

West Wales Care Partners (WWCP) Dementia Strategy



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1. Background

Background

- The West Wales Care Partnership (WWCP) brings together organisations from the statutory, third and independent sectors with a remit of integrating and transforming health, care and support in the region.
- A statutory Regional Partnership Board oversees the work of the WWCP.
- A regional Dementia Steering Group sits underneath the RPB and comprises representation from across the Partnership. It provides a mechanism for developing a regional approach to caring for people living with dementia (PLWD) and their families. This Group worked closely with Attain in developing the draft Strategy and will have a key role in taking forward implementation of the next phases of work.
- Welsh Government provides funding through the Integrated Care Fund (ICF) to support the improvement of care and support for PLWD and their families, This funding is managed through the Dementia Steering Group and will be instrumental in delivering agreed priorities within the Strategy.
- Key partners on the WWCP are:



Carmarthenshire
Association of
Voluntary
Services



Pembrokeshire
County Council



Pembrokeshire
Association of
Voluntary Services



Carmarthenshire
County Council



Ceredigion
Association of
Voluntary
Organisations



Hywel Dda University
Health Board



Ceredigion
County Council

Background

In February 2021, the WWCP appointed Attain to work with partners to develop a regional dementia strategy and service model pathway of care. Alongside this work, we carried out a review of the regional ICF dementia projects which provided a steer as to what services should continue to be funded, as well as an indication of any additional initiatives that should be undertaken during 2021/22. One priority area was for Attain to develop a business case for the introduction of a dementia wellbeing connector which is based on best practice and an intrinsic role within the WW Dementia Wellbeing Pathway.

The context for this work includes:

- Increasing focus worldwide on dementia and its impact on health and social care systems; prevalence is increasing year on year, mainly due to people living longer, particularly in high income economies.
- To clarify its dementia strategy, In February 2018, the Welsh government published the 'Dementia Action Plan 2018-2022'.
- The vision is for Wales to be a 'dementia friendly nation that recognises the rights of people with dementia to feel valued and to live as independently as possible in their communities'.
- In March 2021, Improvement Cymru published the All-Wales Dementia Care Pathway of Standards. This work, directed by the requirements of the Dementia Action Plan for Wales, is overseen by the Welsh Government Dementia Oversight Implementation and Impact Group (DOIIIG).
- The twenty standards have been designed to be dynamic by responding to evaluation and supporting evidence. They sit within four themes: **Accessible, Responsive, Journey, Partnerships and Relationships Underpinned by Kindness and Understanding.**
- The standards have been developed using the Improvement Cymru Delivery Framework and it is anticipated that work will focus on developing a two-year Delivery Framework Guide for the Welsh regions covering the period April 2021 – March 2023.

Prior to the implementation of the Framework, Attain has co-designed this strategy with colleagues, people living with dementia and their carers across West Wales. The high-level strategy also provides a programme governance structure and the foundation on which to fund services which is in line with the Improvement Cymru Delivery Framework.

Project requirements and activities

This slide outlines the project requirements, the outcomes from the work undertaken and key actions.

The Ask:

1. Overarching Dementia Strategy and Delivery Plan

- Facilitate co-production of a regional dementia strategy with stakeholders, PLWD and their carers
- **Develop a sustainable model and associated delivery plan for the strategy in the medium to longer term**, deployment of existing and future funding streams to support this and accounting to Welsh Government and other stakeholders on delivery and impact
- **Consider future regional programme ownership** and leadership requirements to implement and deliver the dementia strategy
- The dementia strategy and associated delivery plan needs to be considered in the context of **changing demographics across the region**, the long-term impact of COVID-19 on people with dementia and evidenced impact of existing workstreams

2. Development of a business case for the dementia case manager role

- In line with All Wales dementia standards and the Health Board's recently developed palliative and end of life care strategy, develop a business case for the dementia case manager role

3. In respect of the above tasks, Attain have been required to:

- Work with a range of national and regional stakeholders, including Welsh Government officials, system leaders, service managers, clinicians and practitioners, elected and independent members and users and carers as appropriate
- Produce high quality proposals and reports to a range of audiences

Attain have:

1. Overarching Dementia Strategy and Delivery Plan:

- Produced a report following a review of national and international best practice
- Worked with colleagues to develop a **regional strategy, vision and service model pathway based on best practice**
- This strategy includes a **proposed programme and governance structure** which fits with the Welsh Government and Regional structures
- The strategy includes a summary of **current and future population demand and prevalence**. Information relating to the impact of COVID-19 upon those with dementia is not available at this stage
- Stakeholders have identified that COVID-19 has impacted timely diagnosis due to late presentations and inability to access assessment services

2. Development of a business case for the dementia wellbeing connector role:

- Carried out a desktop review on best practice in dementia case co-ordination/management and average case load level
- Developed a business case with input from the WWCP dementia steering group members

3. Stakeholder engagement:

- Attain have worked with multiple stakeholders across the region people living with dementia (PLWD) and their carers and front line staff. All West Wales Care Partners have been fully engaged and very supportive in the development of this strategy

Key Recommendations

1. Implementation of strategy and dementia wellbeing pathway

- Once the strategy is formally approved by the WWCP, socialise the recommendations of the strategy, and the dementia wellbeing pathway to ensure that it is owned by colleagues, PLWD and their carers across West Wales
- A communication plan should be developed to run for the life of the strategy
- WWCP to adopt the proposed governance structure and recruit a Regional Dementia programme manager
- A full business case should be developed to take forward the establishment of the dementia wellbeing connector role
- The strategy, vision and service model pathway should be reviewed once information is available regarding the impact of COVID-19 upon those with dementia and their carers
- The waiting time for diagnosis should be reviewed and monitored; solutions should be found to address long waiting times, including the codesign and development of the regional dementia diagnosis pathway

2. ICF Dementia Plan:

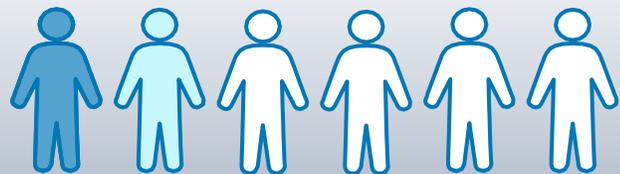
- The strategy recommends that a review be undertaken of ALL initiatives currently funded by the ICF, including evidencing outcomes, align funding to implement the strategic priorities, and ensure any new way of working is fully resourced
- Develop a regional strategic and co-ordinated approach to supporting carers – consider top slicing the dementia ICF funding to enhance the carers' element so ensuring continuation of services, supporting those who are caring for people living with dementia



2. Population needs analysis

For more information on the population analysis please see appendix 1

Population projection of those with dementia in West Wales



1 in 6

Alzheimer's Society UK estimates dementia affects one in six people aged 80+. West Wales records show 1 in 10 people over 85 with dementia.

Alzheimer's Research estimates that the diagnosis rate* is 53% across Wales, suggesting a **current** unmet need across Hywel Dda of 2,400 patients

The table below shows ALL diagnoses of dementia on the West Wales GP register **forecasted forward**, factoring in the increase in over 85s and an estimate of undiagnosed need. Data on waiting lists was not available but it is important to find ways to monitor this as demand increases.

| County | Current diagnosed (on GP register) | Current estimated undiagnosed | Current estimated total prevalence | 2040 projected diagnosed** (based on current diagnosis rate) | 2040 projected undiagnosed** | 2040 projected total prevalence |
|-------------------|------------------------------------|-------------------------------|------------------------------------|--|------------------------------|---------------------------------|
| Carmarthenshire | 1,363 | 1,208 | 2,571 | 2,035 | 1,793 | 3,828 |
| Ceredigion | 578 | 512 | 1,090 | 863 | 760 | 1,623 |
| Pembrokeshire | 871 | 772 | 1,643 | 1,300 | 1,145 | 2,445 |
| West Wales | 2,812 | 2,492 | 5,304 | 4,198 | 3,698 | 7,896 |

7,896
by 2040
(inc. undiagnosed need)



To put this into perspective...

This is equivalent to everyone in **Pembroke** living with dementia.

*The diagnosis rate is the diagnosis percentage compared to the estimated actual prevalence

** projection is based on the diagnosis rate remaining the same as current, this is a strictly 'Do Nothing' scenario

Dementia Diagnosis West Wales

Predominantly **(62%) female** due in part to longer life expectancy of women

65% of dementia patients in UK are women and they also make **up over 60% of carers**

45% of patients are over 85 years old and this population will grow across Hywel Dda

Leading cause of death in the UK (pre-COVID-19) and represents 12.7% of all deaths

Diagnosis prevalence across **Ceredigion is highest: 0.8%** of total list

Ceredigion has the highest proportion of **over 65s at 26%**; the average for Hywel Dda is 25%

The population of Hywel Dda is ageing, **over 10% will be over 85 by 2040**

Adult population is reducing across all areas, in particular in **Ceredigion (-11% 2040)**

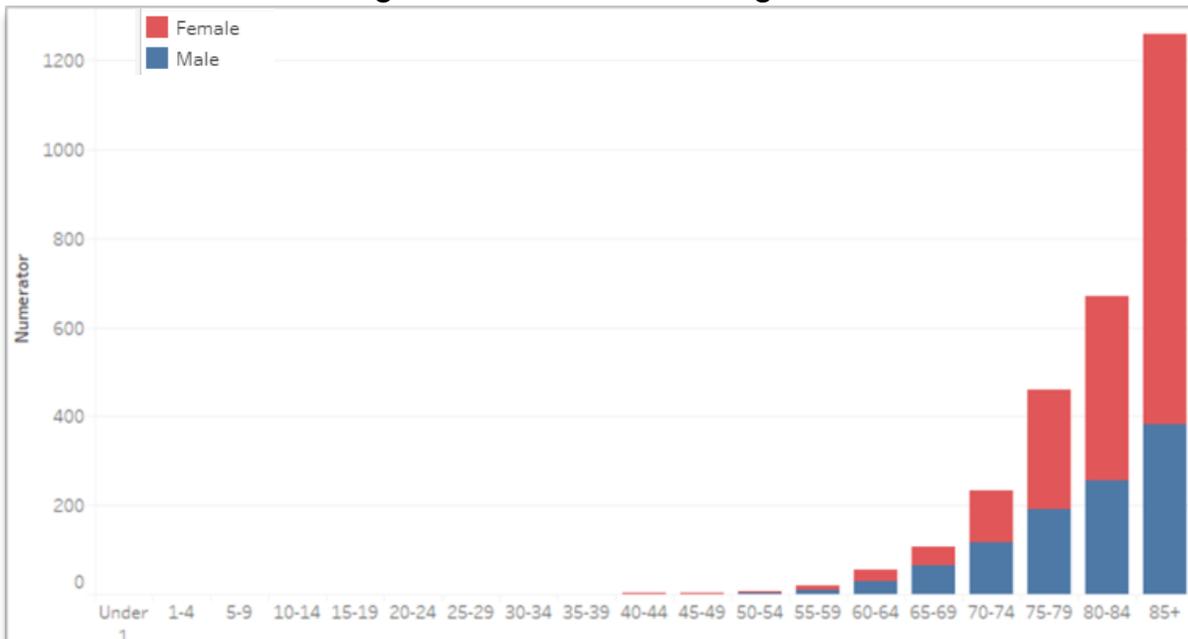
Decreasing adult population reduces supportive care for the older population

84 patients on the register with young onset dementia (0.06% of adults)

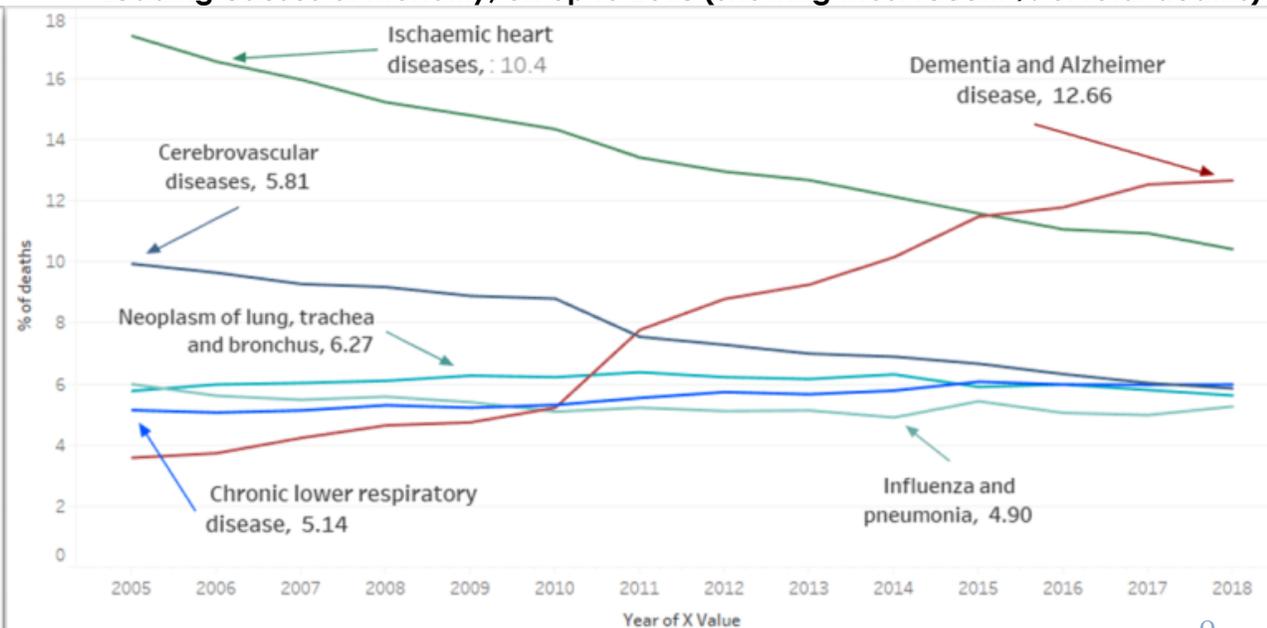
56% of young onset* diagnosis are male (24 are in Carmarthen and 10 in Ceredigion)

*Young onset dementia is the onset of dementia when a person is under 65 years old. Across West Wales there are 84 patients on the registers who are under 65 years old. Of those, 55 are in the 60-65 year age group. This gives West Wales a rate of 0.04% across the population in the adult population, which is very similar to the rate seen across Wales registers nationally.

Patients on GP registers with a dementia diagnosis West Wales



Leading causes of mortality, UK up to 2018 (showing most recent % of total deaths)





3. Current action plans, regional transformation projects

Relevant dementia documents for Wales:

This strategy and the future palliative & EoLC programme will draw on key existing initiatives:

Ageing Well in Wales



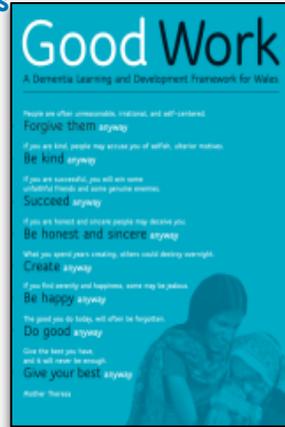
Launched in 2014 **Ageing in Wales: An overview in a European perspective**

5 Priority areas to improve the health and well-being of older people in Wales :

- Age friendly communities
- Dementia supportive communities
- Falls prevention
- Loneliness and isolation
- Opportunities for learning and employment

Appropriate accommodation for older people can help to contribute to addressing all of the above.

