CARDIFF AND VALE DEMENTIA 3 YEAR PLAN (2014/15 to 2016/17)

Introduction

This Cardiff and Vale Dementia 3 Year Plan has been developed for people with dementia and their carers, in order that they can live well with dementia. It has been jointly developed between Cardiff and Vale UHB, City of Cardiff Council, Vale of Glamorgan Council and Third sector partners (including service user and carer representation). It will address the needs of people with dementia and their carers over the next three years, as well as serving future population growth. In order to achieve this, a multi-agency response including service users and carers is required.

The Plan builds on previous national legislation and strategic documents, including: the Mental Health Measure, the Dementia Action Plan for Wales, national Dementia Vision, How to Improve Dementia Guide, 'Together for Mental Health' (the national mental health strategy) and Stronger in Partnership. It also builds on local frameworks, including: The Mental Health Service User and Carer Involvement Framework and the Charter for Mental Health which incorporates the recovery and re-ablement ethos.

Certain actions within this Plan form part of the new partnership framework 'Meaningful and Purposeful Lives, Framework for Older People: Cardiff and the Vale of Glamorgan 2014 – 2019'. This framework builds on the strong foundations of the Wyn campaign, and aims to progress an integrated agenda across the UHB, two local authorities and our Third sector partners around healthy ageing and person-centred models of care. The framework covers six themes including: healthy living; information, support, resources and advocacy; timely assessment; information and guided care about services; co-ordinated Health and Local Authority services; and quality long-term care and support options.

Background

Much has been achieved both nationally and locally for people with dementia and their carers. However, gaps remain and we need to plan for the future predicted increase across health, social care and the Third sector. Estimates of future projections show that for all ages across Cardiff and the Vale of Glamorgan, numbers will increase by 53% between 2013 and 2030. The proportional increase will be larger in the Vale of Glamorgan due to the larger increase in the elderly population size, see Figure 1a and 1b.

There is also an increasing trend of people with learning disability living longer and therefore having an increasing need with respect to dementia care.

