness and understanding of dementia.

Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

Objective 2: Good-quality early diagnosis and intervention for all.

All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Objective 3: Good-quality information for those with diagnosed dementia and their carers.

Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

Objective 4: Enabling easy access to care, support and advice following diagnosis.

A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

Objective 5: Development of structured peer support and learning networks.

The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

Objective 6: Improved community personal support services.

Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.

Objective 7: Implementing the Carers' Strategy.

Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

Objective 8: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

Objective 9: Improved intermediate care for people with dementia.

Intermediate care which is accessible to people with dementia and which meets their needs.

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.

The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

Objective 11: Living well with dementia in care homes.

Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

Objective 12: Improved end of life care for people with dementia.

People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

Objective 13: An informed and effective workforce for people with dementia.

Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

Objective 14: A joint commissioning strategy for dementia.

Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy and set out in Annex 1.

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.

Inspection regimes for care homes and other services that better assure the quality of dementia care provided.

Objective 16: A clear picture of research evidence and needs. Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.

Objective 17: Effective national and regional support for implementation of the Strategy.

Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

CONSULTATION FEEDBACK

Views are sought on the following:

Chapter 1 – Improved Awareness

Recommendation 1: Increased public and professional awareness of dementia

Recommendation 2: An informed and effective workforce for people with dementia

1. Are these the outcomes, recommendations and suggested means of achieving them the right ones?

Yes, especially "help people to understand the benefits of EARLY diagnosis". (DIC, Carer)

The Strategy talks about raising awareness of dementia but can we look at what has worked in the past in terms of awareness campaigns for mental health (and in relation to investment). Where is money best invested for the greatest impact? (OPMH Group, DPT)

Clearly these are the right goals, but how will we be measuring them? (AB, Carer)

One of the biggest problems that I have had has been the lack of understanding of the illness from staff. (JC, Carer)

My husband's care has particularly suffered in hospital as a result of lack of understanding from staff of people with dementia ~ I very much welcome this recommendation. (PS, Carer)

I think there needs to be effective media campaign to help ensure that dementia becomes part of day-to-day life. Storylines could be written in to television soaps, and generally there needs to be much more focus on dementia as being a normal part of ageing. (JC, Carer)

I feel awareness is gradually coming with the general public ~ it is needed more ~ with shopping difficulties. (JB, Carer)

2. Is there anything that has been missed to help us improve public and professional awareness of dementia?

ALL HEALTH STAFF should include All Care Homes, Day Centres and Hospital staff, and private domestic homes' care workers. (DIC, Carer)

The Stroke Society carries cards for people to show, to retail, Post Office, travel etc. This I think is a very good idea, able to show to these people, so that the worry of not being able to explain to others what is wrong. (JB, Carer)

- The campaign needs to be effective but there needs to be substance/capacity and competence within services. The timing of an awareness campaign is crucial ~ carers will not want to know about it until the Strategy is in place.
- The key questions here are about what the campaign should target/raise awareness of, and when.
- Awareness first needs to be raised among professional groups.
- The focus on prevention is minimal ~ more could be said about the available evidence for reducing particular types of dementia, eg Korsakoff's Syndrome and the links with alcohol/substance misuse, diet/cholesterol/blood pressure, and multi-infarct dementia.
- Adults below 40 years could be a useful target. (OPMH Group, DPT)

Schools/Colleges

- Education at a younger level, of dementia/Alzheimer's Disease.
- Speakers to go into schools/colleges to provide awareness.
- Positive PR
- More workshops? (Consultation Event Group)

Media/Delivering Message

- People going into businesses to raise awareness
- Alzheimer's Week/conferences ~ awareness
- Mobile caravan to visit towns, roadshows
- Positive PR on programmes ~ TV/radio
- Better advertising of Safety Home Scheme and other services such as wallet for transport services.
- Greater health promotion through the media to de-stigmatise mental health in older people. (Consultation Event Group)

I visited four carers groups across South Devon over the last three months, and generally it was felt that this was very much welcome. However, there were concerns raised by the groups about how this would be achieved, how it would be measured, etc. (Chris Whitehead)

3. What can you or your organisation do to help implement the recommendations?

This I find a difficult situation ~ my own husband cannot explain himself, by this I mean he cannot converse, so going shopping on his own is now impossible. (JB, Carer)

Encourage the media (BBC etc) to help in education ~ they already do a lot but tend to feature headline news items. (JB, Carer)

Clearly NHS organisations and Council organisations have a huge responsibility to ensure that professional awareness of people with dementia is raised and that we have an informed and effective workforce across our hospitals and community services. We also have a responsibility to work with universities, voluntary sector and others to ensure there is adequate staff training and information to help support staff to deal with the problems that people with dementia may pose.

Some of the ideas raised by the communications we have had with users and carers over the last couple of months will help us with this process. We think we can also use things like Alzheimer's Awareness Week and media campaigns locally to help improve awareness and access to services locally.