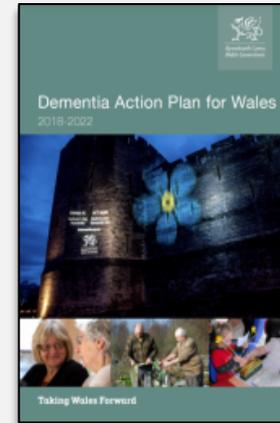
Good Work Framework A Dementia Learning and Development Framework for Wales



Published in 2016 Overall, the aim of the Framework is to support people to freely, creatively and responsibly identify and address their own specific learning and development needs within the context of their lives and circumstances, wherever they happen to be. The intention of the Framework is not to constrain people by providing an overly prescriptive list of who needs to know and do what.

This Framework is intended to support what matters most to the people of Wales, as well as the spirit and requirements of Welsh policy, legislation and guidance regarding the care, support and empowerment of people with dementia, carers and the health and social care workforce.

All Wales dementia action plan



In February 2018 the Welsh government published the 'Dementia Action Plan 2018-2022'

The Action Plan sets out a clear strategy for Wales to be a 'dementia friendly nation that recognises the rights of people living with dementia to feel valued and to live as independently as possible in their communities'.

All-Wales Dementia Care Pathway of Standards



In March 2021, Improvement Cymru published the All-Wales Dementia Care Pathway of Standards. This work, directed by the requirements of the Dementia Action Plan for Wales, is overseen by the Welsh Government Dementia Oversight Implementation and Impact Group (DOIG). **20 standards** have been designed to be dynamic by responding to evaluation and supporting evidence. They sit within four themes: **Accessible, Responsive, Journey, Partnerships and Relationships Underpinned by Kindness and Understanding.**

The standards have been developed using the Improvement Cymru Delivery Framework and the work will focus on developing a two-year Delivery Framework Guide for the regions across Wales covering the period April 2021 – March 2023.

EoLC Health Board dementia specific provision - West Wales area

The HDuHB Together for Health End of Life and Palliative Care Delivery Plan 2016 -2020 outlines the current EoLC resources available to support people with dementia: [Source: HDuHB Together for Health End of Life & Palliative Care Delivery Plan 2016 -2020](#)

Current Services:

- Using Welsh Government funding which was facilitated by West Wales Care Partnership, HDUHB commissioned Paul Sartori and Marie Curie to deliver training on Advance Care Planning and Dementia
- Marie Curie Senior Nurses help patients with advanced dementia access palliative and end of life care services across the region. The nurses support multi-disciplinary teams to meet the care needs of people with dementia in hospital, at home and in care homes. They also aid the safe transfer of care across care settings.
- Paul Sartori Foundation also provide education to a variety of audiences, both to their own staff but also to others across the Health Board, including topics such as dementia.
- In Pembrokeshire various members of the team have also contributed to other educational events, including teaching about Advance Care Planning at a dementia conference.

Areas for improvement:

- More work is needed on early detection of those living with dementia and to provide the support required. This will include education for colleagues within primary care to consider when someone with dementia is approaching their end of life and support to include this group within palliative care registers.
- Improve early detection and care of frail people accessing services, including those with dementia, specifically aimed at maintaining wellbeing and independence.
- Recognise the need to give particular focus to the experience of specific groups including those who have learning disabilities, dementia, hearing or sight problems and those who are elderly and frail. Carers are a particular group of people who often go unrecognised.
- In addition to the development of the Long-Term Care Patient Pathway, each Long-Term Care Specialist Nurse is developing a special interest in a particular area of expertise; these areas include pain management, end of life care, dementia care, nutrition, medication management and other aspects of fundamental care. These skills will be utilised to support safe and person-centred care delivery.

While services are in place in West Wales, implementing the priorities from the Welsh Dementia Action plan have been included in the palliative and EoLC programme plan and will have significant impact on the quality of EoLC services for those with dementia.



4. What does best practice tell us?

Dementia – key areas of focus

- The review of national and international best practice and innovation in dementia, identified many areas of best practice, research and innovation across the whole dementia care spectrum.
- Dementia is a condition that cuts across system wide services and is therefore everyone's business. It is important to understand to recognise that dementia services need to be embedded in the whole system of provision.
- This strategy focuses on key areas to drive improvement and innovation across West Wales, namely:
 1. Implementing strategies to achieve early diagnosis
 - i. Supporting GPs, allied health professionals (AHPs) and nurses to make assessments and improve quality of referrals to specialist services
 - ii. Focus on implementing best practice within social care, domiciliary care, care homes and specialist services
 2. Implementing care pathways, particularly post diagnostic support
 - i. Support and co-ordination for PLWD and their carers
 3. Supporting carers to care for family members with dementia
 - i. Providing support, training and help to navigate/co-ordinate services to families, build resilience and maintain balance across all aspects of their life
 4. Improving end of life care so that PLWD die in a place of their choosing with dignity
 - i. Co-ordination amongst different care providers to ensure they understand the end-of-life plan

Early diagnosis – in the community

- **NICE guidelines suggest assessment and diagnosis take place in non-specialist settings.** This backs up **international models** where **diagnosis is made in Primary Care where possible.**
- GPs, AHPs and nurses can decrease pressure on specialist services through;
 - Assessment and diagnosis in primary care
 - Improving quality of referrals into specialist care
- GPs and colleagues within primary care are also often the first contact for someone living with dementia, but many studies across UK and internationally show a lack of confidence from GPs, AHPs and nurses within primary care to diagnose dementia
- Increased training, awareness and new dementia models within primary care can all help towards optimising resource capacity and achieving earlier diagnosis of dementia
- Some diagnosis models suggest a 3-tier approach 1) initial assessment in primary care 2) a second assessment/diagnosis by dementia care experts within primary care 3) referral to memory clinics for dementia diagnosis.



Improving Primary Care Assessment/ Diagnosis

- Training for GPs, AHPs and nurses aligned with the 'Good work' framework and international best practice
- Funding/frameworks in place to encourage GPs and AHPs to attend training
- Increase confidence of GPs and AHPs to improve dementia diagnosis/quality of referrals to specialist services
- Support framework for GPs and AHPs including toolkits, guidelines and regular training
- Rapid access to dementia experts in primary care and specialist memory clinics

Primary Care Assessment

Primary Care

- Training for GPs, AHPs and nurses based on the 'Good Work Framework' for dementia awareness and to spot early signs of dementia
- Training to undertake some testing to identify people who may have dementia
- Reduce strain on specialist memory clinics by improving quality of referrals
- Remove barriers to GPs and AHPs attending training
- Consider delivering training online to improve accessibility

Primary Care Dementia Experts

Primary Care Dementia Experts

- Identify a cohort of GPs, AHPs and nurses that can act as dementia experts (e.g. GPs, AHPs and nurses with special interest)
- Specialist training for dementia experts based on the 'Good Work Framework'
- People identified in primary care could be referred for additional assessment
- Access to diagnostic tools
- Improve quality of referrals to specialist memory clinics

Specialist Care

Memory Clinics

- Services commissioned in line with frameworks
- Memory Services National Accreditation Service MSNAP
- Review of and alignment with best practice from across UK
- Improved brain scan protocols
- Focus on reducing referral to diagnosis times and managing capacity and demand
- Focus on diagnosis rates
- Seamless link into post-diagnostic support

Implementing care pathways

The Wales Dementia Action Plan outlines the need to develop more formal pathways of care for PLWD and this aligns with best practice strategy internationally.

The post-diagnostic support model in Scotland is the only documented model currently being used across the world.

The Scottish model outlines how best PLWD would be supported as their condition progresses. Beginning at Post Diagnostic Support (5 Pillars Model), through to Community-based Support (8 Pillars) and End of Life (Advanced Dementia Model).



The model:

- Enables the individual and their family to develop a robust personal plan that utilises their natural support networks
- Maintains newly developed peer support mechanisms alongside existing and new community connections
- Supports people to live well and independently with dementia for as long as possible

Support and care co-ordination

- Family and carers play a pivotal role in enabling PLWD to live independently in communities for as long as possible
- They will pick up the majority of care, especially in the early stages if an early diagnosis has been made – both national and international strategy is focusing on the need to minimise the impact of caring for someone with dementia
- They need support to build up resilience, develop the skills for caring for someone living with dementia and still be able to maintain a quality of life outside of their care for the PLWD
- Access to flexible respite care is crucial so that families and carers are able to maintain quality of life
- Being involved and supporting their family member with dementia to make decisions about their care is crucial and understanding the services available is key to helping achieve this
- Dementia hubs are playing an increasingly important role in many areas, providing a single point of access and support across a range of services for both PLWD and their carers

Services provided in dementia hubs include:

- Support staff, including dementia support workers, admiral nurses etc.
- Support groups for PLWD and their carers
- Access to local dementia services
- Training programmes for carers
- Activities for PLWD
- Dementia cafés
- Memory Clinics
- Access to finance/ legal/ benefits advice
- Involvement in research opportunities



End of life care

- In the case of dementia, it can be difficult to predict when a person is nearing death. They may present with signs that suggest they are very close to death, but in fact can show these signs for many months, or even years
- In addition, a PLWD may die from another medical condition, for example cancer or heart disease. They may also have infections and minor illnesses on top of these ongoing conditions
- Other conditions and illnesses may mean the person is cared for, or ultimately dies, in a hospital or a facility that does not specialise in dementia care
- Despite knowledge about end-of-life care increasing greatly over the past ten years, particularly in areas such as cancer care, many PLWD still do not receive good quality end-of-life care
- Where possible, advance care planning should take place so that PLWD can make decisions about their care - early diagnosis of dementia plays a key role as a person can make decisions about their end-of-life care alongside family/carers
- It is important that advance care planning is fully embedded in wider inclusive, personalised care and wellbeing planning for dementia and that support is available for Carers when a PLWD passes away
- A coordinated approach between all organisations that care for a PLWD is required – so everyone understands the person's wishes and how they want to be cared for at the end of their life



5. Feedback from structured interviews

Stakeholder Engagement

The development of this strategy has taken place from February 2021 through to January 2022. It has been led by Attain (an independent provider of health support services) who were commissioned by Carmarthenshire County Council on behalf of the WWCP to work with partners, PLWD and their carers to develop a dementia strategy, vision and Dementia Wellbeing Pathway across the region of Carmarthenshire, Ceredigion and Pembrokeshire. The work has been well supported by stakeholders, PLWD and their carers from across the region who have worked very hard to provide local knowledge and insight, through structured stakeholder discussions. The themes stemming from the interviews have been summarised on the following pages.

Many thanks to those who have engaged in this work:

Name

Carmarthenshire County Council adult social care service managers

Carmarthenshire County Council CRT teams

Ceredigion County Council Directors of adult social care

Ceredigion County Council Corporate Managers for Mental Health and Wellbeing and Planned Care

Age Cymru Dyfed

Pembrokeshire County Council Practitioners Forum

Pembrokeshire Association of Voluntary Services

Pembrokeshire Association of Voluntary Services Provider Forum

Hywel Dda University Health Board (HDUHB) Long term Conditions Team

HDUHB regional admiral nurse team

HDUHB Occupational Therapy Mental Health Team – Older Adults

HDUHB Acute Hospitals Dementia Wellbeing Team

HDUHB Older Adults Mental Health Team

HDUHB Heads of service - Therapies

HDUHB Dementia Wellbeing Community Team

Regional Care Home Provider Forum

Healthier Pembrokeshire Forum

Tywi Taf Cluster

Amman Gwendraeth Cluster

North Ceredigion Cluster

South Ceredigion Cluster

North Pembrokeshire Cluster

South Pembrokeshire

Enormous thanks goes to the 16 carers who gave up their time to provide information on the experiences of the people they are caring for as well as from their own caring perspective – this strategy would not be possible without your input.

The themes stemming from the interviews with carers have influenced the development of the service model pathway and the recommendations within this report.

Wellbeing, risk reduction and delaying onset, raising awareness and understanding

Recognition, identification and initial support

Assessment and diagnosis

| | | | | |
|---|--|--|--|--|
| <p>Training - Mainly have to work it out oneself especially after hospital discharge with a catheter. That was an absolute nightmare</p> | <p>Carers need training on how to deal with and cope with the person. I am learning as I go along</p> | <p>I had to work out what to do. Our finance's, business, everything it was overwhelming</p> | <p>No information advice or support. It is only recently that people are beginning to help me</p> | <p>Couldn't get anyone to admit to the diagnosis</p> |
| <p>Absolutely no training - had to find out by myself. Got lots of leaflets but I really needed someone to sit with me and explain things</p> | <p>Rather a lot of confused phone calls from carers' association. No help from the GP or the carers' association</p> | <p>Stumbled along in the dark. Given support through a fluke re enquiring about council tax</p> | <p>Information and advice at the very beginning was great but there was no joined up thinking</p> | <p>Went to the GP and gave diagnosis of dementia - wanted a referral to MH services in case it was a dementia that could be treated - took 2 years</p> |
| <p>Took ages to connect with the incontinence nurse. Now trying to get through to the dentist</p> | <p>No information - I was reluctant to get help, I thought I could cope. But it was so distressing</p> | <p>Have so much paperwork I loose track of what is what. Half the time I don't know what to do and I don't want to keep going on</p> | <p>Carers and PLWD need clear and accessible information connecting them to local peer groups for support at the outset</p> | <p>Never got to the bottom re diagnosis. Don't understand what type of dementia he has. I would like to know what type of dementia he has</p> |
| <p>Our local library used to have a day centre. It would be useful to have a day centre to go to (Aberystwyth)</p> | <p>Llanethlli information and training over 4 weeks was very helpful - addresses numbers, websites, of services</p> | <p>What provision is there to protect people with dementia who live on their own? Should be high for identification of frailty in GP surgeries</p> | <p>Best people who have helped - Alzheimer's society, I get a call every month and advice on how to claim attendance allowance</p> | <p>No joined up thinking from the psychiatric dept. Just handed us over to the GP who did nothing</p> |

The themes stemming from the interviews with carers have influenced the development of the service model pathway and the recommendations within this report.