Figure 1a: Predicted increase in numbers with dementia in Cardiff

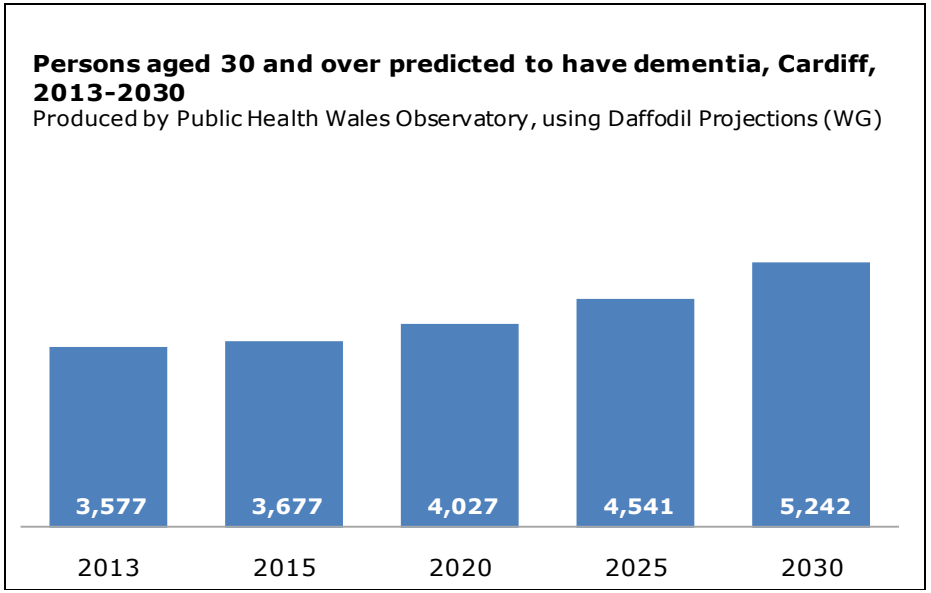
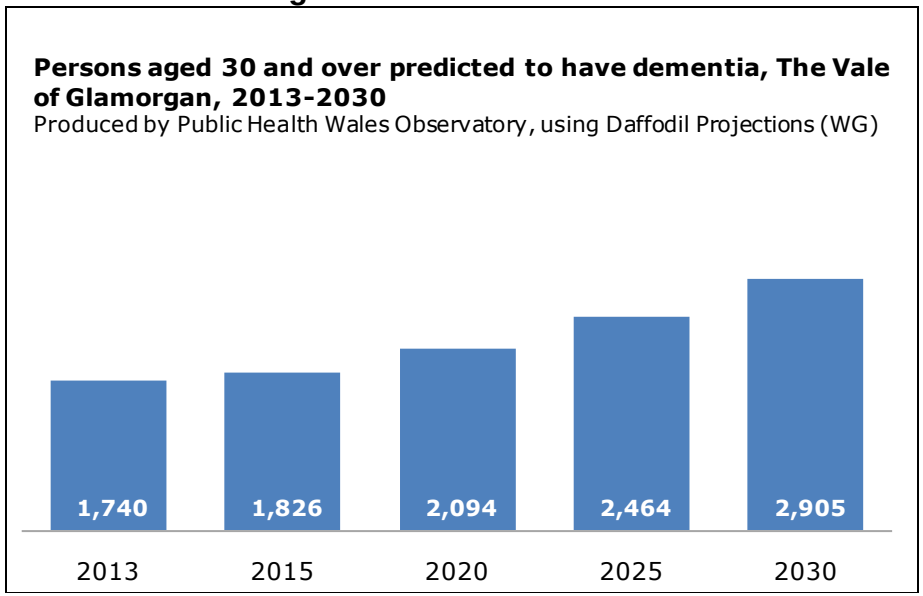
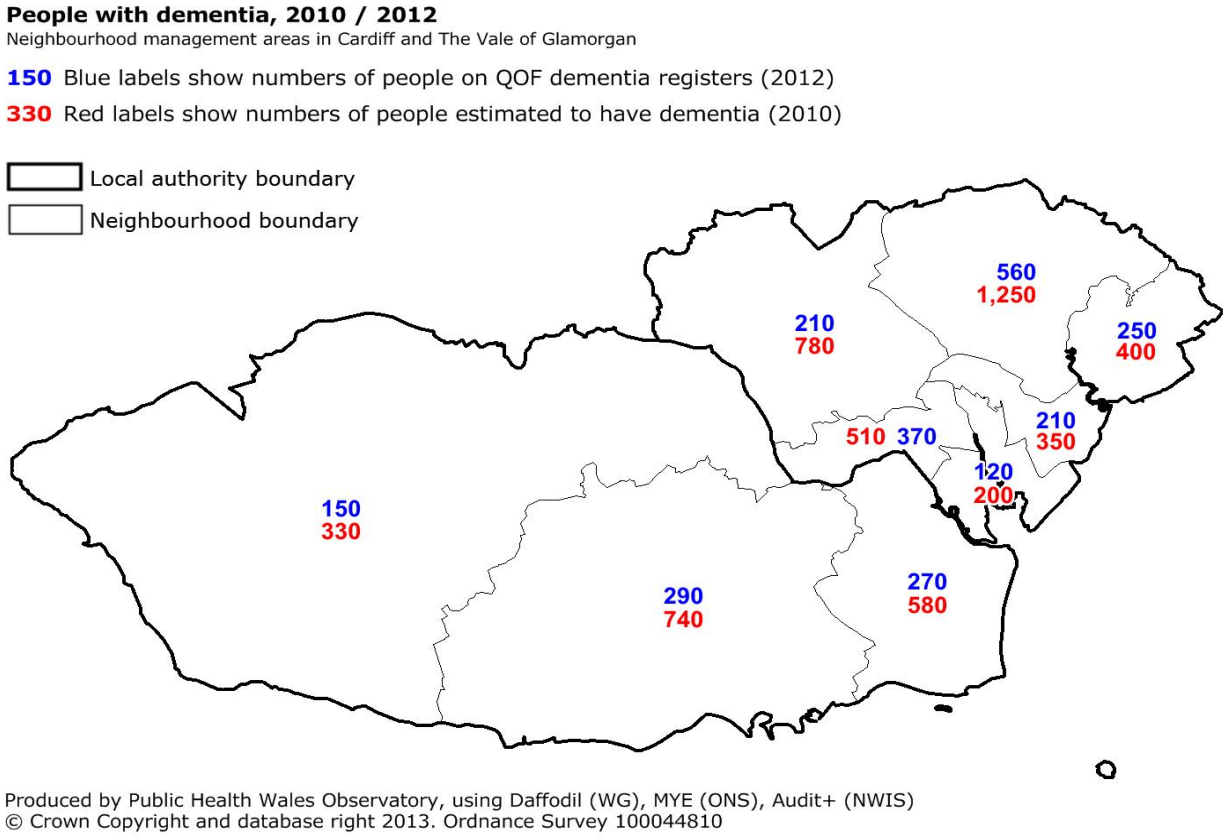


Figure 1b: Predicted increase in numbers with dementia in the Vale of Glamorgan



Under-diagnosis remains an issue within Cardiff and the Vale and also nationally. The current diagnosis rate is 46% in Cardiff and the Vale, which means that over half the cases are undiagnosed. Nationally, the picture is worse at a diagnosis rate of 39%. Figure 2 shows a map of the number of people on the GP register, diagnosed with dementia, and the number of people in the community estimated to have dementia. Therefore steps need to be taken within the community to ensure that people are more aware of dementia and how to signpost to appropriate agencies if they suspect cognitive impairment. An example of this is through the dementia supportive communities initiative, whereby community members are more aware of dementia, more inclusive of people with dementia and able to signpost as appropriate.

Figure 2: Dementia Map



A variety of services and agencies are available for people with dementia and their carers. This includes the statutory (Memory Team, Mental Health Services for Older People, Local Authorities and Community Resource Teams) and Third sector (Alzheimer's Society, Age Connects etc). Within the Third sector there is a co-ordination and engagement role provided by CAVAMH, C3SC and VCVS. Services being developed will be as inclusive as possible for people presenting with a primary dementia need, for example for people with learning disability. The planning process for the future will need to include the UHB Western Vale expansion and will need to be adjusted according to population size.

