West Sussex Joint Dementia Strategy 2020-23 Delivery Plan

Areas	Goals	Actions	By whom
Preventing Well	People live, work and play in environments that promote health and wellbeing and support them to live healthy lives.	1.Explore ways of promoting the NHS Health Check (dementia) leaflet widely. 2.Engage with Long term conditions clinics (i.e. diabetes, hypertension) to explore ways they can be used to identify early signs of dementia. 3.Delivery of lifestyle advice arounda range of risks factors. 4. Deliver Information and advice about weight management. 5. Deliver workplace health offer. 6. Provide Making Every Contact Count' resources and deliver workshops.	Public Health, NHS, Wellbeing programme and wellbeing advisors
	Individuals, families, friends and communities are connected.	1.Explore a Connecting Communities Kite Mark for local businesses. 2. All businesses complete Dementia Friends training. 3. Delivery of social prescribing within GP surgeries.	Public Health, Primary care
	There is greater awareness and understanding of the factors that increase the risk of dementia and how people can reduce their risk by living a healthier life	1.Work with Local Dementia Action Alliances to raise awareness of of the factors that increase the risk of dementia. 2.Increase communications. 3. Raise awareness through commissioned services.	LDAA's, WSCC and CCG comms, commissioners
	Early intervention and ongoing support for hearing and sight loss	1. Hearing tests available at wellbeing events. 2. Explore the viability of a campaign for promoting sight and hearing tests.	Wellbeing hubs, Public Health, Districts & Boroughs
Diagnosing well	People recognise the early signs of dementia. They know what steps to take to receive a diagnosis and the benefits of diagnosis.	1.Facilitate media campaigns particularly around Dementia Action Week 2.Promote Dementia Friends training. 3. Develop a training programme that supports providers in the recognition of the signs of dementia.	WSCC and CCG, Providers, commissioners LDAA's, Dementia Champions
	Improved access to information and advice	1. Explore ways of ensuring information and advice is provided in the right format and is accessible throughout the person's journey and as their needs change.	SPFT, Providers, commissioners, WSCC
Diagnosing well	Improved access to good quality joined up support before and after diagnosis	1. Explore how the referral pathway to support such as Carers Support WS, during the waiting period and post-diagnosis, can be improved.	SPFT, Community & voluntary sector providers, Commissioners
	People have the opportunity to plan for the future along with those around them.	1. Develop a care plan that can be used by the family carer and shared with all those involved in the person's care. The care plan should be holistic and developed with the individiual and their carer. 2. Explore ways of sharing the advance care plan electronically between providers. 3. Look at ways of ensuring there is an easy route back into support if required at any point in the person's journey which could include developing the offer from Proactive care. 4. Explore potential training in care planning and conversations around end of life care.	Commissioners, Primary Care, SPFT, Proactive Care, Ambulance service

Diagnosing well	All groups of people to receive a timely diagnosis including younger people with alcohol related dementia, people with learning disabilities and people from minority groups.	1. Improve recording of ethnicity and sexuality at referral through to diagnosis. 2. Explore training to support sensitive conversations around this topic. 3. Explore ways of ensuring the referral rate for people from BAME groups to reflects the ethnic makeup of that geographic area. 4. Campaign to improve the recruitment and retention of Consultants within the Dementia Assessment Service in Chichester. 5. Clarify the current pathway of diagnosis and post-diagnostic support for people with Alcohol Related Dementia and to agree a map or pathway. 6. Develop, design and deliver a pathway to diagnosis and post-diagnostic support for people with Alcohol Related Dementia. 7. Utilize the DiADem tool to diagnose people in care home settings. 8. GPs and practice nurses to use long term conditions clinics and health campaigns (e.g.: seasonal flu) to consider whether older people at risk of dementia have symptoms that will require further consideration. Communication regarding guide and enagement to all GP practices will be provided. 9. Establish a clear pathway to diagnosis for people with learning disabilities including baseline assessment of functioning. 10. Improve referral routefor people with learning disabilities from Memory	SPFT, Primary care, care providers, acute hospitals, commissioners, community and voluntary sector providers, Community LD team, Health Facilitation team
Supporting well	For people to be enabled to live independently at home	1. Explore ways of promoting the offer of technology that allows people to live at home safely. 2. Work with house planners to see what can be done about ensuring future housing reflects the needs of people with dementia. 3. Procurement of a new care and support at home service that looks to ensure there is sufficient local provision of care and support at home where more support is required. 4. Explore ways of ensuring people with hearing or sight loss have access to regular hearing and sight tests, technological aids, environmental improvements, and accessible information and communications	Commissioners, WSCC Housing planners, Occupational Therapists, Public Health
	For people with dementia to be able to access joined up health and social care and community support throughout the progression of their dementia	1. Work with primary care, hospitals, dementia services and long-term clinics to establish a joined up pathway of support for the patient. 2. Improve access to training/information in Caldicott principles to improve information sharing.	WSCC Learning & Development, Primary Care, SPFT, Alzheimer's Society, acute care, Community & Voluntary sector
	Dementia and carer friendly health and care settings	1. Place based Health and social care providers to conduct dementia friendly environmental audits in buildings accessed by the public. 2. Family carers to be identified and recorded as partners in the care of the person with dementia. 3. Hospitals to promote and reinvigorate the Knowing Me tools. 4. Hospitals to involve patients and family in discharge planning, supporting carers in doing so.	WSCC and CCG, Primary Care, Acute care, Adult Social Care, Care providers, community & voluntary sector providers