Assessment and diagnosis

Living well with dementia

The need for increased support

We saw so many people in the first 12 months. First contact was crossroads and was sign posted to a lot of different activities e.g. dementia cafes

It would be good to have a person help sort out my problems rather than me trying to sort things out and find my way

COVID - Made things 10 time worse as you can't meet anyone. Day service in Cardigan has closed and would have been good to take her

Used to do zoom - music - oblivious to it all. Didn't work for my husband and other carers have said that zoom really doesn't work for those with dementia

Admiral nurse came out and went with the carers to see mum to help support them with their caring role - if mum refuses will leave it up to the family

Diagnosed in 2019. Saw the consultant twice, was given a prescription and not seen anyone since

Doesn't appear to be any activities - quite rural where we live and have to travel half an hour to get anywhere (Ceredigion)

To have a day centre specifically for people with dementia or people present to support people with dementia would be good

Consultants in hospitals need to be trained in power of attorney for health. Hospital staff need training - They lost his glasses, hearing aids and his bottom teeth

Everyone has been wonderful after dad fell - social worker, she acted straight away she liaised with the hospital and got him a place in a nursing home

I was inundated with leaflets and phone calls but I had no idea as to who they were, it was a step into a very deep pool

So many services are providing support but are not talking to each other so I have to tell them what has happened

Made it through lock down with no respite and reduced respite now. Please reinstate all day-care facilities. Carers and those with dementia need it

I live out of the area and find it difficult to know what services there are in my mum's area. GP surgery try to keep in contact

The guilt and stress when he had to go into a home, failure, marriage vows come into question - splitting myself in half - relief and guilt

2019 GP had tried to do a dementia test but my husband couldn't hear. I asked to be referred to hospital. 1yr later was referred

I feel now that he has his diagnosis, I can call on people but there is nowhere to go. Could be sat in 5 days a week - there is nothing (Carms)

More than one carer asked for activities targeted at younger people. List of activities sent out to carers each week is phenomenal - lots of things to do (Pemb)

Direct payment: Great as you can have the money but no good if you can't get the care in place

Very disappointed in the care - it was a dementia specialist ward no specific treatment didn't even check if he was eating or drinking

The themes stemming from the interviews with frontline staff have influenced the development of the service model pathway and the recommendations within this report.

Wellbeing, risk reduction and delaying onset, raising awareness and understanding

Recognition, identification and initial support

Assessment and diagnosis

| | | | | |
|--|--|---|--|---|
| <p>We need a clear understanding of what happens when people get information e.g. who can they turn to for support?</p> | <p>Signposting by GP receptionists can help people access 3rd sector services</p> | <p>People are hitting crisis but don't have a diagnosis – difficult to get CHC without a diagnosis</p> | <p>Support should be provided regardless of diagnosis, including CHC, as it is based on need</p> | <p>Training for all - basic understanding to managing complex behaviours - enabling people to recognise signs, what to expect to support PLWD</p> |
| <p>We need to maximise the use of DEWIS across the region by professionals and the public</p> | <p>Delaying things results in emergency admissions and those being admitted have more chronic conditions</p> | <p>Community activities need developing and co-ordinating – Pembrokeshire is more mature</p> | <p>There are lots of organisations and communities and it can be a barrier for PLWD/carers to access</p> | <p>We need a standardised approach to diagnosis regardless of where it takes place</p> |
| <p>Accessing GP, dentist, hearing clinics has become more difficult since COVID - people jumping through hoops and increases stress for the carer</p> | <p>Support care home staff through providing honest information on discharge so they can meet all the person needs. Support staff through training</p> | <p>MDT based in primary care could be making straight forward diagnosis. MAS should be focusing on specialist diagnosis</p> | <p>Carers and PLWD need clear and accessible information connecting them to local peer groups for support at the outset</p> | <p>We need a clear assessment/diagnosis pathway that sits outside mental health services</p> |
| <p>All staff including dom care and care homes need to be trained to recognise the signs of dementia, especially for those who are deaf, blind and Welsh speakers</p> | <p>We need to raise awareness of young onset dementia and clear pathway and service offer is needed</p> | <p>Access to local networks is better in some areas than others. There is no regional strategic approach to supporting carers</p> | <p>How do people get support without a diagnosis? Dementia is considered separately but shouldn't be, it's very much part of frailty</p> | <p>There needs to be consistency in how people access GP appointments - PLWD many not be able to get past the receptionist or triage</p> |

The themes stemming from the interviews with front line staff have influenced the development of the service model pathway and the recommendations within this report.

Assessment and diagnosis

Living well with dementia

The need for increased support

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| <p>Need formal process for secondary care consultant diagnosis and read code included into discharge – how care homes and GPs are made aware</p> | <p>Proactive care planning through HOLISTIC MDT - consistent approach across the region, providing support wellbeing plan around the person</p> | <p>Maximise the use of technology, for professionals, PLWD and their carers e.g. connect carers to support via an APP on the hospital bed I pads</p> | <p>Education - Training and advice from the Dementia Wellbeing Team (DWT), consider widening membership to include social care and 3rd sector</p> | <p>Care plan and emergency care plan in place for the carer</p> |
| <p>Is it possible to develop: cognitive assessment for Welsh speakers, people who are blind and a fast track assessment for dementia?</p> | <p>Virtual day services may require a carer present to facilitate. PLWD benefit from being in groups without the carer</p> | <p>Optimise patients wellbeing whilst in hospital through admissions check list - diagnosed, working diagnosis etc. - better use of the acute based DWT</p> | <p>We need to be clear that any new way of working will need to be fully resourced</p> | <p>Training in behavioural interventions is needed for carers and dom care providers – preventing unnecessary residential placements</p> |
| <p>As the condition progresses the cross over to health services is often difficult and needs to be better. People are hitting crisis but not getting diagnosed</p> | <p>Can social care and 3rd sector become part of the regional dementia wellbeing team?</p> | <p>There needs to be a consistent approach to medication monitoring, review and prescribing in primary care across the region</p> | <p>Community transport colleagues can help MDTs by providing relevant information in relation to the patient</p> | <p>Dementia recognition tool can help the development of behavioural management plans, key behaviours and what interventions can be used</p> |
| <p>Belief that it can only take place in MAS setting. There is a need for MDT approach to diagnose and prescribe in the community e.g. GPs /AHPs who are fully trained</p> | <p>The overarching thing not addressed is base line wrap around the person, a co-ordinator throughout their journey</p> | <p>Many things are on offer for carers but the ICF carers funding stream is not joined up with the dementia ICF funding stream so there is duplication of effort</p> | <p>Need to ensure employers assess for and implement reasonable adjustments to enable the PLWD services to work</p> | <p>Lots of organisations are going to people's homes and are not talking to each other so people have to keep repeating themselves</p> |

6. West Wales Dementia Service Vision and Wellbeing Pathway

The following pages contain the dementia service vision and Wellbeing Pathway which builds on the Attain best practice research report circulated in January 2021. This service model pathway has endeavoured to incorporate existing services in West Wales. The service vision and Wellbeing Pathway has been co-designed through engagement with staff from across the region, PLWD and their carers.

The All Wales Dementia Action Plan 2018-2022: As a signatory to the Glasgow Declaration (1) the Welsh Government has previously committed to promote the rights, dignity and autonomy of people living with dementia. Through their engagement with stakeholders they heard about the positive work of Dementia Action Alliance in developing a series of statements with people living with dementia and their carers (2). We have aligned these statements to our Dementia Wellbeing Pathway.

1) <https://link.edgепilot.com/s/67f68721/ecxOvtDsBECT3n7Rilzvha?u=https://www.alzheimer-europe.org/Policy/Glasgow-Declaration-2014>

2) <https://link.edgепilot.com/s/8d37d66b/NmKURNiXoUqKCjtzSUiWhQ?u=https://www.dementiaaction.org.uk/nationaldementiadeclaration>

DRAFT - West Wales vision for dementia services

'Support each person to live well and independently with dementia for as long as possible'

Key enablers to delivery:

- Clear **regional dementia vision, strategy and service model** in line with best practice
- Develop **effective** professional and clinical leadership and **governance** to ensure the service model and **new roles** are designed in line with best practice and **are part of the whole health and social care system**
- Strategic and collaborative **PLWD/carer centred commissioning arrangements**
- Cross-organisational working
- **Collective financial and performance management**
- **Joint commissioning for integrated care**, ensuring **equity of access and provision across West Wales**
- **Optimise the use of estate** - build on localities and **provide support closer to home** e.g. local meeting places/hubs where people can connect
- **Adapting IT** so that it reflects activity and **captures person centred outcomes**.
- **Shared system transformation** programmes and plans
- **Systematic involvement** of PLWD and **their carers** and community in the **design and development of the new service model**
- New ways of working expanding the capacity of the Good Work training framework and **new workforce roles** e.g. **Dementia wellbeing connector role**
- **Using technology** to **empower PLWD** and their **carers** and our **staff**.
- **Commissioning** and provision of **primary care services at scale**
- **Interpret population health/social care data, PLWD/family feedback**, design services for networks and **draw in support from wider services**

Specialist dementia care support – in the community and in hospital



Intermediate care to support people at the time of increasing need. We maximise comfort and wellbeing – supporting people in their home if possible



Proactive Care and Care Planning as a multi-disciplinary team. Care is co-ordinated ensuring the right help, at the right time



Prevention, Planning and Education within our communities
Communities prepared to support and help



1. Help for strong communities



2. Help to help yourself



3. Help when you need it



4. Help long term



5. Help in hospital

What good looks like for West Wales – The Dementia Wellbeing Pathway

Working with **partners across West Wales** we have developed **our Dementia Wellbeing Pathway together** focusing on **streamlining pathways** and **placing the PLWD and their carers at the centre** of our **service provision**. We will **implement strategies** to **increase early diagnosis, supporting GPs and allied health professionals in primary care with specialist input where needed** as part of an **MDT approach to community assessment and diagnosis** and to **improve the quality of referrals to specialist services**.

We will focus on implementing best practice within primary care, social care, care homes, domiciliary care and specialist services. Implementation of **the Dementia Wellbeing Pathway** will include the development of the diagnostic pathway and post diagnostic support, **support and co-ordination for PLWD and their carers** and supporting carers to care for family members living with dementia. We will provide **support, training and help to navigate/co-ordinate services to families, build resilience and maintain balance across all aspects of their life**. We will **improve end of life care** so that **PLWD die in a place of their choosing** with **dignity** and **improve co-ordination across different care providers to ensure they understand the end-of-life care plan**.

Dementia action plan Wales 2018-22



As a signatory to the Glasgow Declaration (1) the Welsh Government has previously committed to promote the rights, dignity and autonomy of people living with dementia. Through the Government's engagement with stakeholders they heard about the positive work of Dementia Action Alliance in developing a series of statements with people living with dementia and their carers (2)

Dementia Statements reflect the things that people with dementia and carers say are essential to their quality of life. These statements were developed by people with dementia and their carers, and the person with dementia is at the centre of these statements. The "we" used in these statements encompasses people with any type of dementia regardless of age, stage or severity; their carers; families; and everyone else affected by dementia.

These rights are enshrined in the Equality Act, Mental Capacity legislation, Health and care legislation and International Human Rights law and are a rallying call to improve the lives of people with dementia. These Statements recognise that people with dementia shouldn't be treated differently because of their diagnosis.

We have aligned the dementia statements to the new West Wales Dementia Wellbeing Pathway and the recommendations within this strategy have also been aligned.

For more information see:

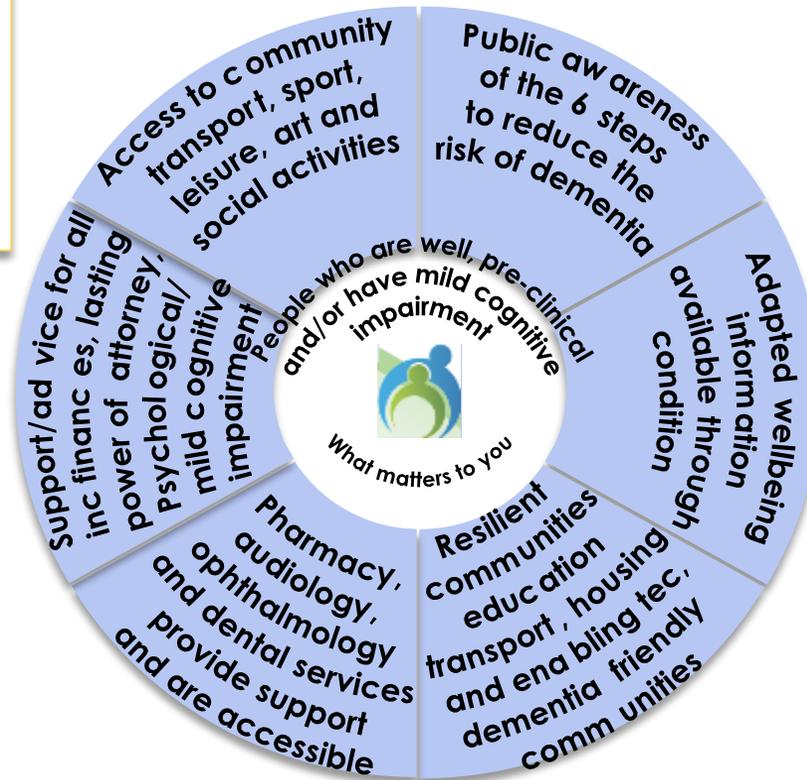
1. <https://link.edgepilot.com/s/67f68721/ecxOvtDsBECT3n7Rjlzvhg?u=https://www.alzheimer-europe.org/Policy/Glasgow-Declaration-2014>
2. <https://link.edgepilot.com/s/8d37d66b/NmKURNiXoUaKCjtzSUIWhQ?u=https://www.dementiaaction.org.uk/nationaldementiadeclaration>

What good looks like for West Wales – The draft dementia wellbeing pathway

Wellbeing, risk reduction, delaying onset, raising awareness and understanding

Creating dementia friendly communities, making dementia everybody's business

We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.

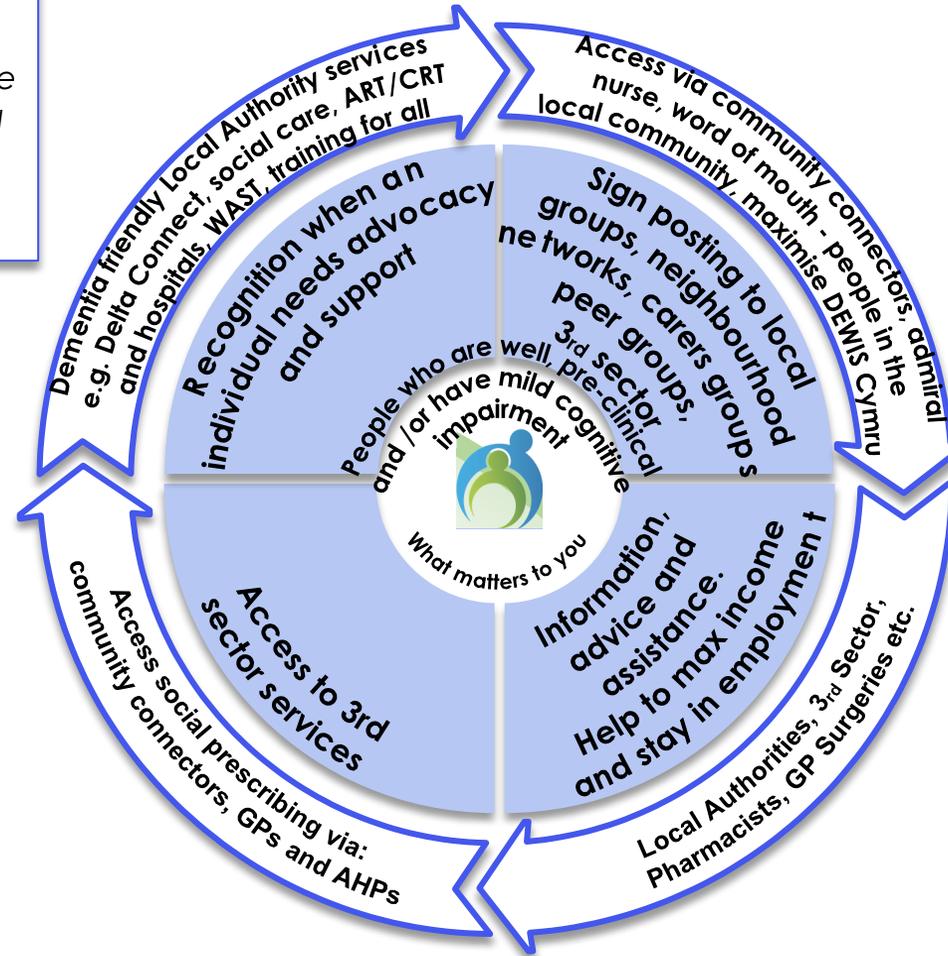


What good looks like for West Wales – The draft dementia wellbeing pathway

Recognition, Identification, Support and Training

Each person gets fair access to care regardless of diagnosis

We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.