The national dementia action plan outlines four key strategic themes, which will be outlined in more depth in the local context below:

1. Making structural changes to economic, cultural and environmental conditions
2. Improving infrastructure and access to services for all
3. Strengthening communities
4. Strengthening individuals

- **Making structural changes to economic, cultural and environmental conditions**

In order to support people with dementia and their carers, the environment in which they live in needs to be inclusive and dementia-aware. One way of doing this is to create what has been coined a 'dementia supportive community'. This is defined as: 'one in which people with dementia are empowered to have high aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them' according to the Alzheimer's Society. It is planned that two such community pilots will take place, one in Barry and one in Cardiff West, prior to further roll out across Cardiff and the Vale. This forms an action under theme two of Cardiff and Vale's 'Framework for Older People', that older people along with their carers will know where they can receive information, support, resources and advocacy in the community to live independently at home for as long as possible.

Another action within this theme is the Communities Around Wyn project, which focuses on supporting frail older people to live well and independently in their community, through improving access to information and services to address some of the factors that lead them to become less independent and eventually to the need for care. The project primarily focuses on social factors which impact upon older people's independence. This can mean, for example, arranging support for people with shopping; making the house safe which can include, changing light bulbs, home heating and insulation; social support where the Third sector can engage with people to combat loneliness; as well as healthcare. The project will harness the knowledge and experience of a wide range of public and Third sector workers who have contact with older people as part of their daily work to deliver this campaign. It is envisaged that the training for advisors, who work for a variety of agencies going into people's homes, will include dementia awareness. The role of Community Resource Teams and associated dietetic service provision is invaluable in supporting

individuals to meet their nutritional needs, alongside day units, day hospitals and luncheon clubs, as people with dementia are more susceptible to malnutrition.

In addition, the Independent Living Project being developed in Cardiff aims to enable people to stay in their own home, access joined up and effective services across a wide range of organisations and take a proactive approach to preventing the need for care and hospital admissions. Independent Living Officers will take a holistic approach to supporting older people in their homes and help them to access the services they need to live independently. It is envisaged that these officers will also undertake dementia awareness training. Elements of the Independent Living Project will make a significant contribution to addressing specific issues such as dementia. For instance, home safety devices could be offered and installed in homes which will assist in monitoring movements of those people with dementia. The Community Alarm Team would be contacted through these devices if the person's movements are considered to be putting them at risk.

The prevention of dementia is important and some dementias share the same risk factors as heart disease. Therefore providing information and access to support on smoking cessation, healthy eating, physical activity and sensible drinking is relevant to this agenda. Pertinent action to support older people with these issues forms part of theme one of the 'Framework for Older People'.

This includes Making Every Contact Count (MECC), which was originally developed by NHS Yorkshire and the Humber[1] and aims to embed health improvement as a systematic element of service delivery i.e. the 'industrialisation' of behaviour change. The approach looks to ensure that people can make informed choices.

'The emphasis of the programme in not about telling people how to live but rather that their choices are at least informed'

A four level competency framework has been developed by NHS Yorkshire and Humber to underpin a programme of graded intervention, ranging from basic awareness-raising through to advanced behaviour change support. At level 1 of this framework (the lowest level), staff opportunistically identify individuals who wish to make changes to a lifestyle behaviour, provide basic information and signpost to appropriate local resources. This is termed a 'healthy chat'. It is not intended that this should add to an already busy workload, but rather to provide staff with the skills and knowledge to discuss health improvement when opportunities arise.

[1] Making every contact count (webpage) Available at: http://www.yorksandhumber.nhs.uk/what_we_do/improving_the_health_of_the_population/making_every_contact_count/

Within Cardiff and the Vale, a pilot has already commenced and full roll-out is anticipated by April 2015. The Healthy Schools initiative looks at healthy living in school children and awareness-raising of dementia features in the 50+ healthcheck website.

Seeking the views of people with dementia and their carers is critical to improving care and support within this process. This process will be supported by a European project called SPIDER. This project will run between January 2014 and July 2015 and engage with staff, service users and carers. The activity will involve service design workshops, service prototyping and the development of pilot projects through SPIDER, all supported by staff from Cardiff Metropolitan University.

- **Improving infrastructure and access to services for all**

Diagnosing people with dementia in a timely fashion is critical to ensure that treatment and support is given at the earlier rather than the later stages of the illness and this can enable people to be cared for at home for longer especially as earlier diagnosis can link carers into informal support networks and formal networks for advice, guidance and signposting to formal assessment in their own right. The Memory Team provides a diagnostic and early support service for people with suspected dementia. Later in the illness the person may need access to Mental Health Services for Older People or Local Authority Social Services for additional support and advice. Most everyday care and support may be given by primary care and a variety of Third Sector organisations.