Supporting Well	Approaches to care and support that are individual to the person's needs and for the person to be enabled to self manage their dementia and other conditions	1. Care providers to provide care and support in a culturally appropriate manner in order to be accessible to people from BAME and religious minority communities. 2. Commissioners and providers of social and health care to consider the needs of LGB&T+ people when planning and/or running services. 3. Promote life story work in care settings to help the person understand their past experiences.	WSCC Care & Business Support team, Care providers, Commissioners, WSCC Contracts
	Compassionate care and support from staff skilled in dementia	1. Provide a clear offer of education, training and development opportunities for those people and organisations providing care and support for people with dementia at a level that fits with their individual responsibilities. 2. Provide a clear offer of training for workers supporting people with learning disabilities and dementia to ensure they are skilled in supporting someone to remain in their normal care setting for longer following their diagnosis. 3. All health and social care providers to have a framework for dementia training that ensures all staff receive training relevant to their role.	WSCC Learning & Development, Community Dementia Matrons, WSCC Care & Business Support team (CABS), Health & social care providers, Primary Care, Community LD
	For support to be in place to avoid wherever possible unplanned admissions to hospital or inpatient facilities. Where hospital admissions are required, for these to be as short as possible.	1. Develop a care plan that can be used by the family carer and shared with all those involved in the person's care. The care plan should be holistic and developed with the individiual and their carer. 2. Provide training and support to care and nursing homes in managing complex and challenging behaviour and in recognising symptoms that do not need a hospital stay. 3.Explore use of the Enhanced Health in Care Homes Framework. 4. Hospitals to involve patients and family in discharge planning, supporting carers in doing so. 5. To continue to reduce length of stay particularly those longer than 21 days.	Commissioners, Community Dementia Matrons, WSCC Care & Business Support team, WSCC Learning & Development, Acute care
Supporting well	The risk of a Crisis is prevented wherever possible and where a crisis occurs there is a comprehensive joined up offer of support	1. Provide a robust offer of information and support for family carers throughout the pathway including an offer of flexible respite. 2. Identify people with dementia and family and friend carers at risk of becoming socially isolated and support them to access their community. 3. Identify ways health, social care and dementia services can work together to support the person and their family at times of crisis.	Commissioners, Adult Social Care, SPFT, Community & Voluntary sector providers, care providers, Community Dementia
	People with dementia and their families have a good experience of support provided by Care Homes and that there is sufficiency of quality, affordable provision within West Sussex that reflects the needs of diverse communities.	1. Care homes have a clear framework of education and training around; identifying the signs of dementia and knowing how to access support, how to avoid an unnecessary hospital admission and leadership. 2. Facilitate a diverse provider care market that can deliver culturally sensitive support and support for people from the LGBT+ community. 3. Work with care and nursing homes to enable them to develop good links into their communities and become part of their local dementia friendly community.	WSCC Learning & Development, WSCC Care & Business Support (CABS), Care providers, WSCC Contracts, commissioners