(Torbay Care Trust)

DRAFT

Chapter 2 – Early diagnosis and intervention

Recommendation 3: Good quality early diagnosis and intervention for all

Recommendation 4: Good quality information for those with dementia and their carers.

Recommendation 5: Continuity of support and advice

1. Are these the outcomes, recommendations and suggested means of achieving them the right ones?

- The impact of early diagnosis ~ what/where is the capacity to follow this through?
- What does this role really mean? Who would do it?
- There are links to NICE/Everybody's Business ~ but these links need to be overt.
- This should be clearly stated to be a new role and about restructuring services ~ not about duplication ~ but where does it leave case management and cost funding management? How do we avoid confusion? (OPMH Group, DPT)

On reflection, early diagnosis might have been helpful, but my husband was very happy gradually dementing, and I had a good idea what was happening. I am not sure how early diagnosis would have changed anything. (SS, Carer)

Early diagnosis was really effective in helping me plan my future. (DD, Client)

Recommendation 3 ~ Early diagnosis!!! I only found this out when a friend said: "is S..... alright?" ~ therefore detection cannot always be found in the early stages. Looking back I now think [my husband] should have been diagnosed two years earlier. (JB, Carer)

Early diagnosis was fine and helpful because it helped me know where I was with my husband, who had been diagnosed with dementia. However the problem was after that, as we were given the diagnosis and then left, and our next appointment at Chadwell was a year later. (AP, Carer)

Carer's right to carer's assessment and care plan must be reinforced.
(Consultation Event Group)

2. Is there anything that has been missed to help enable early diagnosis and intervention?

My doctor told me that my husband "did not respond to questions as expected" about 18 months before I felt there was a problem ~ I had thought it was his hearing. A suggestion by the doctor of his suspicions and a hint of his "diagnosis may have meant an earlier referral and decision.

(DIC, Carer)

- Where is the leadership for GPs in this area?
- Should GPs be the gatekeepers for early diagnosis/intervention? But currently GPs are seen as a barrier.
- There needs to be a direct access for memory services in the context of primary care triage.
- But then how do you control the floodgate issue? (OPMH Group, DPT)

There was a general welcoming around the groups of early diagnosis as being a productive tool which helped people have genuine choices and dignity within the illness. However there was concern that this was not for everybody and also that it would need education amongst GPs and other health care professionals to ensure that early referral happened. Referral systems need to be open to ensure easy access to specialist services.

(JC, Staff)

My husband was young when he developed dementia. Staff in younger people's mental health services had no understanding of the illness and therefore it was a very difficult time for both of us as we struggled to understand what was going on for him. Anything that can be done to help earlier diagnosis would have been a help for me.

(CB, Carer)

- A lot of concern about GP response to carers.
- A lack of understanding at professional level with people with dementia.
- Carers need opportunity to speak freely to professionals away from the patient without feeling guilty.
- Early diagnosis important ~ every surgery should have expertise in the practice to refer to specialist diagnosis.
- More cohesive local approach ~ pockets of excellent practice but difficult to get information.
- Avoid "assumptions" ~ build relationship with patient
- GP surgeries need to have a "specialist" for early recognition and disseminate information.
- Where the patient accepts they have a problem and will access health advice its OK, but family/carer need to be able to go to the GP or other health professional if they are worried about the relatives condition when the patient doesn't accept it.
- GP's may not pick up early stages of dementia. Need to recognise that planning for the future takes time so we should not be leaving it until the illness is critical. GP's need training in early diagnosis.
- Early diagnosis (warning signs) could be improved by ensuring people over 50 are offered an annual health check, but that this must incorporate screening on mental health to identify possible dementia. Currently some practices in Torbay offer an enhanced health check which includes social care issues, but does not cover relevant mental health e.g. memory. To work such a scheme must be offered pro actively.
- Too often carers feel they have to push hard to get someone seen, and this then requires levels of assertiveness which not everyone has.
- It is crucial to get early information/diagnosis services organised and available in the community. Too many people are leaving it until it is too late.
- Need to provide support and advice at earlier age to people with learning disability and their families/carers on issue around dementia. (Consultation Event Group)

Is there anything that has been missed to help enable early diagnosis and intervention? *Continued 2*

I wish there was early diagnosis; my life and I'm sure other carers would wish for this.

(JB, Carer)

Recommendation 4: More information given by doctors, usually the first point of contact. In my case it took a long time to get information and support, one does not know which questions to ask at the start.

(DB, Carer)

3. Do you agree that the diagnosis of dementia should be made by a specialist?

Yes DIC, Carer)

Yes! Most definitely ~ but how? (JB, Carer)

4. How open should referral systems to a memory service be? Should people be able to refer themselves, or should they have to go to a GP first?