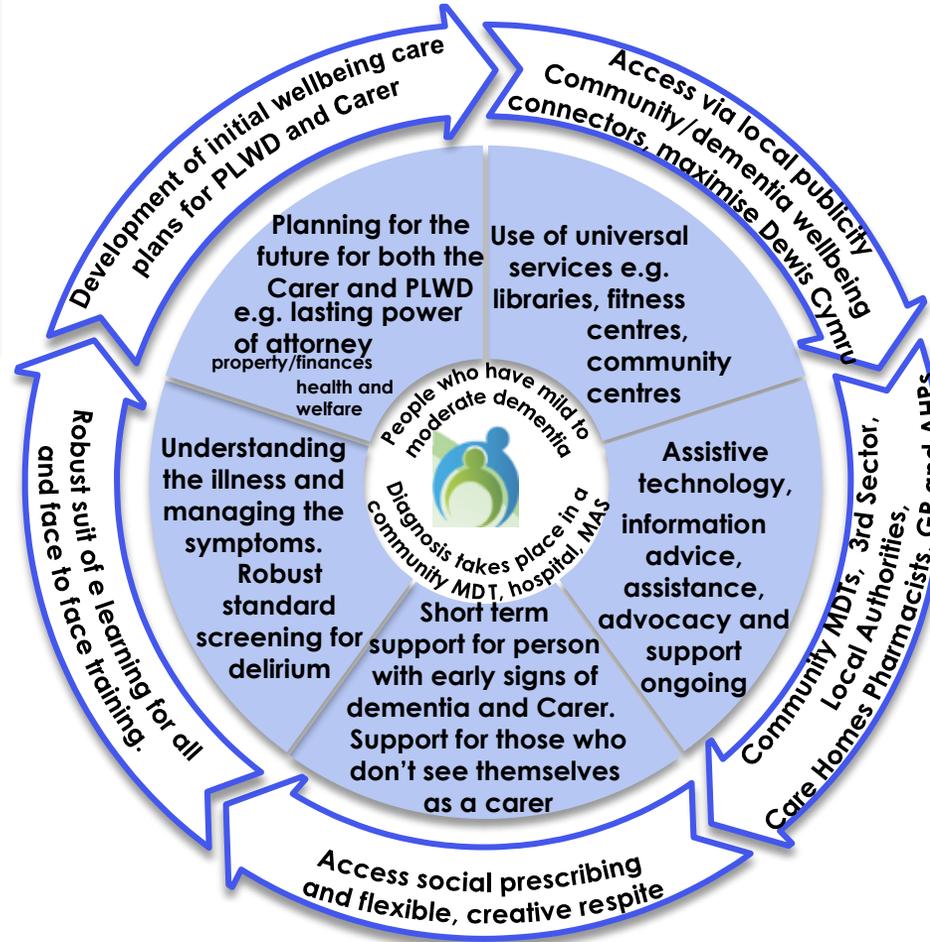


What good looks like for West Wales – The draft dementia wellbeing pathway

Assessment and diagnosis

Each person is seen as an individual

We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.

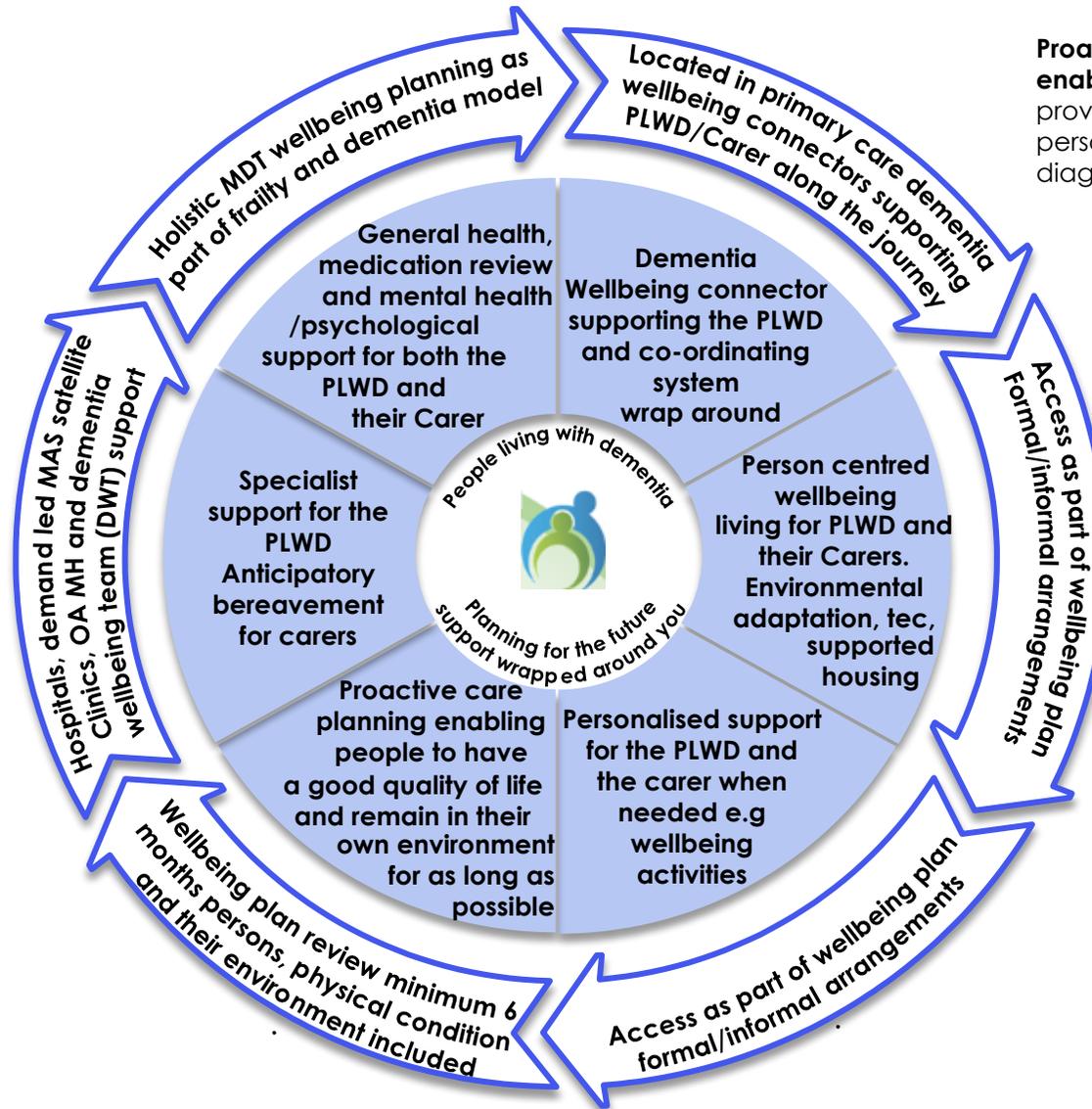


What good looks like for West Wales – The draft dementia wellbeing pathway

Living well with dementia

Care is co-ordinated

We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future. We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.



Proactive care planning through **HOLISTIC** MDT (colleagues enabled to attend virtually) - consistent regional approach, providing stable support and wellbeing plan around the person and where appropriate, their carer, regardless of diagnosis including:

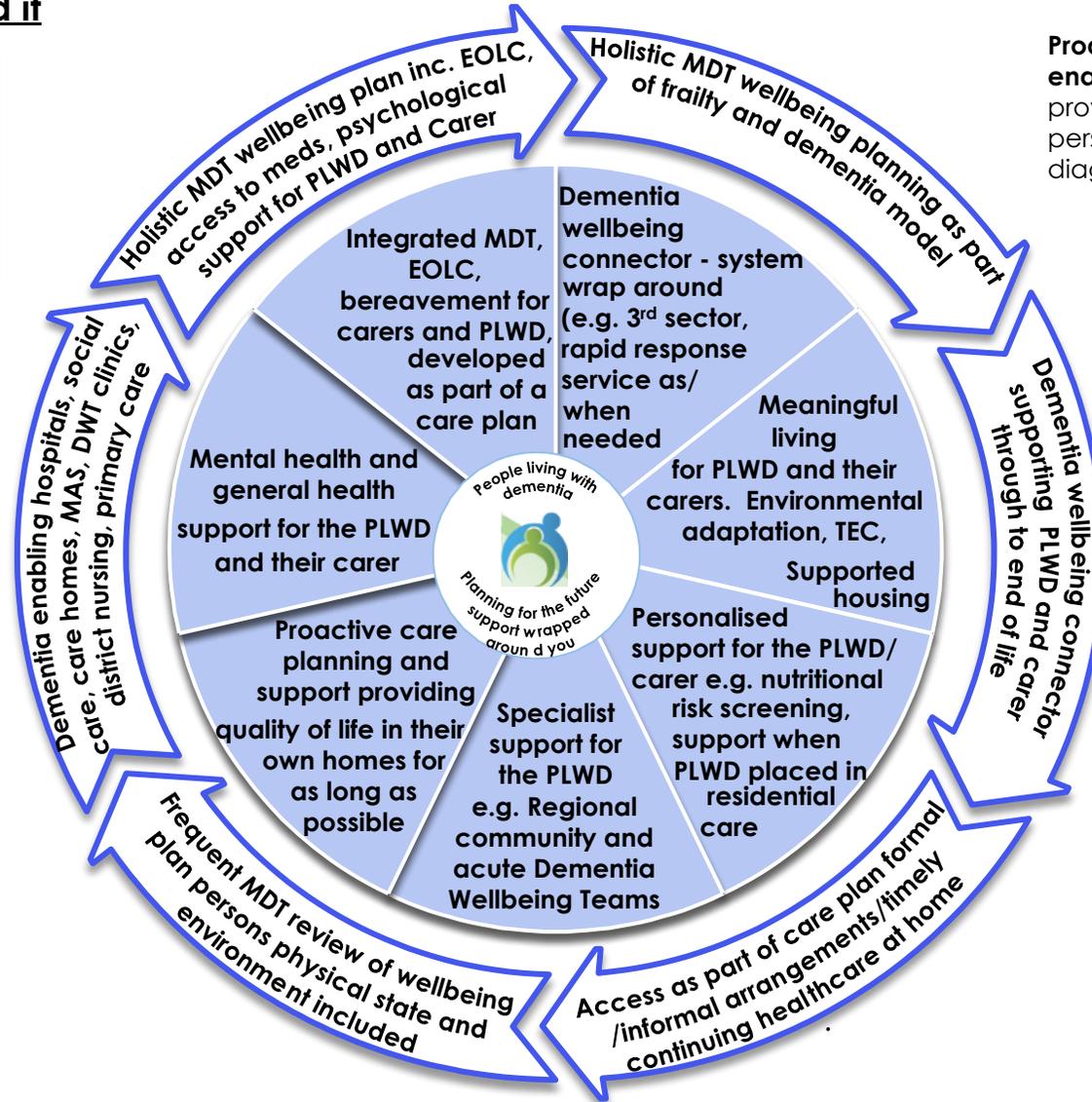
- Dementia wellbeing connector
- GP
- Advocate
- Social care
- District nurse (DN)
- Allied health professionals (AHPs) e.g. OTs, physio, dietetics, speech and language etc.
- Key workers/ assistive technology lead
- Admiral nurse
- Primary care
- 3rd sector
- Pharmacist
- Psychologist
- Care homes
- Older Adult mental health
- Adult MH for young onset
- Advice and advice on training as required from DWTs in the community and acute settings
- Secondary care and SPC consultants as required

What good looks like for West Wales – The draft dementia wellbeing pathway

Increased support when you need it

All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.



Proactive care planning through **HOLISITC** MDT (colleagues enabled to attend virtually) - consistent regional approach, providing stable support and wellbeing plan around the person and where appropriate, their carer, regardless of diagnosis including:

- Dementia wellbeing connector
- GP
- Advocate
- Social care
- District nurse (DN)
- Allied health professionals (AHPs) e.g. OTs, physio, dietetics, speech and language etc.
- Key workers/ assistive technology lead
- Admiral nurse
- Primary care
- 3rd sector
- Pharmacist
- Psychologist
- Care homes
- Older Adult mental health
- Adult MH for young onset
- Advice and advice on training as required from DWTs in the community and acute settings
- Secondary care and SPC consultants as required

Implementation of the Good Work Framework - we need to consider the learning and development needs of everyone who is affected in some way by dementia. This includes people living with dementia, carers, frontline staff, managers, commissioners, regulators, researchers, shopkeepers, next door neighbours etc. Resulting in people who are informed, people who are skilled and people who can act as influencers

Services aligned to the dementia wellbeing pathway



Wellbeing, risk reduction and delaying onset, raising awareness and understanding

Everyday services:

- Community networks and activities
- Sports and leisure activities
- Health and arts activities
- Libraries
- Cinemas
- Shops
- GP surgeries
- Police
- Fire service
- Dentists
- Opticians
- Audiology
- Pharmacies
- Education
- Housing
- Transport

Recognition, identification support and training

Information, Advice and Assistance - Local Authority's statutory responsibility. Initial advice and information is provided at the initial entry point into social care.