Living Well	People have access to a range of affordable flexible activities that reflects their interests and needs	1. Provide an offer of services designed to meet the needs of all people with dementia. Services should be inclusive of people from diverse groups. Consideration to be given to the needs of LGB&T+ people and people with sensory impairment. 2. Co-produce an offer of activities with the BAME community. 3. Provide an offer of age appropriate activities for younger people living with dementia. 4. Explore ways of supporting people with dementia to take part in everyday mainstream activities. 5. Provide a seamless offer of support for the person when their needs change or their dementia progresses that includes an element of personal care.	WSCC Day Services, Community & voluntary sector providers, commissioners, care providers
Living Well	There is a whole community response to living well with dementia in safe and enabling communities	1. WSCC, CCG and District & Borough Councils to work together to explore ways the Local Dementia Friendly Community Groups can become sustainable. This includes how they are supported and funded. 2. Support the development of new Dementia Friendly Community Groups. 3. Public sector organisations to become dementia friendly organisations including the use of Dementia Champions in all departments delivering dementia friends training. 4. Place based Health and social care providers to conduct dementia friendly environmental audits in buildings accessed by the public. 5. There is a proactive approach from services such as Fire, Police and Trading Standards that supports people living with dementia to live safely in their communities. 6. Community transport plan. 7. Work with WSCC community planning to provide dementia friendly environments. 8. Improve links to Dementia Champions in delivering dementia friends training. 9. Improve links between Local Dementia Action Alliances and Wellbeing hubs to better promote local activities	WSCC, CCG, District & Boroughs, WSCC Transport, Fire & Rescue, Trading Standards, voluntary and community providers
	People can maintain and develop their relationships and be able to contribute to their community	1. There is a clear offer of support for people affected by dementia to be enabled to maintain and develop social connections through peer support, carers groups and similar initiatives to help build resilience. 2. There is a clear offer of practical and emotional support for family members and dependent children of people with Early Onset Dementia. 3. There is an offer of support for people with dementia and family and friend carers to take part in paid and unpaid work.	Community and voluntary sector providers, WSCC & CCG Commissioners
Living Well	Carers of people with dementia are able to access information, support as needed and feel able to continue with their caring role	1. Providers identify and record family and friend carers and treat them as partners in the care of the person with dementia. 2. Carers are offered an assessment of their own needs and have access to psychological therapies. 3. Explore ways of ensuring there is a well coordinated approach to information and advice where a similar level and quality of information can be accessed through all information providers. 4. Provide an offer of education and training for family carers that helps them to build up an individual strategy for supporting the person they care for. Training to be provided in a format that is right for them and at a time that is suitable for them. 5. CRISP and similar training for carers to be promoted. 6. Provide a offer of flexible respite. 7. Promote the Short breaks offer for carer. 8. Support the carer to pursue activities individual to them including paid and unpaid work.	Commissioners, Community & Voluntary Sector providers, Primary Care, Acute care, care providers

Dying Well	There is support for people to die with dignity in a place of their choice	1. All health and social care providers to be trained in completing advance care plans and the sensitivities around these conversations. 2. Explore ways of sharing the advance care plan electronically between providers.	Health and social care providers, commissioners, Ambulance
	People with dementia approaching the end of life, should experience high quality, compassionate and joined-up care	1. Provide a training framework to ensure there is a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia in the end stages of life and is equipped to do so. 2. Provide training and support to care and nursing homes in managing end of life care in people with dementia and in recognising symptoms that do not need a hospital stay.	WSCC learning & development, WSCC Care & Business Support (CABS), Care providers, WSCC Contracts, commissioners, Acute care, Ambulance service, SPFT, hospices
Dying Well	Families and carers are provided with timely co-ordinated support before death, at the time of death and bereavement	1. Improve access to training/information in Caldicott principles to improve information sharing amongst all providers involved in the end of life stage. This should extend to ensuring the family understands what is happening and are updated regularly. 2. Families and carers are offered bereavement support at a time that is right of the them.	Commissioners, Community & Voluntary Sector providers, Adult Social care, Ambulance service, SPFT, Acute care, hospices, primary care

Suggested initiatives for the future

The following initiatives look at what might be achieved if there was some additional funding available in the future.