People should be able to refer themselves when they recognise what the problem is ~ IF they recognise the problem! Otherwise through the GP. (DIC, Carer)

The trouble with memory services is that they focus on memory. My husband's memory was not a problem. There were other areas of his character which were failing. Eventually they were diagnosed as dementia. If we had been able to refer direct to a memory service I would not have done so as memory was not the main issue. (BC, Carer)

My wife was referred to the Memory Service which was extremely good. However, following diagnosis nothing happened and we were left to fend for ourselves. (DA, Carer)

The Memory Service at Chadwell was extraordinarily good and comprehensive. I would recommend it to anybody. (JC, Carer)

I do not think my husband would have referred himself ~ in fact I know he wouldn't. Partners (like myself) we've been married 55 years and just thought it was old age creeping on.

(JB, Carer)

- "Beginners or Idiots Guide" to what next, ie Enduring Power of Attorney.
- Keep as many options open as possible, ie flow chart of options, contact numbers etc ~ where to go next if not satisfied ~ self-referral.
- Essential: **one** point of contact or **team** to manage individual patients so that support is available regardless of holidays or sickness.
- Transparent open discussion across professionals and with carers.

(Consultation Event Group)

5. How would the dementia advisers be able to ensure continuity of care?

By treating the condition as a disease and treat as a medical condition, which it is. By NOT just treating it as a "social" problem ~ It is called a "disease". (DIC, Carer)

GP surgery support staff already do this function ~ that is, if they exist! (DB, Carer)

Like belonging to a helpful group such as ours in Paignton, "Chadwell", who look after the carers as well as the patients. (JB, Carer)

There is a minimal resource in health so there needs to be caution about shifting any funding to social care. Do we mean shifting the balance (of funding) or working in partnership ~ it should not be about drawing territory. (OPMH Group, DPT)

- Right from day one, where to get information? what is it? practical help; financial support; what next? etc
- Information on what is available for ongoing home care
- Importance of "life story" so that people not connected to patient have ideas for conversation and understanding of person's life and interests.
- All "professionals" or those potentially dealing with dementia must receive training at national level, ie nurses, GPs etc.
- Access to day care with "carers" not with other mentally ill patients. Important for stimulation of patient.
- Help carers use the internet to access information (i.e. more than just giving address).
- Health Professionals need to know what is available so they can signpost people to good information and support, particularly at early stages. This must be at local level.
- More promotion of local low key support and access e.g. Memory Café..
- Some people find existing day services very difficult because they have lost their ability to communicate (and so feel left out) or the service is not tailored to their interest/ability/personality etc. One size does not fit all.
- Specific dementias need tailored services that address the individual needs.
- Explore the possibility of ex carers being befrienders/mentors as part of support.

(Consultation Event Group)

There was almost universal welcoming across all the groups and the people I spoke to for the idea of a worker for the individual and family to support the person with dementia right through the period of time they have dementia. What is not clear is what form this worker's role will take, where they will be based, who they will link with, and what contact they will have with clients. (Chris Whitehead)

6. What can you or your organisation do to help implement the recommendations?

Push for more help and keep putting dementia more to the forefront of the NHS. (JB, Carer)

Clearly Devon Partnership Trust and Torbay Care Trust, and other organisations, need to work together to implement some of these changes, to give all people with dementia a named worker throughout the period of their illness, which can be many, many years, is a huge challenge for organisations.

Locally we feel we need to work with partner organisations in the statutory and voluntary sector, and users and carers to develop these recommendations. We will very much welcome the idea of early diagnosis, good quality information and continuity of support and advice. Through our work during the consultation process we now have many ideas as to how we might be able to put these proposals into action. (Torbay Care Trust)

DRAFT

Chapter 3 – High-quality care and support

Recommendation 6: Improved quality of care in general hospitals

Recommendation 7: Improved home care for people with dementia

Recommendation 8: Improved short breaks for people with dementia and their carers

Recommendation 9: A joint commissioning strategy for dementia

Recommendation 10: Intermediate care for people with dementia

Recommendation 11: Improved dementia care in homes

Recommendation 12: Improved registration and inspection of care homes

1. Are these the outcomes, recommendations and suggested means of achieving them the right ones?

Yes, plus Recommendation 12 ~ add: "Inspection and testing of care home staff" to ensure they understand the problems of the person with dementia. (DIC, Carer)

- Is there funding?
- All partners/organisations need to understand the whole pathway successfully to enable the balance of care to be shifted appropriately in line with the PWD needs ~ this should not be about drawing lines around services but based on PWD need. This work would need to be clearly defined.
- Is there an agreed pathway available to share anywhere?
- There is a minimal resource in health so there needs to be caution about shifting any funding to social care. Do we mean shifting the balance (of funding) or working in partnership ~ it should not be about drawing territory.
- A key success of the Strategy will be the ability for staff to draw on the appropriate skills and an empathic nature.
- But care home staff are poorly paid ~ what is the incentive for them? How do they take on the vocation of this care?
- How do you recruit people? Training and person-centred care are important, but recruiting the right people with the right skills is essential, especially with choice, individual budgets and the propensity for PWD to recruit their own carers. (OPMH Group, DPT)

The most difficult time by far for me as a carer was when my husband was in hospital. Staff had no understanding of his illness, and made me feel awful that he was being difficult. (AP, Carer)