For some people diagnosed with a dementia, symptomatic treatment may be appropriate. This may take the form of an Acetylcholinesterase Inhibitor or Memantine. Carers are entitled to a carer's assessment and access to group and psychological support. As the illness progresses behavioural problems may emerge. Evidence shows that routinely giving anti-psychotics to treat behavioural symptoms can be detrimental to health: where someone presents with behaviours that challenge, a careful assessment should be undertaken in order to identify an appropriate non-pharmacological method. Non-drug interventions include: cognitive stimulation, memory strategy groups and post-diagnostic groups. There may also be some potential in cognitive rehabilitation if proven beneficial in ongoing clinical trials.

Everyone has a role to play in improving the infrastructure for people with dementia. This includes rapid access for and discharge home of patients in the District General Hospital, medical and surgical wards alike. Looking after the emotional and physical needs of people with dementia requires more time and staffing levels need to reflect this. Whilst people with dementia are inpatients, they need to be prevented from falling, getting delirium or becoming malnourished. A recent Royal College of Psychiatrists audit of Cardiff and Vale wards showed some failed level 1 standards, which are basic requirements on a hospital ward. We need to aim to pass these at the next audit. Staff training in this area needs to be widespread and to include: primary care, secondary care and

social care which includes domiciliary care, care home and day care staff/providers. It goes without saying that the inpatient unit for people with dementia must also pass the required standard and currently the Mental Health Services for Older People Directorate has reached this and is aiming for Accreditation for In-patient Mental Health Services (AIMS)[2] accreditation with Excellence.

Dementia may also present in the younger years (under 65), and services need to be developed that are shaped around this younger age group. The community younger onset dementia service is near completion, and the inpatient unit is being established in Barry Hospital. However, accommodation with care models such as supported living needs further consideration, with jointly commissioned services for people with young onset dementia.

Dementia can also be a significant additional component of the care and treatment of adults with learning disabilities. The action plan below is deliberately inclusive of all service user groups and covers all protected characteristics. The cultural needs of people accessing services also needs to be considered.

Furthermore, the physical health of people with dementia is paramount. Whilst there is primary care cover for mental health inpatient units, out-of-hours nursing cover needs review. Everyone needs to have care as close to home as possible, a commissioning options paper will determine the best course of action as currently placements are out-of-area.

- **Strengthening communities**

It is important to ensure that the public have an awareness and understanding of dementia. To a certain extent, the national Dementia Vision created some visibility of the condition. However, more can be done locally to create awareness. Primarily this will be achieved through the dementia supportive communities work. The Alzheimer's Society will be rolling out their Dementia Friends Strategy from March 2014. There will also be an ongoing role within the Third sector to raise awareness at events and through campaigning activities, for example the Alzheimer's Society provides Awareness Training to a range of organisations and professional groups, including GPs, Private Sector, Public Sector and both statutory and Third Sector bodies. However, we all have a role to play in awareness-raising. In the longer term it will be advantageous to develop 'an army' of volunteers for people with dementia to enhance their support in the community.

[2] More information on AIMS accreditation can be found on: http://www.rcpsych.ac.uk/quality/qualityandaccreditation/psychiatricwards/aims.aspx

To ensure that the workforce is better equipped to support people with dementia, a training strategy will be developed for the Health and Social Care settings, to include Dementia Awareness as well as POVA and Dignity and Respect training. This will then be rolled out from April 2015. Furthermore, medical training needs reviewing to enhance the content of dementia management and to promote awareness of dementia and the levels of support required. Support also needs to be commissioned to support Nursing and Residential Care home and Domiciliary Care providers where staff find it difficult to provide care for those whose behaviour challenges. This can be achieved through having a named speciality contact to whom registered managers can refer for guidance with care planning and for support for staff who work in these settings.

When someone is in crisis, they need to have a responsive service that will support them to manage their condition as appropriate, therefore the Community REACT team has been established. Further work is required to fully establish a single point of referral for urgent and emergency referrals.

Joint planning with service users and carers, the Third sector and across the public sector is essential for this to happen successfully. A recovery, person-centred agenda will ensure that we are on track, as per the Cardiff and Vale Recovery Charter.

- **Strengthening individuals**

Following a diagnosis of dementia it is important that the person with dementia and their carers have access to good quality information to enable them to understand and come to terms with the diagnosis and to be able to access support with ease. The Memory Team have a series of information leaflets written to meet the needs of individuals with dementia and their carers. The Alzheimer's Society was commissioned to provide an information pack, but supplementary information may be needed for some people, for example, on the Mental Capacity Act, Advance Decisions to Refuse Treatment and Lasting Power of Attorney and on the variety of care options available. Cardiff and Vale Action for Mental Health produce 'Directions' the hand book of Older People's Mental Health Services in Cardiff and the Vale of Glamorgan which includes a supportive guide for carers living with people with dementia. The Mental Health Services for Cardiff and the Vale of Glamorgan provides information on older people's mental health services including legal matters such as the Mental Capacity Act. Seeking the views of people with dementia and their carers is critical to improving care and support within this process.

Furthermore, in addition to written information, an important part of the support provided for people with dementia and their carers is psychosocial. The Memory Team offer psycho-therapeutic groups for people with dementia in partnership with Solace and the Alzheimer's Society. Alzheimer's Society provides: an Advocacy Service and a Dementia Support service (including home visiting,

advice and guidance); therapeutic group activities including Singing for the Brain and Life Stories programme and community based programmes including Dementia Cafes. Solace provides support to carers and social activities for people with dementia and their families, in addition to education and training.