- Delta - for Carmarthen, Porth Gofal for Ceredigion, XXX for Pembrokeshire.
- Community networks
- 3rd sector services/activities
- Community/dementia wellbeing connectors/ social prescribers
- Local authority staff e.g. social care support workers, social workers, domiciliary care, Delta Connect,
- GPs and primary care staff
- Allied health professionals
- District nurses
- CRT/ART teams
- Care homes
- Community transport
- Hospital health staff
- Welsh ambulance service
- Everyday services

Assessment and diagnosis

MDT assessment in the community by trained staff with support from MAS. Hospital based MAS assessment for specialist diagnosis

- Community MDT: Dementia wellbeing connector, GPs, allied health professionals, nurses (all fully trained) see list on wheel 3 MAS – community based
- MAS hospital based
- 3rd sector – initial information and support post diagnosis
- Admiral nurse

Living well with dementia

Community MDT proactively care planning with dementia coordinator

- Person centred wellbeing activities available across the 3 counties to meet the needs of PLWD for both young and old
- Everyday services

Increased support when you need it

Timely access to services including CHC assessment, care packages agreed regardless of dementia diagnosis

- Dementia wellbeing connector
- Admiral nurse
- CRT/ART – health and social care
- Local authority staff e.g. social care support workers, social workers, domiciliary care, Delta Connect
- Care homes
- GPs and primary care staff
- Allied health professionals
- District nursing
- Specialist palliative care services
- Dementia wellbeing service community
- Dementia Wellbeing service hospitals

People with cognitive impairment should be able to be as independent as possible with people supporting them in everyday life. Access to services and support should be regardless of diagnosis. The pathway is designed to enable wrap around care for the PLWD and their carer, with people accessing support as and when they need it.

7. Our approach to Implementing the Dementia Wellbeing Pathway

The following slides summarise the priority areas required in order to implement the new dementia strategy and well being pathway.

Along with the co-design of the Dementia Wellbeing Pathway, the priority areas have been identified following extensive stakeholder engagement across West Wales and take into account best practice as well as the All Wales Dementia Action Plan and the recently published All Wales Dementia Care Pathway Standards.

The All Wales Dementia Action Plan 2018-2022: As a signatory to the Glasgow Declaration (1) the Welsh Government has previously committed to promote the rights, dignity and autonomy of people living with dementia. Through their engagement with stakeholders they heard about the positive work of Dementia Action Alliance in developing a series of statements with people living with dementia and their carers (2). We have aligned these statements to our priorities and recommendations.

1) <https://link.edgepilot.com/s/67f68721/ecxOvtDsBECT3nZRjlvhg?u=https://www.alzheimer-europe.org/Policy/Glasgow-Declaration-2014>

2) <https://link.edaepilot.com/s/8d37d66b/NmKURNiXoUaKCjzSUiWhQ?u=https://www.dementiaaction.org.uk/nationaldementiadeclaration>

Wellbeing, risk reduction, delaying onset, raising awareness and understanding



Creating dementia friendly communities, making dementia everybody's business

We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.

What we are doing and our plans in this area:

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|--|---|
| <p>Implementation of the Good Work framework – Training for ALL</p> | <ul style="list-style-type: none"> • Refresh the West Wales learning needs analysis training framework and work with partners to implement it. Ensuring that training provided is evidence and rights based approach where appropriate and to also build in training provided by the Welsh Government to help achieve the implementation of the All Wales Dementia Care Pathway of Standards (AWDCPS) • All staff, including those in everyday services and services such as domiciliary care and care homes, to be trained to recognise the signs of dementia and be trained in how best to support PLWD - appropriate to the level of contact - from basic understanding to managing behavioural expression of unmet need - enabling generic services (e.g. social work, personal assistants, domiciliary care, care homes, district nursing, OT, physio etc.) to support PLWD especially for those who are deaf, blind and Welsh speakers • Training for all staff in basic understanding to managing person centred care/behavioural expression of unmet need - enabling people to recognise signs, what to expect to support PLWD • Arrange for those professionals who are interested to be trained through the All Wales faculty dementia diagnosis course which is available for all professionals – consider if a bespoke regional training would be appropriate for the West Wales region • Ensure there is access to training in behavioural interventions for carers and domiciliary care providers – preventing unnecessary residential placements <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none"> • Within 12 weeks of receiving a diagnosis, PLWD will be offered education and information on the importance of physical health activities to support and promote health. (AWDCPS 9) • Implementing the All Wales expert by experience courses (Licenced by Harvard university) - PLWD, carers and families will be offered learning, education and skills training. This offer will be stage appropriate and will be provided at significant parts of a person's journey. It will include a range of peer support and shared experience opportunities. (AWDCPS 10) • All staff delivering care at all levels within all disciplines and settings, will have the opportunity to participate in person centred learning and development with support to implement into daily practice. This will be a joint regional approach to identifying a range of learning and development opportunities including quality improvement. (AWDCP 17) |
| <p>Communication, raising awareness enabling access to timely information/ services</p> | <ul style="list-style-type: none"> • Promote the UK and Welsh Government public health messages across the region • Raise awareness of young onset dementia and develop a clear service offer • Carers and people living with dementia (PLWD) need clear and accessible information connecting them to local peer groups for support at the outset • Maximise the use of DEWIS across the region by professionals and the public • Create a standard approach across organisations for the provision of information to PLWD and their carers • Primary care consider how PLWD access GP appointments - PLWD may not be able to get past the receptionist or the triage system if living on their own • The introduction of a Dementia wellbeing connector role, which will work with local services within the communities they are aligned to and will enable better access to everyday services such as dentists, opticians and GP surgeries • Develop a range of individual and group based physical and activity based interventions and opportunities that are person centred for PLWD to access • Recognise that transport, particularly in rural areas, to get people to community activities is challenging and identify ways of addressing this |

Recognition, identification support and training



Each person gets fair access to care

We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.

What we are doing and our plans in this area

| | |
|---|---|
| <p>Proactively supporting people</p> | <ul style="list-style-type: none"> • Strengthen access to local networks across the region for those with mild cognitive impairment and for those with dementia • Ensure dementia is an indicator as part of risk stratification within primary care and PLWD and their carers who require support receive proactive MDT care planning with support from the Dementia wellbeing connector • Develop a proactive case management approach (shared care/decision making) through MDT working, developing plans to lower the likelihood of PLWD hitting crisis, even for those who don't have a diagnosis <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none"> • People living with Mild Cognitive Impairment (MCI) will be offered a choice of holistic services monitoring their physical, mental health and wellbeing, with reviews taking place as a minimum six monthly. This will include a range of options including peer support. Signposting and community resources should be at the centre of all intervention (AWDCPS 8). |
| <p>Support regardless of diagnosis</p> | <ul style="list-style-type: none"> • Carers and people suspected of highly likely living with dementia to access clear and accessible information connecting them to local peer groups for support at the outset • Carers and people suspected of highly likely living with dementia receive advice and support in relation to managing their every day lives throughout their journey • Community activities need developing and co-ordinating for people suspected of highly likely living with dementia and their carers – activities should be person centred and be available regardless of diagnosis |
| <p>Enabling structures</p> | <ul style="list-style-type: none"> • Develop a regional strategic/co-ordinated approach to supporting carers – consider top slicing the dementia ICF funding to be included in the carers' ICF funding, thereby ensuring all carers' services support those who are caring for people living with dementia • Review CHC assessments which have taken place over the past 18 months to identify whether people are accessing CHC regardless of a dementia diagnosis – develop a report and action plan to address, if needed • Develop a comprehensive communication programme to promote the strategy and its messages. Keep the plan alive and ensure the public are aware of any new service developments in their area or across the region. Regularly report progress and review the plan via the WWCP Dementia Steering Group |

Assessment and diagnosis



Each person is seen as an individual

We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.

What we are doing and our plans in this area

| | |
|---|---|
| Getting the diagnosis pathway and information right first time | <ul style="list-style-type: none">• Develop a regional diagnosis pathway, maximising the use of AHPs, designing new ways to diagnose in the community, develop an outline business case to implement the new pathway with modelled resourcing. The new pathway will include the implementation of the AWDCPS: 3, 5, 6, 7 and 15 – (See standards below).• Ensure the new pathway includes a formal process for acute hospital consultant diagnosis and READ codes included into discharge papers – so care homes and GPs are made aware• Following the recent development of an outline business case, develop a full business case for the Dementia wellbeing connector role, to include system savings aligned to a phased roll out. WWCP dementia steering group to agree the preferred option. Develop plan to implement the new role. |
| Supporting those with a learning disability | <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none">• Memory Assessment Services (MAS) and Primary Care (GP) will adopt the READ Codes. Those diagnosed with dementia within settings outside of MAS (including primary care, community resource teams, psychiatric liaison and neurology) will provide the GP and MAS the specific READ Code within two weeks of a diagnosis (AWDCPS 3)• Health and social care services will provide the correct information to assist MAS when they undertake assessments and in providing diagnosis. This will also support the person to manage any identified daily living difficulties. (AWDCPS 5)• MAS, within a 12 week period from point of referral, will provide a range of interventions (listed in the AWDCPS 6) to support diagnosis. Consider what digital platforms and other adaptations and approaches are needed to enable the implementation of this standard.• People will have access to a contact that can provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis and ensure following this period, it is offered as required. (AWDCPS7)• People within 12 weeks of being diagnosed with dementia will be offered support to commence planning for the future, including end of life care. This offer will include the opportunity to revisit and update this plan throughout the person's journey. Where appropriate, representation and the use of advocacy will ensure the rights of the person are upheld. (AWDCPS 15) <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none">• Learning Disability (LD) services will define a process to capture the total population of people living with a learning disability and specifically Down Syndrome to offer a cognitive wellbeing check. (AWDCPS 4) |

Living well with dementia



Care is co-ordinated

We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part. We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.

What we are doing and our plans in this area

| | |
|---|---|
| <p>Enabling people to have health reviews and to attend appointments</p> | <ul style="list-style-type: none"> Following sign off of the full business case, roll out of the Dementia wellbeing connector service which will promote proactive care planning through HOLISTIC MDT - consistent approach across the region, providing stable support wellbeing plan around the person – develop a regional holistic care plan template Dementia wellbeing connector to co-ordinate support throughout a person's journey Develop a pre and post diagnostic service (PPDS) standard operating procedure. This will set out expectations, processes and data recording requirements from the PPDS. Develop a consistent approach to medication monitoring, review and prescribing in primary care across the region <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none"> PLWD will have a current face to face appointment where a physical health review will be delivered in partnership by primary and secondary care. Where there is justifiable reason for not providing a face to face appointment, a physical health review will be delivered by other approaches i.e. digital platforms, telephone consultation. (AWDCPS 14) PLWD, their carers and families will have support and assistance to engage with appointments. This will avoid receiving multiple health and social care appointments that can overwhelm, confuse and isolate the person. Practical streamlining of operational processes will support the service to avoid duplication and maximise opportunities to exercise prudent principles to service delivery. (AWDCPS 18) |
| <p>System wide response</p> | <ul style="list-style-type: none"> Support PLWD to live well; continue with implementing the Journey Through Dementia OT programme which includes implementing 'dementia-friendly design principles' within peoples own environments and any new building or service Ensure employers assess for and implement reasonable adjustments to enable the PLWD to work Regardless of diagnosis, Dementia wellbeing connector role to act as the co-ordinator for the PLWD reducing the likelihood of them or their carer having to repeat their story or to be accountable for relaying information between services – capturing the essence of who the person was - explore using the patient knows best APP Review ALL initiatives currently funded by the Regional Integrated Fund, evidencing outcomes, align funding to implement strategic priorities, ensure any new way of working is fully resourced Consider whether social workers from each county and 3rd sector colleagues could become part of the regional dementia wellbeing community team Review community activities available across the region for PLWD and support activities for carers. Address gaps, including activities for those with young onset dementia Maximise the use of technology, for professionals, PLWD and their carer e.g. connect carers to support via an APP on the hospital bed l pads Implement the remaining actions from the All Wales Dementia Action plan Identify an area in which to implement the All Wales Dementia Care pathway Standards in line with the 2 year programme of work outlined in the standards. (AWDCPS 1) <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none"> Services at the points of contact will provide reasonable adjustments to care that is meeting the person's needs and personal preferences. (All Wales Dementia Care Pathway Standard 2) Person-centred reasonable adjustments will support the person to live well by maximising their independence and ability to participate in their communities. (All Wales Dementia Care Pathway Standard 2) People living with dementia and their carers will have a named contact (connector) to offer support, advice and signposting, throughout their journey from diagnosis to end of life. (AWDCPS 12) People living with dementia will have access, when needed, to relevant (and when accessing mental health services) dedicated services post diagnosis no matter their residence. This identifies with the care and team wrapped around the individual (AWDCPS 13) Organisations and care settings providing intensive dementia care (this includes mental health and learning disabilities inpatient settings) implement the dementia care mapping tool to evaluate and learn about person-centred enabling practice. Supporting clinical reasoning and decision making. Mental health DCM services will offer DCM support to acute care, prisons and care homes settings. (AWDCPS 16) Working in partnership, the region will deliver on the requirements of the agreed data items (measurement workbook) for reporting and assurance. (AWDCPS 20) |

Increased support when you need it



All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

What we are doing and our plans in this area

| | |
|--|--|
| Consistent care while in hospital | <ul style="list-style-type: none">• Optimise patients' wellbeing while in hospital through admissions and discharge check list - diagnosed, working diagnosis etc. Fully adopt the Dementia Friendly Hospital charter, raising awareness among staff and volunteers, preventing issues such as personal effects getting lost or hearing aids not being put in correctly – develop action plan to implement and regularly review through the WWCP Dementia Steering group• Ensure hospital staff are trained to understand what power of attorney for health means <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none">• Wales will adopt the Dementia Friendly Hospital Charter with a regular review of implementation and outcomes. (AWDCPS 11). |
| Maximise the power of MDT working, accessing support when you need it | <ul style="list-style-type: none">• Develop a regional, standard, interdisciplinary care plan and through proactive MDT working which enables colleagues to join virtually, and shared decision making with the patient and carer, plan ahead to prevent crisis as well as to increase support as and when it is needed including agreeing ceilings of care - consider if the plan should be placed in an APP that can be accessed by the patient, carers and colleagues• Maximise the circle of support e.g. community transport colleagues can help MDTs by providing relevant information in relation to the patient• Ensure that organisations communicate with each other rather than PWLD or their carers having to co-ordinate communication across services• Identify when the carer lives outside the region to ensure they have local information to enable the person they are caring for to access services in their local area• Ensure that there is an crisis contingency care plan in place for the PLWD and their carer and that the carer can also access support when they need it• Training in person centred behavioural expressions of unmet need is needed - implement the dementia recognition tool across the region which can help the development of behavioural management plans, key behaviours and identifying what interventions can be used <p><u>All Wales Dementia Care Pathway of Standards (AWDCPS)</u></p> <ul style="list-style-type: none">• Services will ensure that when a person living with dementia has to change or move between any settings or services, care with supportive interventions will be appropriately coordinated to enable the person to consider and adapt to the changed environment. This will ensure that all care partners will communicate and work jointly with each other to support a seamless transition. (AWDCPS 19). |