People in hospital are at their most vulnerable. My wife caused the surgical ward extreme problems when she had a small operation, creating havoc around the ward as she wandered all over the place. She was more confused than ever, difficult with staff, and did not like being encouraged to stay in one place. Measures to address this would have been extremely helpful. I can only describe the period of time as a nightmare. (CJ, Carer)

When my husband went into hospital to have an operation to remove his infected wisdom teeth, the hospital worked extremely well with me. They allowed me to stay in the hospital with him during all waking hours. I arrived at 7 o'clock in the morning, spent all day with him, and left about 8 o'clock in the evening. He had been very difficult leading up to the time, presumably because his infected abscesses in his teeth were causing him so much pain. The hospital admission caused me loads of worry, but actually went extremely smoothly. The staff were very supportive; because I was around my husband at all times he was relatively relaxed and in fact became increasingly less difficult, presumably because he was in less pain. (FT, Carer)

Are these the outcomes, recommendations and suggested means of achieving them the right ones? *Continued 2*

Recommendation 6 ~

- Treatment on general wards of dementia patients not adequate. Essential more staff training ~ at least one member of staff with specialist awareness ~ more at basic nurse training (common sense?)
- Appropriate awareness training and education for all staff working at the DGH, particularly around behaviour management and medication.
- Carers involvement in the admission process ~ "life books"
- Carers contribution being valued
- Flexible visiting times and ability of involvement in providing care by carers, eg at mealtimes.
- Observation and safety of people with dementia ~ need for 24-hour observation ~ use of beds near the nurses station and not side rooms.
- Reduce length of stay to a minimum ~ use of alternative to hospital and intermediate care.
- "Discharge" planning should commence on admission.
- Need for information and advocacy for patient with dementia and carer/family at point of admission to hospital for general treatment.
- Carer needs to continue to be involved (if they wish) in care of person when they go into hospital or care and services should promote this and make flexible arrangements.

(Consultation Event Group)

This must be made more aware ~ hospitals need people to feed people with dementia.

(JB, Carer)

Recommendation 7 ~ Issues identified at a local level

- Domiciliary care ~ capacity issues have led to delayed discharge from hospital.
- Lack of continuity ~ different people providing the care from day to day.
- Lack of reliability
- Lack of a "specialist" domiciliary care service.
- Clearer structure for medication on discharge. (Consultation Event Group)

I myself feel very lucky to have found "Levanto" [day care home] in Paignton ~ [my husband] is happy going there ~ would be nice if everyone had this chance. (JB, Carer)

~ Feedback on the Strategy

- Promotion of direct payments which enables carers to purchase services which meet individual needs, eg sitting service
- Care at home should be maintained wherever possible to enhance user and carer experience

Recommendation 8 ~ Issues identified at a local level

- Lack of a night "sitting service"
- No access to a crisis resolution and home treatment service
- Ongoing training and education programme for carers
- Lack of information on services available and how to access them
- Continuity issues
- Lack of specialist day, with a structured programme, leading to a positive experience for the person with dementia.
- More "care" in the person's own home. (Consultation Event Group)

My first short break in 8 years starts 5th September ~ it's been awkward doing this, but the staff have been so helpful. (JB, Carer)

~ Feedback on the Strategy

- Stress that dementia is "everybody's business"
- Need for 24-hour community support for carers.

Are these the outcomes, recommendations and suggested means of achieving them the right ones? *Continued3*

Recommendation 10 ~ Issues identified at a local level

- Need for a crisis helpline
- Lack of information
- Emergency "sitting service"
- Carers to be involved in discharge process as soon as possible
- Improved services to prevent admission and facilitate early discharge.

(Consultation Event Group)

I think to make them feel wanted!! Such as give them musical exercises, or singing of the old songs. (JB, Carer)

Recommendation 11 ~ Issues identified at a local level

- Robust monitoring processes which involve carers
- Ability of carers to remain as "carers" whilst the person with dementia is in residential care
- Lack of structured day programmes.
- Why can there not be an advice service to help people choose between providers when they are looking for residential/nursing care?

General Hospital Care

- Designated ward to people with dementia?
- Specialist dementia link nurse?
- Need for more awareness/understanding of hospital staff towards people with dementia
- Immediate involvement of family/carers in person's care plan for admission.

(Consultation Event Group)

2. Is there anything that has been missed that would help to ensure high-quality care and support for people with dementia and their families?