Activities and workshops undertaken through the SPIDER project will support this information work, providing planning tools that will help stakeholders to better provide information consistently across the region.

The role that carers play is frequently underestimated. However, recognition of their role was highlighted through the Welsh Carers Measure. Locally, a Cardiff and Vale Carers Strategy has been developed which sets out the needs for all carers. Carers should be routinely offered a carer's assessment and then if need arises, services to include psycho-educational support. A carers' educational pathway will be developed to ensure that carers have access to learning and support at all stages of the pathway. This will be further supported by the SPIDER project, which will focus on the design of supporting services provided to informal carers to those with dementia.

Finally, good quality end of life care needs to be in place, where people die at their place of choice, at home instead of hospital where appropriate. This requires active involvement of appropriate palliative care services, district nurses and General Practitioners in line with the 'Together for Health - Delivering End of Life Care Plan'.

Action Plan

This 3 year action plan follows the objectives set out in the National Dementia Action Plan, divided by the four strategic themes outlined above.

Each objective states what has been achieved to date, the outstanding actions, who will lead on delivering the outstanding actions and by when, recognising that some actions need to be delivered jointly.

1. Make structural changes to economic, cultural and environmental conditions

Objective	Actions to date	Outstanding actions	Lead	Milestone
1.1 Promote healthy living initiatives in dementia	Local: • Pilot of Making Every Contact Count since March 2013, training social care, UHB, Third Sector and Housing Association staff.	1.1.1 Roll out the independent living initiatives set out in the Wyn campaign (now the Wyn Programme) 1.1.2 Roll out of dementia supportive communities pilots, with evaluation of the pilots and consideration given to integrating these across all Cardiff and Vale communities 1.1.3 Roll out of Making Every Contact Count	Wyn Programme Cardiff West Older People's Group and Barry Dementia Supportive Communities Group Cardiff and Vale UHB (Public Health)	Roll out to pilot areas from March 2014 Pilots to be complete by Summer 2014. Full roll-out by March 2017. Pilot completed. Roll out by April 2015
1.2 Promote dementia research	Local: • Launch SPIDER project with Cardiff Council and UHB staff National: • Research into national provision of reablement services	1.2.1 Undertake SPIDER project research into dementia re-ablement services and support for informal carers 1.2.2 Roll out a stakeholder workshop programme as outlined in the SPIDER project to inform future service design and innovation activities.	Cardiff Metropolitan University (PDR) SPIDER Project	SPIDER project to take place between January 2014 and July 2015

		1.2.3 Undertake study and research visit to Sligo (EIRE) and Geel (BEL) for comparative study into dementia specific services through SPIDER	SPIDER Project	

2 Improving infrastructure and access to services for all

Objective	Actions to date	Outstanding actions	Lead	Milestone
2.1 Ensure a timely diagnosis	National: • NICE Dementia Guideline updated to extend Acetylcholinesterase Inhibitors prescribing to Memantine Local: • Shared care protocol for Acetylcholinesterase Inhibitors developed (although not all GPs subscribe to it). • GP DES training ongoing in partnership with Alzheimer's Society, CAVAMH and PMHSS.	2.1.1 To develop Memory Team capacity further to cope with increasing demand. 2.1.2 To develop primary care Quality and Outcomes Framework 15 month review to a standardised template and train primary care clinicians. 2.1.3 To promote and provide a menu of training opportunities for GPs, to	Cardiff and Vale UHB (Memory Team) Cardiff and Vale UHB (Memory Team) Directly Enhanced Service (DES) Steering Group	Increased capacity and reduced waiting time for Memory Team by March 2017 Template fully rolled out by March 2017 Ongoing

		include awareness of social care and other support initiatives		
2.2 Ensure appropriate use of anti-psychotic medication	Local: • Anti-psychotic prescribing audit undertaken by all GP surgeries • Pilot project aiming to undertake anti-psychotic review clinics in a chosen Care Home undertaken and analysed. • Pilot project aiming to produce standard guidance on how to conduct an anti-psychotic review being undertaken in one Care Home – due to commence in October 2013. • Audit of new prescriptions for anti-psychotic medication in patients diagnosed with dementia undertaken in an in-patient setting – due for completion by November 2013.	2.2.1 Develop anti-psychotic initiation policy 2.2.2 To develop standard guidance on how to conduct an anti-psychotic review. 2.2.3 To promote the positive learning from the two pilots and the agreed guidance, across Cardiff and the Vale. 2.2.4 To re-audit the prescribing of anti-psychotics in people with dementia	Cardiff and Vale UHB (MHSOP) Cardiff and Vale UHB (Primary care pharmacy/MHSOP) Cardiff and Vale UHB (Primary care pharmacy – for GPs; MHSOP – for Care Home staff) Cardiff and Vale UHB (Primary Care Pharmacy)	Policy created by March 2015 Guidance created by July 2014 March 2015 March 2017