Outcome	Objective/Action	Measurements (to be further developed)
Minority Groups	Funded community champions and project workers	Role spec, Role Objectives, Appraisal and individual local KPI's Increased diagnosis rates for BAME. Increase in number of carers assessments
	Training and education for community champions	Evidence of training completed and put into practice Increased diagnosis rates for BAME. Increase in number of carers assessments
	Co-production with people from BAME communities	X no. of focus groups per annum and number of people involved. Increased diagnosis rates for BAME. Increase in number of carers assessments
	Faith groups holding their own funding pot.	Criteria and outcomes and KPI's set and monitored. Increased diagnosis rates for BAME. Increase in number of carers assessments
	Embassy links and celebrity endorsements.	Increased diagnosis rates for BAME. Increase in number of carers assessments and registrations with Carers Support WS.
Dementia Friendly Communities	Develop a business case for sustainining the work of the Local Dementia Friendly Communities Groups	Increase in number of dementia friends and dementia friendly organisations
		Long term increase in diagnosis rate.
		Increase in number of carers assessments and registrations with Carers Support WS.
		Growth in number and reach of Local Dementia Friendly Community Groups particularly into more rural areas.
	Facilitate shared learning across Local Dementia Action Alliances	As above
	Increase number of dementia friends by 1% increase which potentially equates to 2,000 dementia friends per year.	As above
	Annual conference for Local Alliance leads to share knowledge, grow and network and annual local events.	As above
	Support with comms, social media and dementia website(s)	As above
		Increase engagement and comms by x%
	2 funded f/t co-ordinators for Local Alliances	A measurement tool which could sit alongside the Wellbeing Indicators (developed in conjunction with Public Health)
	Funding all Local Alliance leads.	A measurement tool which could sit alongside the Wellbeing Indicators (developed in conjunction with Public Health)
		Growth in number and reach of Local Dementia Friendly Community Groups particularly into more rural areas.
	Individual funding pot for each Local Alliance for pop up events, training, education and comms.	Work with Public Health to develop a measurement tool which could sit alongside the Wellbeing Indicators.
		Growth in number and reach of Local Dementia Friendly Community Groups particularly into more rural areas.
	Training for volunteers and communities.	Work with Public Health to develop a measurement tool which could sit alongside the Wellbeing Indicators.
		Growth in number and reach of Local Dementia Friendly Community Groups particularly into more rural areas.

Support for family and friend carers and meangful day activities	Commission Immersive training for care staff such as the 'Dementia Tour'.	Nos. using training.
		Reduction in unplanned admissions to hospital for the individual care home.
		Fewer referrals to the DCS from the individual care home.
	Training and education for GP's and Primary Care Networks including 'Top Tips' for GP's tool.	Nos. using training.
		Reduction in unplanned admissions to hospital for the individual care home.
		Fewer referrals to the DCS from the individual care home.
	One stop shops in the north and south of West Sussex that provides information, advice and support for people with dementia and their families and carers based on the Dementia Support/Sage House model.	Usage.
		More joined up support for people as their dementia progresses.
		Fewer referrals to secondary care services such as Living Well with Dementia and Dementia Crisis Service.
	Mapping services to identify gaps and linking people into support.	More joined up support for people as their dementia progresses.
	Central database of all services/activities.	Fewer referrals to secondary care services such as Living Well with Dementia and Dementia Crisis Service.
	Website such as Dementia Roadmap	Reduction in unplanned admissions to hospital for the individual care home.
	Commissioning 'Keeping In Touch' Programme (Alzheimer's Society).	Fewer referrals to secondary care services such as Living Well with Dementia and Dementia Crisis Service.
		Reduction in unplanned admissions to hospital for the individual care home.
		More joined up support for people as their dementia progresses.
		A measurement tool designed with Public Health to measure distance travelled.
	Weekend away breaks for people with dementia and their family carer. Either fully costed or with a financial contribution from the service user.	Usage/Uptake. A measurement tool designed with Public Health to measure distance travelled. Evaluation report.
	Personal care support within Short Breaks service.	Improved customer experience
	Use Crossroads Emergency Care service for ad-hoc needs.	Improved customer experience

Dementia & Learning Disabilities	Training and education around prescribing	Clearer more robust pathway for people with learning disabilities
	Baselining for people with Downs Syndrome from age 30	Early detection and diagnosis fo dementia for people with Downs Syndrome
	Baselining for all people with learning disabilities not just people with Downs Syndrome	Early detection and diagnosis for all people with learning disabilities
	Commission a severe LD specialist to support diagnosis in MAS.	Improved customer experience and early diagnosis
	Upskill Proactive Care to provide support for people with LD and dementia.	Improved customer experience