A great deal more training in dementia for all staff involved; To be treated as a *disease* ~ not a "social" problem. (DIC, Carer)

If carers had more confidence in the care standards in care homes, they would take more short breaks. I personally have not had any short breaks for several years ~ twice the family have taken on my role to give me a day off. (DB, Carer)

- Has it missed an opportunity to really focus on the needs of PWD and their carers?
- Does it present an opportunity for changed practice / to do things differently?
- Does it have the right ingredients to meet the projected needs for PWD in the context of demographic factors and the ageing population?
- The Strategy does not go far enough to focus on the impact of ageing populations and the decrease in working-age adults and funding.
- There is no reference to the role of community hospitals.
- What is their role and to what extent will CH be reshaped as part of the care pathway to meet mental health needs?
- There is no reference to specialist mental health inpatient beds for older people. "Everybody's Business" saw the need to segment care for PWD and PWF illnesses/co-morbidity, yet there are still many services providing integrated care. (OPMH Group, DPT)

3. What more could be done in acute care, home care and care homes?

Ensure staff have good ~ really good training and a really good understanding of the way people with dementia think. Funding by Government as a medical condition ~ after all, it is a disease.
(DIC, Carer)

The inspection should be more rigorous, unannounced visits to check a random sample of clients for lack of hygiene, proper nutrition etc.
(DB, Carer)

Hospitals

- More awareness of hospital staff and it would be a good idea for a nominated member of staff, ie specialist nurse, to be responsible for advising all concerned with the clients' care to be notified of their condition and what it entails.
- Hospital is not a "secure unit" so security must be improved for people with Alzheimer's.
- Mental health nurses who understand the condition rather than general nursing.
- Life-Book would explain dementia/Alzheimer's Disease to both the carer and cared-for.
- Admission policy ~ fast-tracking A&C (as children)
- Stays ~ ability to remain with patient
- Discharge ~ medication arrangements. (Consultation Event Group)

Acute Care

More acute care beds provided locally to patient. (Consultation Event Group)

Community

- More awareness of surgery staff and GPs ~ education on how to recognise carers.
- More services, ie support group, "out-of-hours" contact (specialist).
- More media awareness, especially in "twilight" stage. If not under Chadwell (Community Mental Health Centre), no support available.

More "Memory Cafés". Carer needs to continue to be involved (if they wish) in care of person when they go into hospital or care and services should promote this and make flexible arrangements.

Care Homes

- Awareness of care staff ~ better training. Some homes will not take Alzheimer's/dementia sufferers. Carers need to know that all homes are registered to take "sufferers".
- More inspections ~ ensure family involved/included.
- How do inspectors assess night care?
- Ensure structures of home meet needs of patients rather than needs of staff ~ example of home staff getting patients up at 5.30am by night staff, because easiest time for care home staff.
- Need for range of meaningful activities for patient in a care home.
- Training strategy for all staff at care homes. (Consultation Event Group)

Care Plans

- Insufficient for carers
- Staff don't appear to disseminate to colleagues to seek communality of need.
- Individualised care plans that carers/family jointly agree.
- Care homes often seem to cater for the "lowest common denominator", ie all residents given luke warm tea because someone might scald themselves.
- Link community nurses for individual care homes as resource for homes.
- More therapists ~ holistic. (Consultation Event Group)

4. What could be done to make the personalisation of care agenda (including individual budgets) work for people with dementia and their family carers?

We've had our monies looked into, and a pleasant surprise awaited us. Thanks to Cheryl Bowden MBE ~ not may OAPs know of this, or are too proud to be assessed. (JB, Carer)

In Torbay there is an implement group for individualised budgets for people with mental health problems, including people with dementia, to ensure that this way of delivering care is available to this client group. We would expect the process to evolve and become available to users and carers over the next six to nine months. (Torbay Care Trust)

5. What can you or your organisation do to help implement the recommendations?

Fill in forms like this for the Government to see how we as carers manage (with the help of our families). (JB, Carer)

Give the benefit of my experience when asked ~ generally I am not able to attend meetings. (DB, Carer)

Once again the Care Trust, in line with Devon Partnership Trust and South Devon Healthcare Trust have a huge role in implementing the recommendations suggested. We already have a Psychiatric Liaison Team in the planning, to be based in South Devon Healthcare, to support the quality of care for people with all mental health problems in the District General Hospital. We clearly need to support the development of this team and ensure that we give equivalent support and education to staff working in general hospitals.

With respect to home care for people with dementia, following this consultation it has become more clear that we need to work locally to develop a service specifically for those people with dementia.

In Torbay short breaks are available for people with dementia and their carers, however what has become really apparent through the consultation process is that not enough people know about these services and what they can offer them. We clearly need to work with our teams to ensure that our users and carers are well informed about what is on offer, and how they can access it.

As a Care Trust we already have a joint commissioning strategy for people with dementia, which also includes older people with functional mental health problems, and is developed through our local implementation group for standard 7 of the older people's NSF.

We are about to launch a residential service for people with dementia for intermediate care. We are also developing intermediate care services in the community across Torbay (which are already in existence) to include those people with dementia.

Through our Commissioning Department with the private sector we can monitor and improve dementia care in homes. We can also do this in line with our Safeguarding Adults Team and our colleagues at CSCI.

(Torbay Care Trust)

Recommendation 13 Clear information on the delivery of the strategy
Recommendation 14: A clear picture of research evidence and needs
Recommendation 15 effective support for implementation

General comments

Do you have any other comments you would like to make in relation to this consultation?