	• Falls prevention procedures for in-patient settings include guidance on medications associated with increased falls. • Same guidance available for primary, community and intermediate care.			
2.3 Ensure appropriate alternatives to anti-psychotic medication are available	Local: • Alternatives to anti-psychotic medication are being explored in the two pilot Care Home areas.	2.3.1 To roll out training on non-pharmacological methods in behaviour management and to ensure that this covers health and social care staff in pilot areas 2.3.2 To support carers to understand behaviour that challenges and to develop alternative and positive management strategies	Cardiff and Vale UHB (Clinical Boards) and Local Authorities Alzheimer's Society	Fully rolled out by March 2017 Ongoing
2.4 Improve dementia care in general hospital and social care environments and reduce length of stay	Local: • Butterfly scheme implemented across UHL and UHW in some clinical areas • Cognitive impairment pathway developed and piloted.	2.4.1 To implement recommendations from Royal College of Psychiatrists Audit 2.4.2 To identify multi-disciplinary dementia leads	Cardiff and Vale UHB (Clinical Boards) Cardiff and Vale UHB (Clinical	Implemented by March 2015 Leads identified by

	• Falls prevention and management procedures reference need to take into account the ability of a patient to understand and retain information and to identify their cognitive state. • Falls resources and tools all reference dementia and Mental Capacity Act and recognise the inter-dependency of falls, restraint and provision of 1:1 support. • Estates have worked with the RNIB to make the best use of materials and colours to prevent falls on wards. • Nutritional screening and swallowing training undertaken across the UHB by Dietetic service and Swallowing Team. • Protected mealtimes training undertaken across UHB.		Boards)	June 2015
		2.4.3 To identify dementia leads for the Butterfly scheme	Cardiff and Vale UHB (Clinical Boards)	Leads identified by June 2015
		2.4.4 To take the development and testing of the dementia pathway to inform its future development.	Cardiff and Vale UHB (Clinical Boards)	Ongoing
		2.4.5 To review anti-psychotic prescribing for all people with dementia	Cardiff and Vale UHB (Clinical Boards)	System in place by March 2015, then ongoing
		2.4.6 To consider cognitive and sensory impairment design standards as wards and care facilities are refurbished	Cardiff and Vale UHB (Clinical Boards/Estates) and Social Care Commissioners	Ongoing
		2.4.7 To ensure appropriate staff to patient ratios	Cardiff and Vale UHB (Clinical Boards)	Ongoing
		2.4.8 To audit length of stay for people with dementia and to consider whether in-reach rehabilitative services can support people with	Cardiff and Vale UHB (Clinical Boards), Wyn Programme and Social Care	Routine audit achieved by March 2015, then ongoing

	• Mealtime service provision includes texture modified meals across the UHB.	dementia to enable temporary stays at time of crisis in care facilities.	Commissioners	
		2.4.9 To implement Dementia '2 minutes of your time' Carers survey widely	Cardiff and Vale UHB (Clinical Boards)	All carers to be offered the survey by March 2015
		2.4.10 To ensure there is an easily understandable route for access to appropriate agencies and Social Care services	Local Authorities and Third Sector	March 2015
		2.4.11 To ensure that nutritional screening and awareness of swallowing difficulties happens on all wards	Cardiff and Vale UHB (Clinical Boards)	Ongoing (audit by Dietetics)
		2.4.12 To ensure that protected mealtimes are undertaken across the UHB	Cardiff and Vale UHB (Clinical Boards)	Ongoing
2.5 Improve dementia care in the mental health hospital setting	Local: • All acute MHSOP beds and day services transferred to purpose built accommodation in UHL • Falls prevention and	2.5.1 To peer review all wards to gain AIMS accreditation with Excellence	Cardiff and Vale UHB (MHSOP)	Excellence achieved by March 2015
		2.5.2 To roll out the ethos of person-centred dementia care using quality	Cardiff and Vale UHB (MHSOP) and Local Authorities	March 2016

	management procedures reference need to take into account the ability of a patient to understand and retain information and to identify their cognitive state. • Falls resources and tools all reference dementia and Mental Capacity Act and recognise the inter-dependency of falls, restraint and 1:1 support.	improvement vehicles such as DCM or CSSIW 'SOFI' tool, targeting extended assessment wards and specialist nursing and residential care homes for people with dementia 2.5.3 To fully apply the refocusing model 2.5.4 To widely implement '10 Minutes of your time' carers survey	Social Care staff as part of support reviews incorporating feedback from CSSIW Cardiff and Vale UHB (MHSOP) Cardiff and Vale UHB (MHSOP)	 July 2014 July 2014
2.6 Improve services for people with younger onset dementia	Local: • Younger onset dementia community service phased development near completion, supported by continuing healthcare repatriation. • Younger onset dementia continuing healthcare inpatient unit being established in St Barucs ward, Barry Hospital under continuing healthcare repatriation.	2.6.1 To develop respite opportunities by assessing need and then rolling out the new opportunities 2.6.2 To develop the quality of residential and nursing care home placements if appropriate and consider supported living options. 2.6.3 Development of Extra Care in the Vale as a less restrictive alternative; and further alternatives in	Cardiff and Vale UHB (MHSOP) and Assessment teams for people with learning disabilities Social Care Commissioners Local authorities by commissioning new provision and considering the	Assess need by March 2016 and roll out by March 2017. Adequate provision by March 2017 Extra Care Facility open in July 2014