Delivering the initiatives through programme management

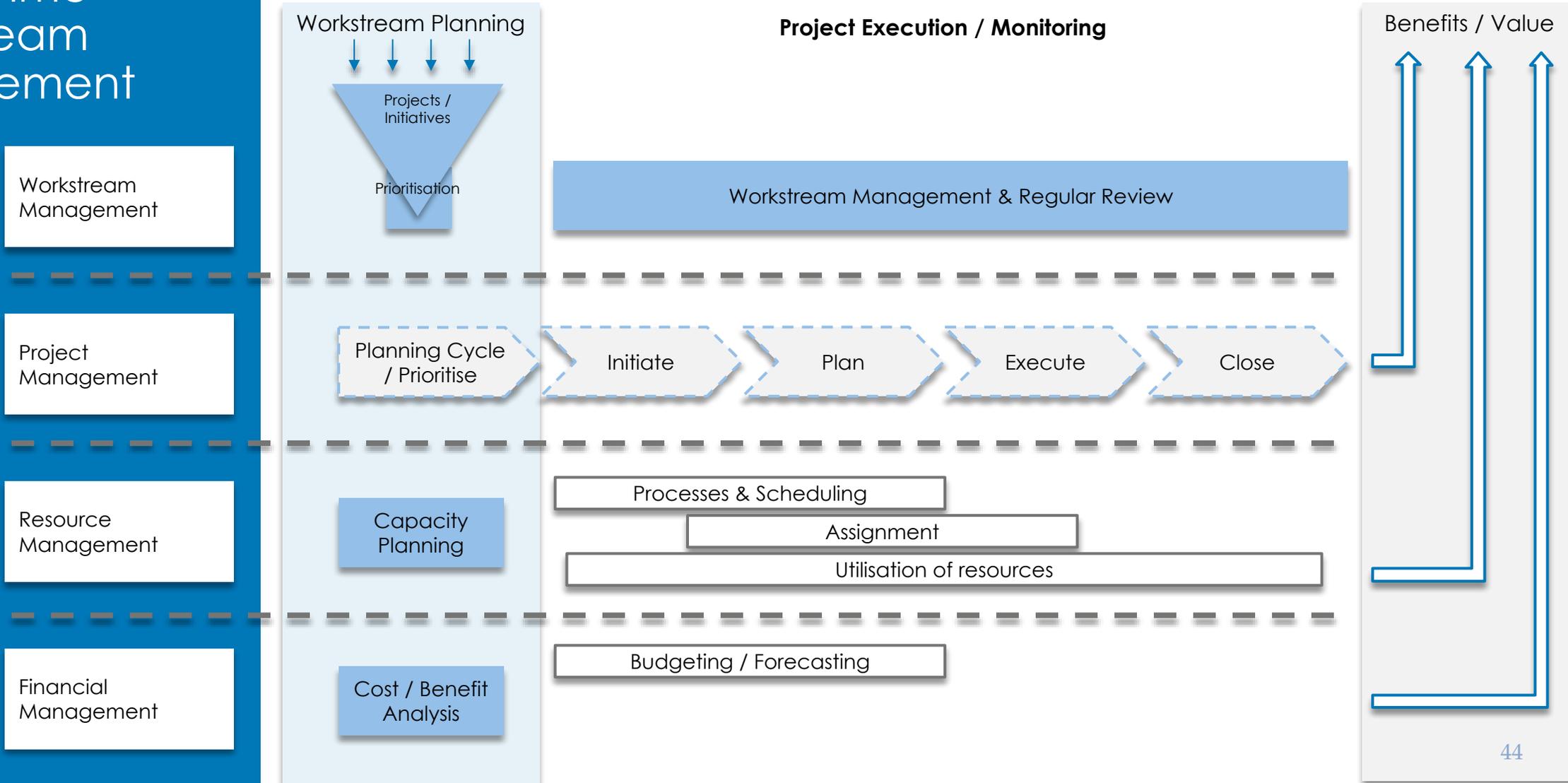
In addition to developing the vision, service model pathway, strategy, Attain were asked to review existing regional governance to ensure robust, multi-agency ownership of the ICF Plan, its delivery and evaluation. To begin with Attain highlighted what good programme management looks like (for more detail see appendix 3)

The following slides describe the proposed programme management framework for the Regional Dementia Programme.

What does good programme management look like?

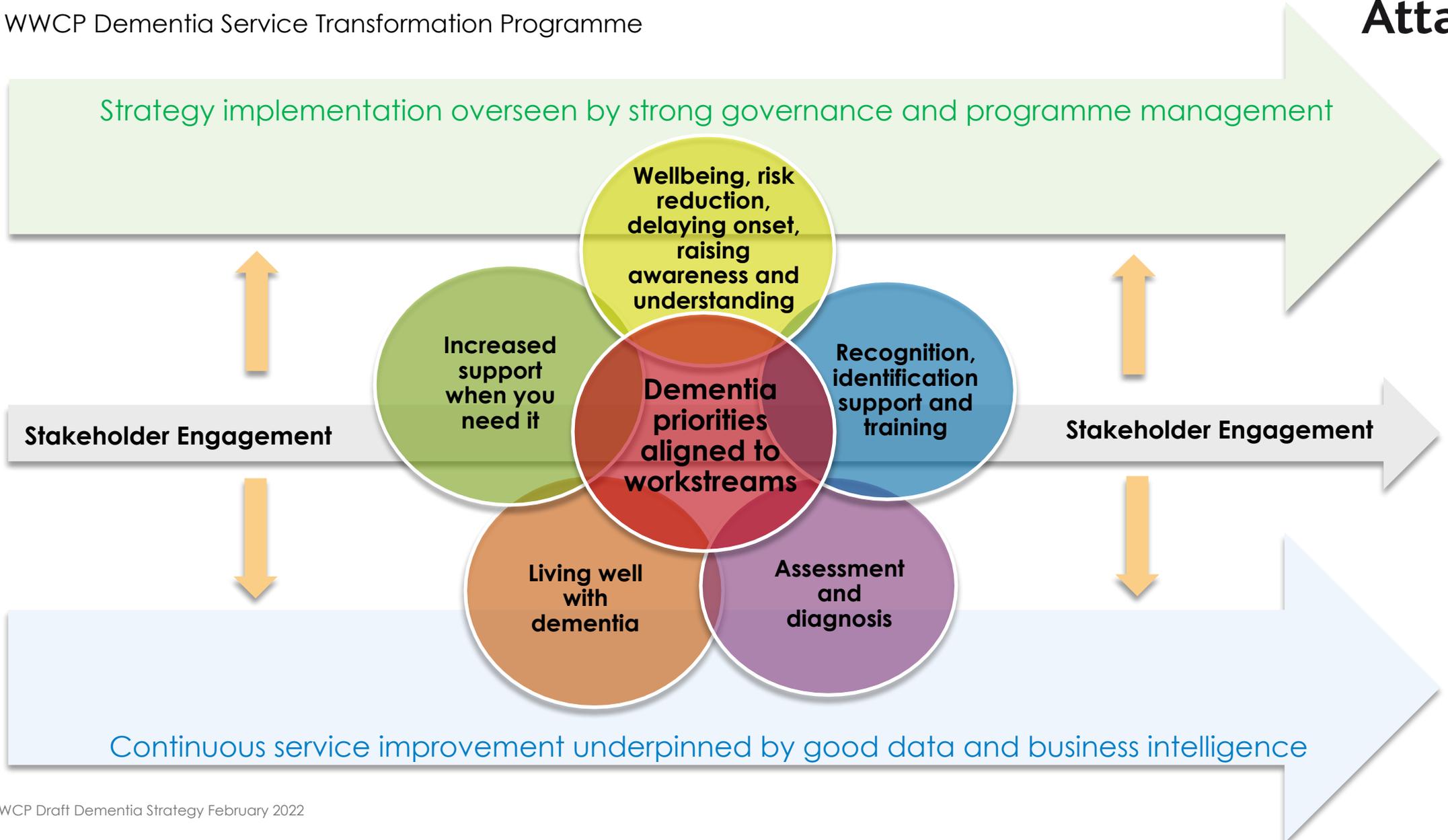


Proposed Delivery Approach: Programme Workstream Management



Approach to implementing the Dementia strategy and Wellbeing Pathway

WWCP Dementia Service Transformation Programme



Proposed workstreams to deliver the WWCP Dementia strategy

WWCP Dementia Service Transformation Programme



Strategy development and implementation overseen by strong governance and programme management

Workstream 1
Programme
governance
and system
enablers

**Programme
management
and culture of
working
together and
sharing best
practice**

Workstream 2
Dementia
Service
transformation

Workstream 4
Dementia
BI and data

Workstream 3
Dementia
workforce
development
and training

Stakeholder Engagement

Stakeholder Engagement

Continuous service improvement underpinned by good data and business intelligence

Period of service transformation is 5 years

Proposed Delivery Approach: Portfolio Management

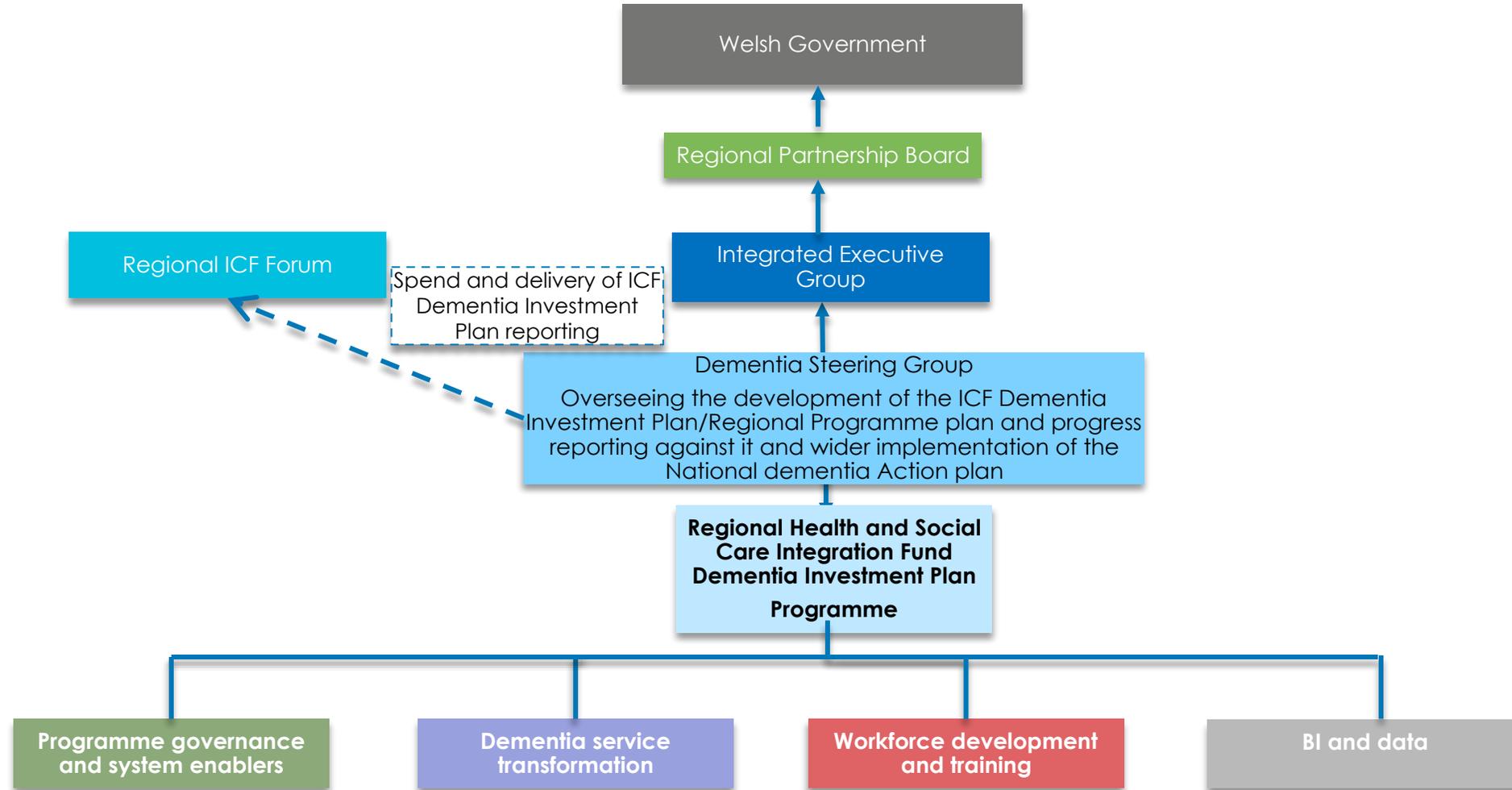


The below indicative set of portfolios will provide structure to deliver the next phase of work developing the dementia strategy/programme plan. The dementia strategy priorities are in line with the All Wales dementia care pathway standards and builds on the current good practice already in place. The dementia priorities should be led by a senior leader within the system and will be overseen by an SRO, along with the WWCP dementia steering group. However, the whole programme of work will also be overseen by the Integrated Executive Group and the Regional Partnership Board. Resources will need to be identified over the life of the programme to enable continuation of service delivery while frontline staff work to design and develop the services.

| | Programme governance and system enablers | Dementia service transformation | Workforce development and training | BI and data |
|----------------|--|---|--|---|
| Aim | Implementation of the regional dementia strategy fully signed up to by the WWCP. Robust achievable implementation plans. | Implement recommendations stemming from the dementia strategy that relate to service transformation. | Implement priorities stemming from the dementia strategy that relate to workforce development and training. | Implement priorities stemming from the dementia strategy that relate to a uniform approach to collection of business intelligence and outcomes. |
| Priority Areas | <ul style="list-style-type: none"> Recruit regional programme manager Regional programme plan developed to deliver the strategy recommendations. WWCP programme governance structure Oversight of 2021/22 projects and allocation for 2022 onwards Enable data intelligence to support decision making and planning Set up and implement the enabling structures stemming from the recommendations within the strategy Communication plan running alongside the strategy, raising awareness, promoting service developments locally | <ul style="list-style-type: none"> Proactively supporting people Support regardless of diagnosis Getting the diagnosis pathway and information right first time Supporting those with a learning disability Enabling people to have health reviews and to attend appointments Actions in relation to implementing a system wide response Consistent care while in hospital Maximise the power of MDT working, accessing support when people need it | <ul style="list-style-type: none"> Implementation of the Good Work framework – Training for ALL and recommendations in the strategy relating to training e.g. Refresh the West Wales learning needs analysis training framework, work with partners to implement it. Ensuring that all training provided is evidenced based Development of a workforce plan to support service transformation delivery Support the development of the dementia recognition tool Take forward the development and role out of the Dementia wellbeing connector role | <ul style="list-style-type: none"> Data driving change – develop ICF dementia programme performance dashboard Develop the Dementia wellbeing connector full business case with detailed population needs, workforce and demand and capacity modelling for Dementia wellbeing connector role to provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis Implementation of the dementia strategy recommendations in relation to BI and data. |

Patient and Carer co-production - improving patient experience through easy access and standardisation of information, services and user/family voice in service change

Proposed Integrated Care Fund (ICF) Dementia Programme Governance Arrangements





8. Next steps for 2022/23

Next steps

Delivering the programme:

- Agree the rationale to continue funding during 2022/23
- Identify resource to set up and manage the programme of work across partners - recruit to the role
- Create a programme plan, prioritise projects and revise timelines to ensure that there is a realistic and deliverable plan in place. Use Workstream Management as the process for delivery
- Identify Workstream SROs to drive work with PMO support; provide ownership and accountability to deliver
- Regular progress updates should be provided at the monthly WWCP Dementia Steering Group

Implementing the strategy:

- Seek sign off from Integrated Exec Group and Regional Partnership Board, develop communications plan to socialise the strategy so all partners are aware of the direction of travel for dementia services within West Wales.
- Communications plan to cover the life of the strategy, enabling the public to be aware of any new developments in their area
- Update the programme plan with the new service developments required to deliver the dementia wellbeing pathway
- Ensure robust governance is in place to oversee the implementation of the new service initiatives, ensuring all new initiatives take a programme approach reporting progress regularly to the Regional Dementia Steering group

Implementation of the new West Wales Dementia Strategy

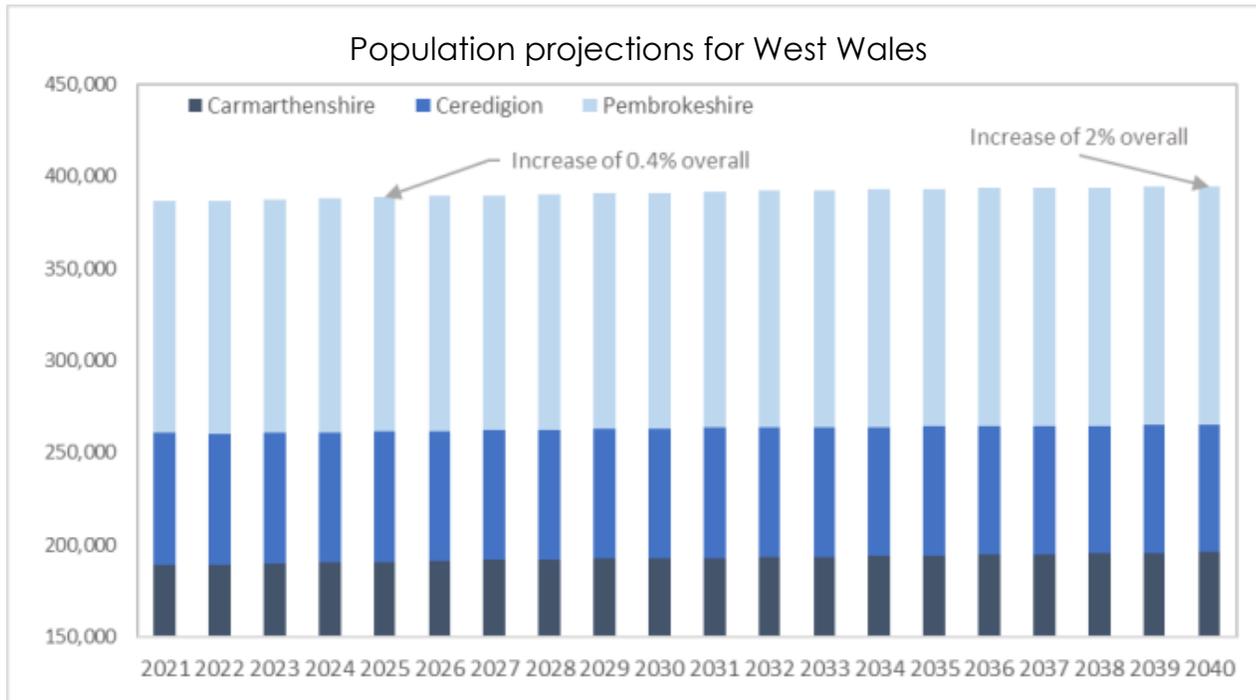
9. Appendix 1: West Wales Population Analysis

West Wales population analysis (ONS)

Overall the population of West Wales looks like it will increase by **0.4% overall by 2025** and by **2% by 2040** (20 years). Pembrokeshire and Carmarthenshire will see the similar population increases of 0.6% and 0.7% by 2025 and 2.7% and 3.5% by 2040. Ceredigion is expected to have a population decrease (0.7% at 2025 and 3% at 2040). However, in terms of age; **all areas are going to see an increase in their elderly populations.**

Overall, the elderly population is set to increase, and the child and working age population decrease

- By 2025 (in 4-5 years) the population of **over 65s is likely to increase by 6%** (over 80s by 11%)
- By 2040 (roughly 20 years from now) the over 65 population is looking likely to increase by 27% and the over 80s 55%
- The over 65s currently make up a quarter of the population. In 5 years around 26.8% and by **2040 it is likely to be nearly a third of the population** with the **over 80s becoming over 10%** (from just over 6% now)



WWCP Draft Dementia Strategy February 2022

| | % change from Current | | | |
|-----------|-----------------------|--------|--------|--------|
| | 2025 | 2030 | 2035 | 2040 |
| 0-4 yrs | 96.6% | 93.7% | 94.2% | 97.4% |
| 5-9 yrs | 95.1% | 91.1% | 88.8% | 89.4% |
| 10-14 yrs | 99.0% | 92.2% | 88.4% | 86.4% |
| 15-19 yrs | 109.5% | 111.2% | 104.3% | 99.9% |
| 20-24 yrs | 96.6% | 107.2% | 109.6% | 103.3% |
| 25-29 yrs | 89.8% | 84.1% | 93.4% | 96.1% |
| 30-34 yrs | 97.1% | 87.7% | 82.2% | 91.3% |
| 35-39 yrs | 107.1% | 106.4% | 97.5% | 91.6% |
| 40-44 yrs | 102.5% | 109.2% | 108.5% | 100.2% |
| 45-49 yrs | 94.3% | 99.0% | 105.0% | 104.5% |
| 50-54 yrs | 89.4% | 81.2% | 85.7% | 90.5% |
| 55-59 yrs | 95.9% | 85.7% | 78.6% | 83.4% |
| 60-64 yrs | 111.3% | 108.9% | 98.2% | 90.8% |
| 65-69 yrs | 105.7% | 120.5% | 118.6% | 107.7% |
| 70-74 yrs | 92.9% | 99.5% | 114.0% | 112.9% |
| 75-79 yrs | 115.9% | 108.8% | 117.7% | 135.7% |
| 80-84 yrs | 115.8% | 141.4% | 134.3% | 147.4% |
| 85-89 yrs | 105.8% | 125.6% | 155.4% | 150.3% |
| Age 90+ | 107.8% | 120.1% | 145.4% | 183.6% |

West Wales Dementia (QOF Register)

The data in this pack is an extract from the GP systems using the QOF definition.

Women make up approximately 62% of the registered dementia patients in West Wales but this is partly due to higher life expectancy in the female population

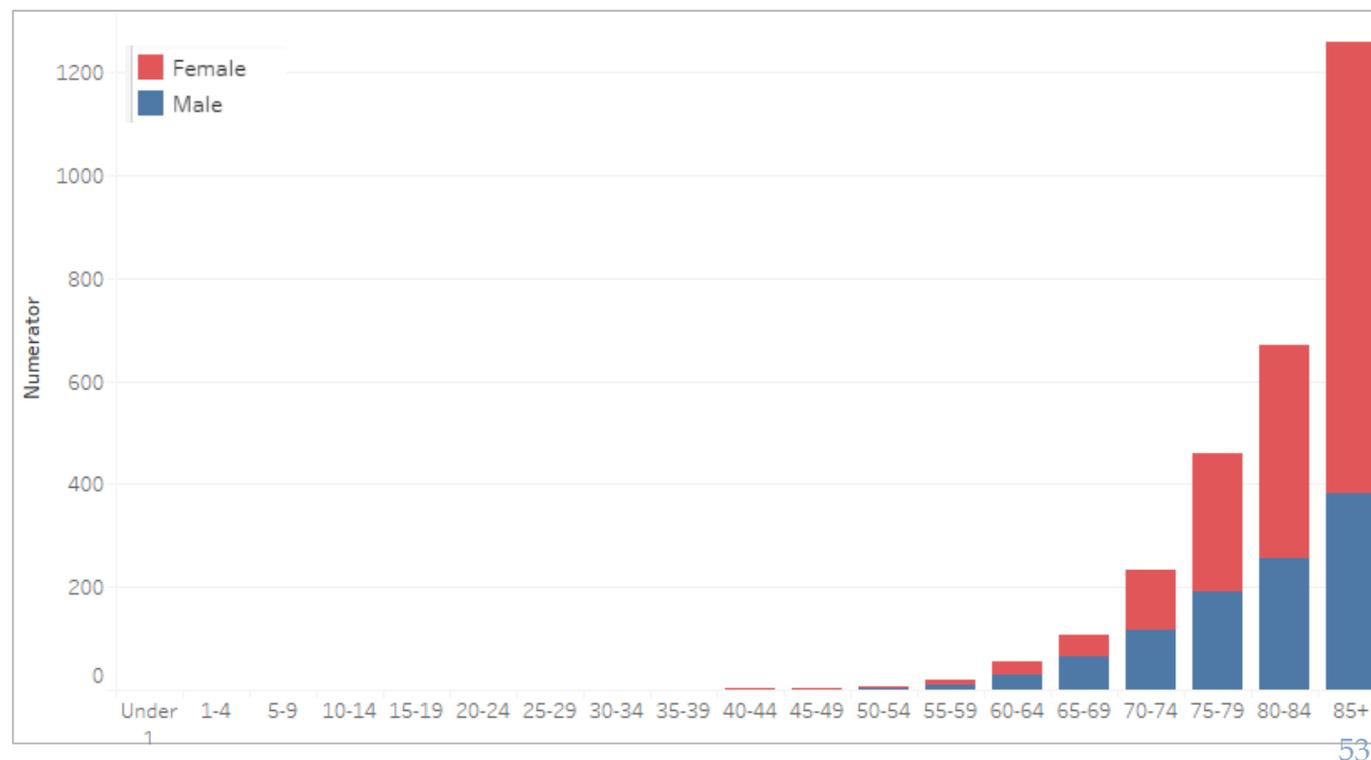
Nearly 50% of the female dementia patients are over 85 years old compared to 36% of the male patients. This means that 45% of the total dementia patients over the age of 85 years old. This age group is set to grow substantially over the next 20 years, and is due to make up over 10% of the West Wales population by 2040. Recent studies show that the incidence of dementia is not increasing substantially but due to increased life expectancy and better outcomes for care, prevalence will continue to increase.

Mortality from dementia became the leading cause of death in the UK in 2015 and has continued to displace other causes of death. Pre-Covid (2020) it represented 12.7% of deaths and that number had grown yearly

The prevalence across the whole population of patients on the QOF register diagnosed with dementia is just over 0.7%. However, the prevalence in the over 60s (people on the register/population in the age group) is 2.3%. Young onset dementia is defined as those under 65 being diagnosed.

These represent a very small number of GP diagnosed cases but potentially a larger portion of the unmet and undiagnosed need

People over 60 represent around a third of the population and 98.9% of the registered dementia patients in West Wales



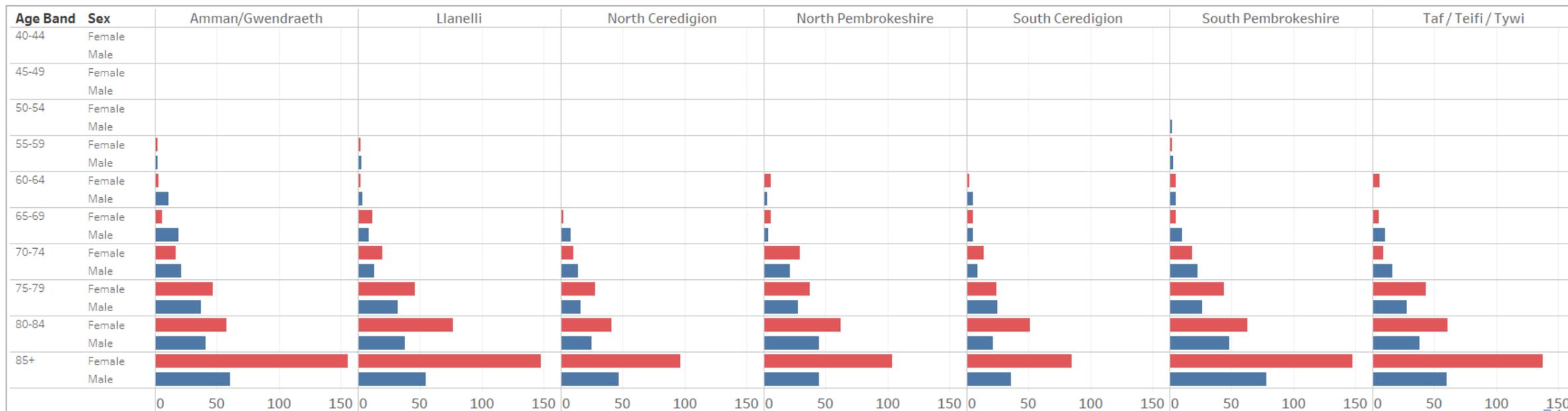
Dementia by cluster

Carmarthenshire has the largest population of the 3 counties across West Wales, it has around 49% of the whole population and 46% over the Over 65s, with 24% of its own population over 65 years old. They have 48% of the dementia diagnosis. It is also the most rural area of the three counties.

Pembrokeshire GPs have a recorded population with dementia diagnosis of around 870 patients, which represents around 31% of the dementia diagnosis in West Wales. As a county they have 32.5% of the population and 34% of the over 65 population. The over 65 population represents nearly 27% of the total population in Pembrokeshire. However, by 2040 the growth for Pembrokeshire will be 6.6%

Although Ceredigion's population is set to decrease overall, the over 65s is set to increase by over 4% in the next 20 years.