Home care workers who get the person up, wash and dress them, give them breakfast etc, need MORE TIME to do this work. The demented person can be rushed, hassled and left in a totally exhausted state when the care worker has left after a very short time. (DIC, Carer)

I feel sure there are quite a lot more people who are suffering, who have no idea that there is help out there. (JB, Carer)

I found that in my early days of caring, there was a lack of information on how to care and what appropriate support existed. Training courses are offered on handling, hygiene, continence, institution, but are of little use when you are a full-time carer. In my experience a visit from an expert is very much more valuable. (DB, Carer)

- National -v- Local interpretation ~ while a prescriptive approach is not wanted (ie targets), there is concern that locally nothing will happen (eg there was an example from one organisation where no-one locally is owning up to taking the lead on dementia).
- There needs to be greater emphasis in commissioning frameworks.
- Is there funding? (OPMH Group, DPT)

Improving short-breaks

- Host day carers scheme to include people with continence difficulties
- Ensure people/families aware of all available options for short-breaks
- Allow people to trial options to make choices
- Need for appropriate homes and services for younger adults with dementia
- Engage churches/voluntary organisations to provide respite opportunities
- **More** intermediate care appropriate to the person's needs.
- Ensure all patients given all available options and criteria.
- Better integration of services to ensure everyone knows what everyone does. (Consultation Event Group)

General Comments ~

- The Strategy is weak on outcome measures and monitoring processes
- The value of carer involvement in monitoring and commissioning of services is not stressed
- Medication ~ hardly mentioned and no mention of value of medication.
- Carers highlighted important need to have co-ordinated services delivered by professionals and carers with good understanding of dementia from beginning to end of disease journey.
- Carers want to remain in person's life in caring role even if patient now in care home.
- Carers often feel very isolated from care plan once person is in care home.
- Need for better support to bereaved family members.
- How to meet the needs of carers and individuals once they are in longer-term residential/ nursing homes, ie
 - Accessing health professionals
 - Being involved in care plans
 - Still being the carer!

Key observations and areas for development against 14 objectives in the National Dementia Strategy for Torbay Care Trust

Objective	Observations	Areas for development	Actions	Lead	Timescale
Objective 1: Improving public and professional awareness and understanding of dementia	<ul style="list-style-type: none"> - Limited strategy or plan in place to raise awareness amongst general public. - Dementia Care Pathways booklet ~ 2,000 published currently. 	<ul style="list-style-type: none"> - Develop and implement local campaign to raise awareness. Involve all partners and make full use of variety of media. - Involvement of public health/health promotion expertise on an alcohol/dementia prevention campaign. - Finalise local dementia commissioning strategy and formal validation process - Costed business case for 2010-11 	OPMH staff to work with surgeries to increase awareness	Joanna Wildgoose	12 months
			Develop public awareness and staff training strategy	Ann Redmayne	12 months
			Present to SMT, TCT Board, PEC, OSC	Ann Redmayne	Dec 09
			Finalise priorities and develop costed business case for 2010-11	Ann Redmayne	Feb 10
Objective 2: Good-quality early diagnosis and intervention for all	<ul style="list-style-type: none"> - ↓% of expected dementia prevalence registered with general practitioners. - Good assessment and diagnosis from Devon Partnership Trust. - Memory clinics operating - EDI Policy Implementation Guide developed by the professional expert group. 	<ul style="list-style-type: none"> - Need to monitor actively the % of general practitioner registered patients with dementia diagnosis. - Promote and monitor general practitioner uptake of awareness training offered. - Commissioners to lead work to establish clear service specification for memory service, with defined outcomes and capacity. - Improve case finding within the Community Learning Disability Service and identify services to meet needs ensuring linkage to an integrated dementia pathway. 	OPMH team to work closely with surgeries to ensure registers are accurate	Jane Batstone	12 months
			Link to training plan in Objective 1	Ann Redmayne	12 months
			Write service spec based on EDI PIG and local need data. Commission expanded EDI service	AR,DS,CW,JH	By Feb10
			LIG to seek input from LD service and request they nominate a dementia champion (letter from AR to consultant & service manager).	AR/Nikki Henderson	By Feb 10

Objective	Observations	Areas for development	Actions	Lead	Timescale
Objective 3: Good-quality information for those with diagnosed dementia and their carers	<ul style="list-style-type: none"> - Dementia Care Pathway booklet for carers. - DPT run post-diagnostic groups from memory clinic. - "One Stop Shop" - Carer's education sessions. - Memory clinic feedback interview. - Carer's education group. - Dementia pathway – Alzheimer's Society. - No leaflets from Alzheimer's Society about Alzheimer's Society Café. 	<ul style="list-style-type: none"> - Commissioners to work with partners in Health & Social Care and third sector to monitor information available with view to improving access. - Undertake programme of audits to evaluate effectiveness of the information accessed by people with dementia. 	Review what is available	SLL & David Mannion	6 months
			Audit department	AR	6 months
Objective 4: Enabling easy access to care, support and advice following diagnosis	<ul style="list-style-type: none"> - "Days out" service. - Carers Support Groups. - Carers Support Workers. - OT post diagnosis group. - Sensory memory stimulation group. - Need to access follow on resources possibility outside mental health expertise base. - Memory cafe in Paignton all that is available but is appreciated and valued. - Comprehensive cohesive working in zonal teams. - Joint working at CMHT level – good relationships between health and social care. 	<ul style="list-style-type: none"> - Learn the lessons from the Department of Health Dementia Advisors' Demonstrator sites and apply to local practice. - Memory Clinic needs to be developed to provide a variety of support and education options. - Also needs to link with a dementia pathway. 	Apply learning, develop service specification, business case, consider pilot in one area	AR	12 months
			Review Clinic and medication protocol	JW, SLL	3 months
			Develop a fully commissioned comprehensive dementia pathway	AR	12 months