	• Ensuring that Extra Care design and services and tenancy allocation protocols can facilitate take up for people with dementia. • Ty Hapus facility is available in Barry for people with Younger Onset Dementia and their carers.	Cardiff.	development of more supported living alternatives to long term care Social Care Commissioning and Strategic Housing	 September 2014
2.7 Improve continuing healthcare processes	National: • Awaiting new All Wales CHC Policy revision. Local: • Need to review eligibility criteria for MHSOP extended psychiatric assessment beds provision	2.7.1 To review previous work on continuing healthcare 2.7.2 To continue exploring repatriation opportunities	Cardiff and Vale UHB (MHSOP) Cardiff and Vale UHB (MHSOP)	March 2015 Ongoing
2.8 Improve access to intermediate care	Local: • Co-location of home care and community resource service	2.8.1 To develop dementia champions and dementia training in Community Resource Teams 2.8.2 To review Day Hospital and Day Care provision across partner agencies 2.8.3 To ensure that relevant staff have dementia training	Community Resource Teams Cardiff and Vale UHB (MHSOP) and Local Authorities Local Authorities	Developed by March 2015 July 2015 Ongoing

		(home care and day services) through SSIA funded project		
2.9 Improve physical health for people with dementia	Local: • Salaried GP service established across Mental Health Clinical Board inpatient units, providing cover for acute and chronic physical illness.	2.9.1 To review out-of-hours cover for acute medical decline in people with dementia. 2.9.2 To further develop DGH Liaison Psychiatry for Older People Service, in particular to ensure a presence in unscheduled care. 2.9.3 To develop primary care Quality and Outcomes Framework 15 month review to a standardised template and train primary care clinicians	Cardiff and Vale UHB (MHSOP) Cardiff and Vale UHB (MHSOP) Cardiff and Vale UHB (Memory Team)	July 2014 March 2015 Template fully rolled out by March 2017
2.10 To improve the care for people with alcohol related brain injury	Local: • Currently out-of-area placements are in place for people alcohol related brain injury. • Commissioning Options paper being created within 2013/14.	2.10.1 To consolidate the alcohol related brain injury service so that health and social care will be integrated.	Substance Misuse Commissioner	Consolidation by March 2016

3 Strengthening communities

Objective	Actions to date	Outstanding actions	Lead	Milestone
3.1 Increase public awareness and understanding of dementia	National: • Dementia Vision published by Welsh Government created visibility Local: • Alzheimer's Society has developed a volunteer inclusion programme to include BME Befrienders, Telephone Befrienders (for carers), Dementia champions and Community Befrienders. • Nexus has engaged minority ethnic communities and veterans to raise awareness about access to services, in partnership with the statutory and Third sector.	3.1.1 To create two dementia supportive communities pilots, one in Cardiff, one in the Vale 3.1.2 To increase public awareness of dementia through campaigns, education programmes and events and the Dementia Friend's initiative 3.1.3 To create a volunteer army for people with dementia	Cardiff West Older People's Group and Barry Dementia Supportive Communities Group Alzheimer's Society, working with UHB and Local Authorities for joint campaign Cardiff and Vale UHB (Volunteers lead) in liaison with Third sector, joining up with Local Authority VCS/Third Sector Strategy	Pilots to be complete by Summer 2014. Full roll-out by March 2017. Ongoing Ongoing
3.2 Improve the skills of the workforce in dementia care and	National: • Dementia care training initiative (2011-12)	3.2.1 To develop a training strategy for dementia within the Health and Social Care settings, to include POVA,	Cardiff and Vale UHB Training Lead and Local Authority Training	Training strategy developed by March 2015

support	established two training officer posts to: scope training availability, build a resource of materials and develop a Train the Trainers programme (time limited). • Dementia care advisor posts established across Health Boards to provide additional clinical posts with the aim of providing training in addition to specific client and carer supports (in Cardiff and Vale targeted at vulnerable groups) Local: • 'Providing Care for Individuals with Dementia' course established (6 days), aimed at skills development for non-specialist staff (Agored Cymru accredited) • Achieving psychological well-being course (6 days) established to support development of Level A psychological skills (PIG	Dignity and Respect. 3.2.2 To spread the training of 'Providing Care for Individuals with Dementia' and Psychological Well-being courses across the DGH setting and appropriate training across care homes 3.2.3 To review and enhance dementia training within the medical, nursing and social work undergraduate programmes	leads Cardiff and Vale UHB (Clinical Boards) and Local Authorities, using SCDWP grants for health and social care training Universities	 Ongoing from April 2015 Ongoing

	2012) • Joint training on dementia and falls prevention and management provided for trauma nurses.			
3.3 Improve community crisis intervention	Local: • First phase Community REACT service established in MHSOP (crisis and out-of-hours service) • Single point of access for urgent and emergency referrals (in development)	3.3.1 To fully establish a single point of referral for urgent and emergency referrals	Cardiff and Vale UHB (MHSOP)	Single point of referral fully established by March 2015.
3.4 Ensure effective joint planning and commissioning	Local: • Development of a commissioning strategy specifically for services for people living with dementia.	3.4.1 Formation of the Dementia Taskforce (linked to the Mental Health Partnership Board, Health Services Management Board, Learning Disabilities Strategic Board and People, Performance and Delivery) 3.4.2 To review joint commissioning arrangements	All relevant agencies, service users and carers Local Authorities and Cardiff and Vale UHB	Dementia Taskforce fully functional by April 2014. Joint commissioning arrangements reviewed by

				March 2015.

4 Strengthening individuals

Objective	Actions to date	Outstanding actions	Lead	Milestone
4.1 Provision of accessible, thorough and good quality information for those with a diagnosis of dementia and those who care for them	National: • Alzheimer's Society commissioned to publish and information pack for clients and carers. Now available in services which diagnose and offer support (online information and advice sheets already available) • Book Prescription Wales service now has books for people living with cognitive impairment and their carers. • UK-wide dementia helpline, including text message service for clients and carers Local: • Alzheimer's Society run psycho-therapeutic support groups in their Day Care Provisions, Singing for the	4.1.1 To review information pack further to ensure that content includes: Mental Capacity Act; Advance Decisions to Refuse Treatment; Lasting Power of Attorney information; and Mental Health Measure information on Primary Care Mental Health Support 4.1.2 To monitor appropriate usage of information packs by diagnostic agencies and replenish stock as required. 4.1.3 To signpost to Directions Handbook as appropriate.	Cardiff and Vale UHB (MHSOP Practice Development Unit) in liaison with Nexus, CAVAMH and Alzheimer's Society. All diagnostic agencies All diagnostic agencies	Packs complete by March 2015 Monitoring – ongoing Ongoing

	Brain, Life Stories, Film Club and Dementia Cafes. • Solace carers support service offers information and support on request or referral. • Directions Handbook for Carers – a supportive guide and directory about Older People's Mental Health Services, produced by CAVAMH. • Mental Health Services Directory produced by CAVAMH			
4.2 Ensure active carer role and carer support	National: • Carers Measure • Mental Health Measure – ensures carers are consulted during Care and Treatment planning. Local: • Psycho-educational support for carers audited and	4.2.1 To develop carers education pathway 4.2.2 To engage service users and carers within the multi-agency Dementia Taskforce and in service developments, as appropriate	Cardiff and Vale UHB (MHSOP Practice Development Unit) Nexus	Pathway developed by March 2015 Ongoing

	publicised • Services which offer individual counselling and support audited and publicised • CAVAMH and the GP counselling service produced a booklet of counselling services. • Alzheimer's Society run the CRISP programme, Carers' Support Group. • Cardiff and Vale Carers Strategy (implemented as part of the Carers Measure) • Dementia Carers Implementation Group (part of Intelligent Targets work) • Nexus Carer and Service User Involvement Development Project.	4.2.3 To increase the number of carers for people with dementia accessing information on relevant Part 1 of the Measure services 4.2.4 To increase the opportunities for different respite opportunities and publicise them	Local Authorities Local Authorities (joint commissioning)	Ongoing Opportunities increased and publicised by March 2017
4.3 Increase housing options	Local: • Development of Extra Care Facility in the Vale and	4.3.1 To map and deliver additional supported housing opportunities for people with dementia.	Local Authorities	March 2015

	ensuring that Extra Care design and services and tenancy allocation protocols can facilitate take up for people with dementia.			
4.4 Maximise use of telecare and assistive technology	Local: • Evidence of increased uptake of telecare across adult services in Cardiff and the Vale	4.4.1 To develop a telecare strategy and aim to co-ordinate with telehealth (using funding from RCF to commission and create telecare, including 'Just Checking')	Local Authorities	First Report – June 2014 New Strategy - September 2014
4.5 Improve dementia care in the home	Local: • C1V is the named point of contact for information and signposting. • The ICT service and MHSOP links CPNs into the Care Home setting.	4.5.1 Dementia awareness training and basic skills training for health and social care (including private sector) provider staff. 4.5.2 Dementia champions developed within CRTs with strengthened liaison with MHSOP	Cardiff and Vale UHB and Local Authorities Community Resource Teams	Enhanced Plan via SSIA and SPIDER by June 2014 Roll out from July 2014 Champions developed by June 2014
4.6 Appropriate end of life care	National: • All Wales Integrated Care Priorities for the Last Days of	4.6.1 To review the All Wales Integrated Care Priorities for the Last Days of Life	Cardiff and Vale UHB (jointly between MHSOP, Palliative Care,	Pathway reviewed by March 2015

	Life issued to guide end of life care • Dignity in care guidance issued by NMC, RCN and CNO • Fundamentals of care audit in place across all health settings. Local: • Together for Health – Delivering End of Life Care Plan created and signed off at UHB Board level.	4.6.2 To increase opportunities for people with dementia to die at their place of choice	Medicine and Primary, Community and Intermediate Care) Cardiff and Vale UHB (Jointly between MHSOP, Palliative Care, Medicine and Primary, Community and Intermediate Care)	Increased opportunities by March 2017