Objective	Observations	Areas for development	Actions	Lead	Timescale
Objective 5: Development of structured peer support and learning networks	<ul style="list-style-type: none"> - Host carer scheme open to people with early dementia. - Plans to commission a Memory Café network. - CMHT input into Memory Café. - Dementia Café runs every week. - Memory Cafés in Torquay & Brixham. - Carer's Education Group. - Carers' Support Group. - Memory Café well established (45-50 per week). - CPN input weekly - Memory Café entirely volunteer run (sustainability) may be issue but very good model. 	<ul style="list-style-type: none"> - Low intensity support (dementia adviser and peer support networks) are consistently cited by carers of people with dementia as their top priority. Support networks are generally inexpensive, and hence offer a potential early on. - Opportunity to review coverage and funding arrangements and learn from national demonstrator sites. 	Commissioners to develop a comprehensive pathway and commission it. This may involve transfer of resources.	AR	12 months
			Fully Implementation of DOH peer support demonstrator project implementation plan. Ensure sustainability (commissioning strategy)	AR, SO, DM	18 months
Objective 6: Improved community personal support services Objective 6 continued:	<ul style="list-style-type: none"> - Host carer service innovative. - "Days out" service Age Concern limited to early stages (+ personal care element). - Host families – alternative day service. - Parkview Trust – flexible person centre day. - Self funders appear left very much to own devices. - Well managed dynamic leadership in zonal teams. - SWAP, host families. - St. Edmunds Residential Intermediate care and community support team. - Currently reviewing day services. - Joined up commissioning plans voiced by John Bryant. 	<ul style="list-style-type: none"> - Review capacity of domiciliary care to meet actual and predicted demand. - Range and quality of day care 	Consider specialist dom. Care service Review day care provision Encourage individual budgets	AR	12 months
				Hannah Horrocks	6 months
				SS, CW & Nicola Barker	6 months

Objective	Observations	Areas for development	Actions	Lead	Timescale
	<ul style="list-style-type: none"> - Eclipse lodge residential home. 				
Objective 7: Implementing the carers strategy	<ul style="list-style-type: none"> - Dementia Care Pathway for carers. - Carers assessment completed by social worker at CMHT base. - Carer's assessment not universal. - "Yellow folder system for complex cases (travels with the patient). Carers support workers in GP surgeries. 	<ul style="list-style-type: none"> - Promote Carers Strategy and link to programme of training amongst staff to raise awareness. - Review systems for collecting data about carers and identify improvements. - Consider an out of hours' helpline for carers. - Promote the work of the Carers Support Worker in each GP practice. - Range and quality of day care 	SW to link with training programme	Linda Hammett /AR	12 months
			Systems review	LH/Katie Heard	12 months
			To be commissioned	AR	12 months
			SW to work with practices to increase awareness	LH	6 months
			Review day care provision and develop community hubs	Hannah Horrocks	By April 10
			Fully implement DOH demonstrator carer programme (dementia)	James Drummond	18 months
Objective 8: Improved quality of care for people with dementia in general hospitals	<ul style="list-style-type: none"> - Commissioning of a liaison service. - Have a dementia specialist acute/lead clinician in place. - Lots of innovative work in wards/departments. - Staff highly motivated. - Educational package very extensive. 	<ul style="list-style-type: none"> - Raise profile of, and training for, DOLs and MCA to improve safeguarding. - Dementia awareness training to be comprehensively rolled out. - Environmental issues need attention using the Alzheimer's Society reference tool. - Liaison service and also care/intermediate care need to be properly commissioned and service specification formalised with provider input. 	Prioritise training for key staff ~ plan to be developed for all staff	Liz Childs/ Maggie Dunbar	6 months
			As above		
			Staff to work with University of Stirling to review environments	MD	6 months
			Commissioner to develop service spec with DPT	AR	Fully operational by April 09

Objective	Observations	Areas for development	Actions	Lead	Timescale
Objective 9: Improved intermediate care for people with dementia	<ul style="list-style-type: none"> - Existence of intermediate care not age rigid - Excellent. - St. Edmunds Rehab Unit 9 beds for PwD-design friendly environment. 	<ul style="list-style-type: none"> - Undertake a training needs analysis. - Regularly monitor effectiveness of intermediate care for people with dementia. 	Undertake analysis	David Jones & Sally Pritchard	6 months
			Audit care	DJ & SP	6 months
Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers	<ul style="list-style-type: none"> - Telecare show flat – clients known to CMHT have access to telecare via community alarm providers. - Designated team for equipment provision, including occupational therapist. - Several moves in and out of family homes to supported lodgings all broken down due to dementia symptoms (undiagnosed at time). - 45 flat ECH (John Boyne site) on track Oct 2010 with some designated dementia flats. - RSLs developing community hubs in sheltered and ECH. 	<ul style="list-style-type: none"> - Telecare in St. Edmunds needs development - Further extra care housing for people with dementia + their carers planned (e.g. Guineas Trust 65 flats ECH remodelled from sheltered). Ensure plans linked with the local Dementia Strategy. 	<p>Sally to discuss options</p> <p>Strategies for housing and dementia need to link closely</p>	SP	6 months
Objective 11: Living well with dementia in care homes	<ul style="list-style-type: none"> - One nurse providing support/advice into care homes with additional support from CMHT. - Although homes mainly rated 'good' or 'excellent' by CQC, engagement with people with dementia in care homes could be improved. - Referrals into CMHT from nursing homes for fairly routine advice. - Fee level may tend to reduce quality. - Initial placement broke down 	<ul style="list-style-type: none"> - Consider expanding current support to allow for training and education within care homes. - CPN and multi professional in-reach to care homes. - Consider and develop further preferred providers. - Need specialist pathway for dementia and roll out yellow folder. - Preferred provider lists or specific homes that are contracted with. - Contract specifications to focus on qualitative aspects and to be taken 	Commission care home support team	AR	6 months
			As above		
			Tender to preferred providers	AR	6 months
			Develop pathway	AR & DS	6 months
			Develop contract	Ray Hodgson	6 months

Objective	Observations	Areas for development	Actions	Lead	Timescale
	<ul style="list-style-type: none"> - after 6/12 (carer) . Eclipse lodge private residential home– excellent model incl. outreach to local community. 	<ul style="list-style-type: none"> - into account alongside CQC rating. - Stimulate the role of dementia champions in care homes. 	Care home link CPN	Bob Bartrum	6 months
Objective 12: Improved end of life care for people with dementia	<ul style="list-style-type: none"> - Joint advance statements which include sign up by Ambulance Trust. - Non-malignancy EOL pathway being considered. - Joint EOL care training available. - Auditing, care home admissions including DGH. - EOL strategy group not fully established. - Strategy for EoL care being developed but not yet implemented. - EOL care possible at St. Edmunds with input from Palliative Care Team. - Gold standard framework in place but not for dementia 	<ul style="list-style-type: none"> - Consider expanding current support to allow for training and education within care homes. - Develop pathway in EOL strategy that is dementia specific. 	Extend current developments	AR & Maggie Clough	6 months
			End of Life strategy to link directly with DS	DS, AR & Reine	6 months
Objective 13: An informed and effective workforce for people with dementia	<ul style="list-style-type: none"> - Co-located CMHTs but 2 record systems can increase duplication. - Degree- level modules in University of Plymouth. - Eclipse lodge residential home excellent training and support for staff. 	<ul style="list-style-type: none"> - Workforce development strategy required to address training needs across all partners in relation to dementia. - Extend dementia awareness training within the SDHFT to wider range of staff. - Improve awareness within zonal teams and with general practitioners and build confidence of staff to respond appropriately to needs of people with dementia and their carers. 	Develop training strategy and implementation plan	AR	6 months
			Increase training in hospitals	Maggi Dunbar & community hospital matrons	12 months
			Increase specialist team presence in the zones	CW	12 months
			GP communication and education programme	JW	12 months

Objective	Observations	Areas for development	Actions	Lead	Timescale
Objective 14: A joint commissioning strategy for dementia Objective 14 continued:	- Dementia Strategy in draft form.	<ul style="list-style-type: none"> - Approve and publish the local Dementia Strategy. - Include milestones, target dates, lead individuals and clearly identified short and medium term priorities and investment in action plan. - Consider how core messages from local Dementia Strategy can be reinforced to relevant staff whose main focus is not dementia. - Develop capacity planning, looking at quantifying supply of services at different points of an agreed commissioner determined dementia pathway, as well as demand in the JSNA. - Re-clarify the lead general practitioner role for dementia. - Seek opportunities to involve clinicians and practitioners in a leadership role for certain work-streams. - Begin work to define outcomes for objectives in the local Dementia Strategy and commissioned services for monitoring and evaluation. 	Publish local strategy redraft - Present to January LIG - Communication plan	AR CW Jim Delves	Feb 2010
			Link with training strategy	AR	6 months
			Clear plan to increase capacity over 5 & 10 years	AR	6 months
			AR to discuss and clarify with LT	AR	3 months
			AR & CW to identify key individuals	AR	6 months
Local strategy to include a review and evaluation process bi-annually	AR	6 months			

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