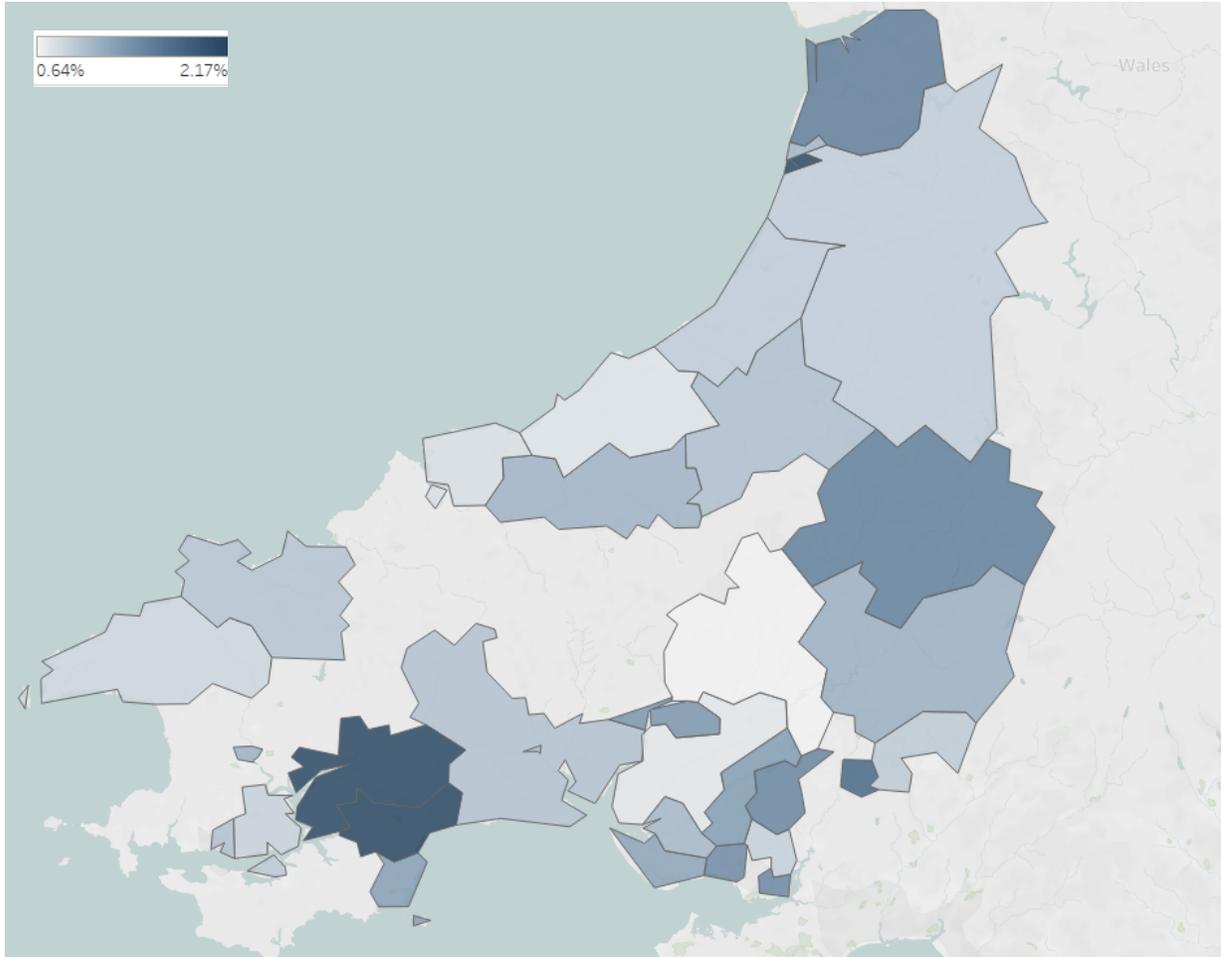
The below graphic shows the male and female actual numbers by cluster and as you can see, the three Carmarthenshire clusters have very high numbers, comparatively, in the female over 85s category. Notably South Pembrokeshire also has high numbers of both male and female over 85s diagnosed with dementia



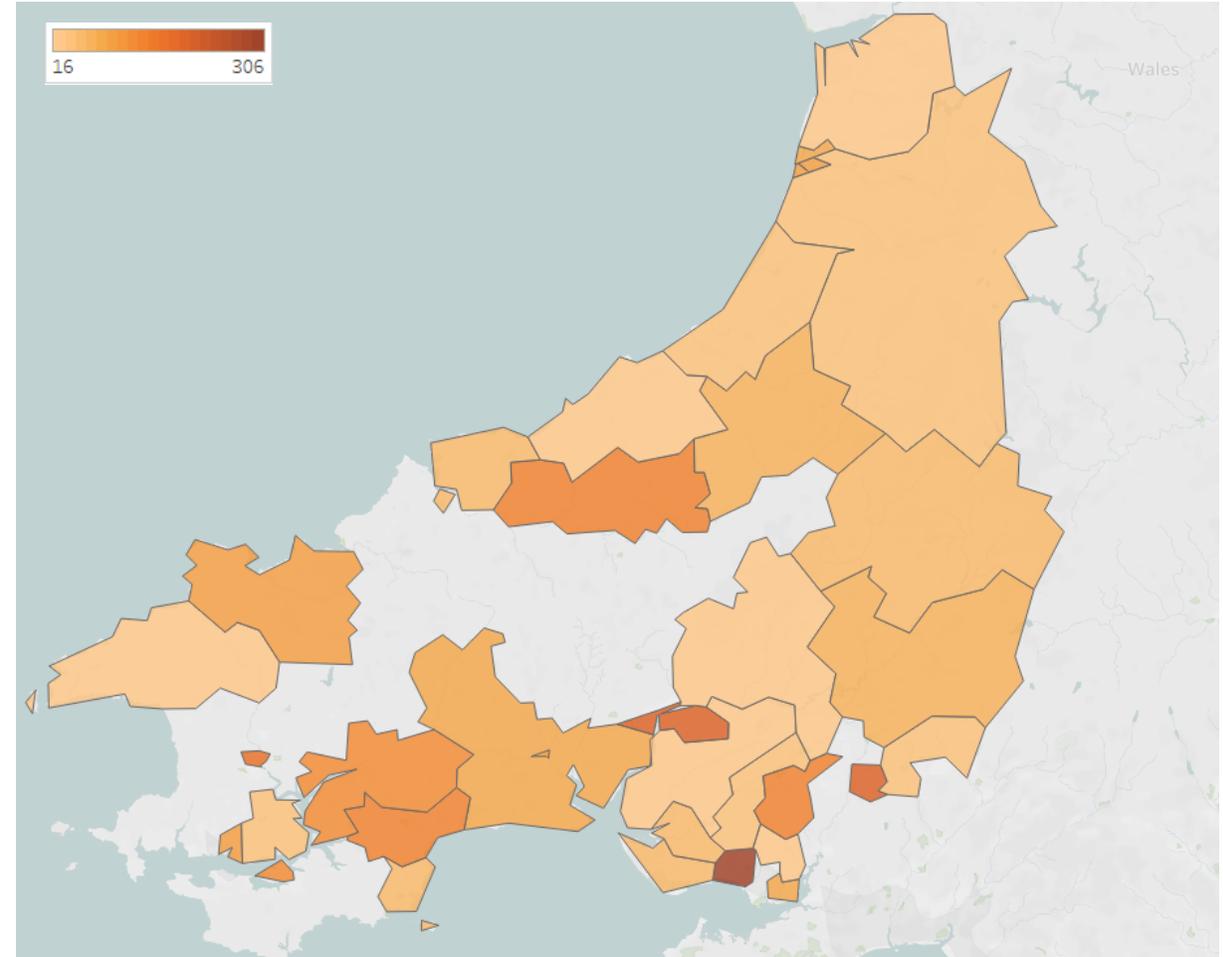
Map

Lower Layer Super Output Areas (LOSA) data for patients was not available and so the below information shows the pressure for the GP practices at a Middle Layer Super Output Area (MOSA) level which is why there are gaps.

Proportion of over 40s population based on practice list, by MOSA of practice location

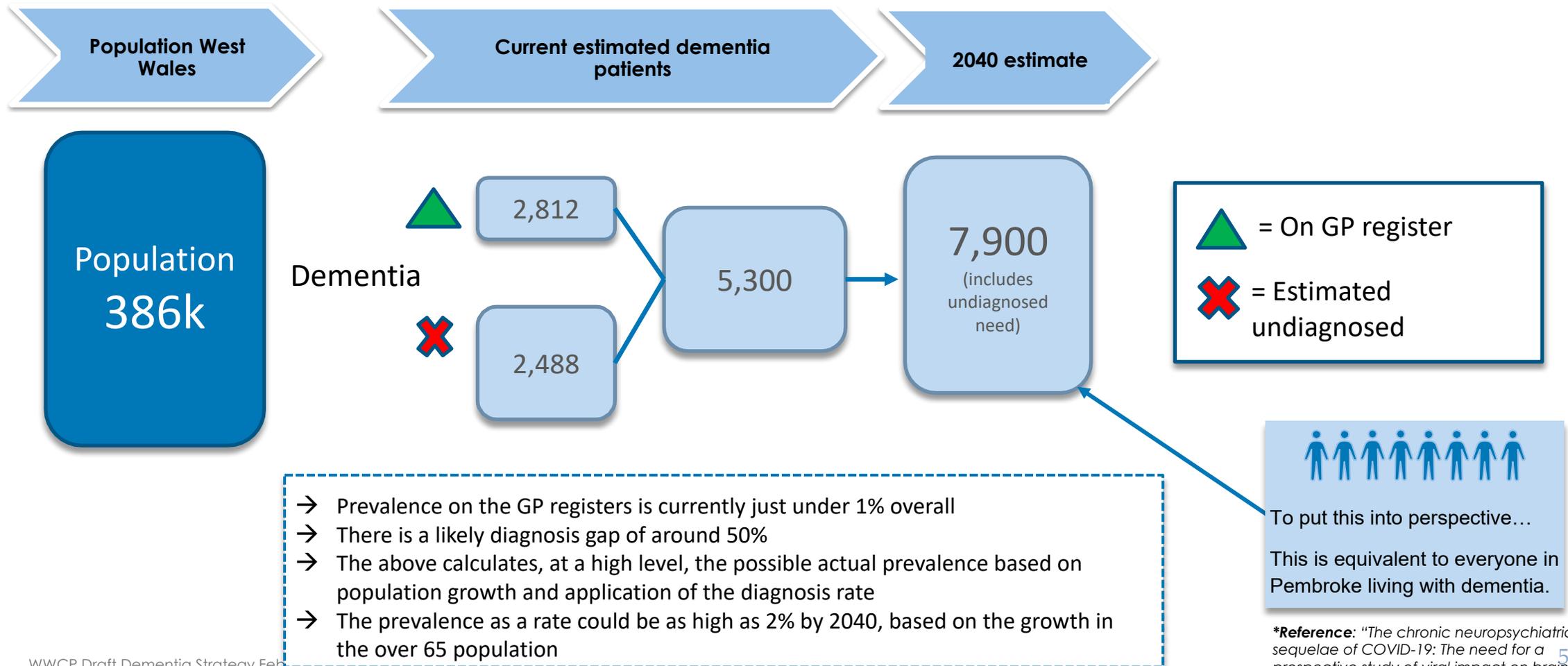


Total diagnoses population based on practice list, by MOSA of practice location



Dementia- prevalence

The chart below shows the current registered dementia population and the possible undiagnosed level; it then predicts, based on both the undiagnosed rate and population growth, the possible number of patients living with dementia across West Wales by 2040. It is important to note that the impact of COVID-19 on the diagnosis and incidence rate of dementia is still unknown. There is concern that, in some cases, COVID-19 causes damage to the brain and long term this could lead to increased risk of developing dementia*



*Reference: "The chronic neuropsychiatric sequelae of COVID-19: The need for a prospective study of viral impact on brain functioning" - Gabriel A. de Erausquin et al

Health board comparison

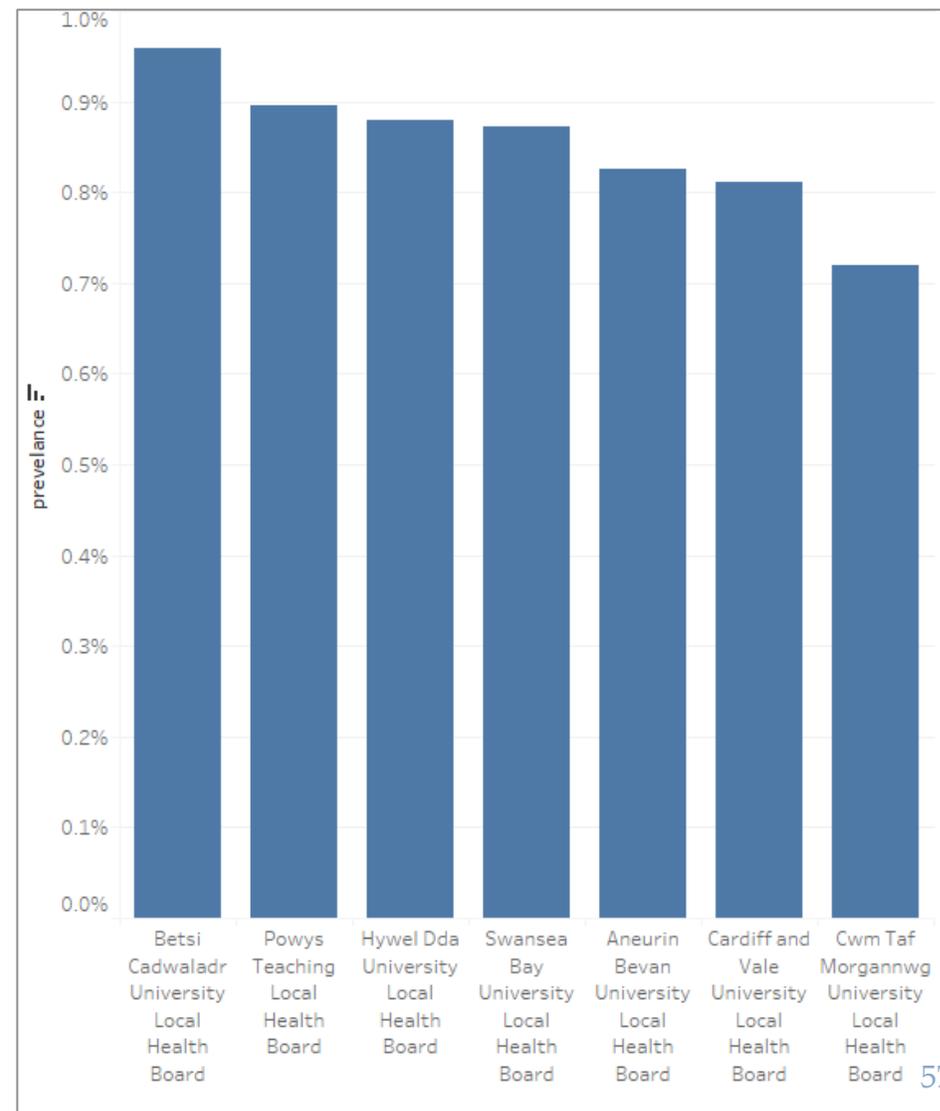
The graph to the right shows the prevalence rates for dementia recorded in the GP registers (according to QOF definitions). Note, this is likely to be a lower than actual prevalence rate due to using GP registered population from the GP system as the denominator (and not resident population, it also includes all age groups)

However, the important thing to note is the differences rather than the numbers. West Wales are the 3rd highest and they are slightly above the Wales average (circa 0.87% compared to 0.85%)

Numbers of patients on dementia register by sex and UHB

| | Aneurin Bevan University Local Health Board | Betsi Cadwaladr University Local Health Board | Cardiff and Vale University Local Health Board | Cwm Taf Morgannwg University Local Health Board | Hywel Dda University Local Health Board | Powys Teaching Local Health Board | Swansea Bay University Local Health Board |
|--------|---|---|--|---|---|-----------------------------------|---|
| Female | 2,560 | 3,492 | 2,189 | 1,659 | 1,753 | 622 | 1,692 |
| Male | 1,500 | 2,048 | 1,166 | 985 | 1,059 | 346 | 1,047 |

Dementia GP register prevalence (among adult population)

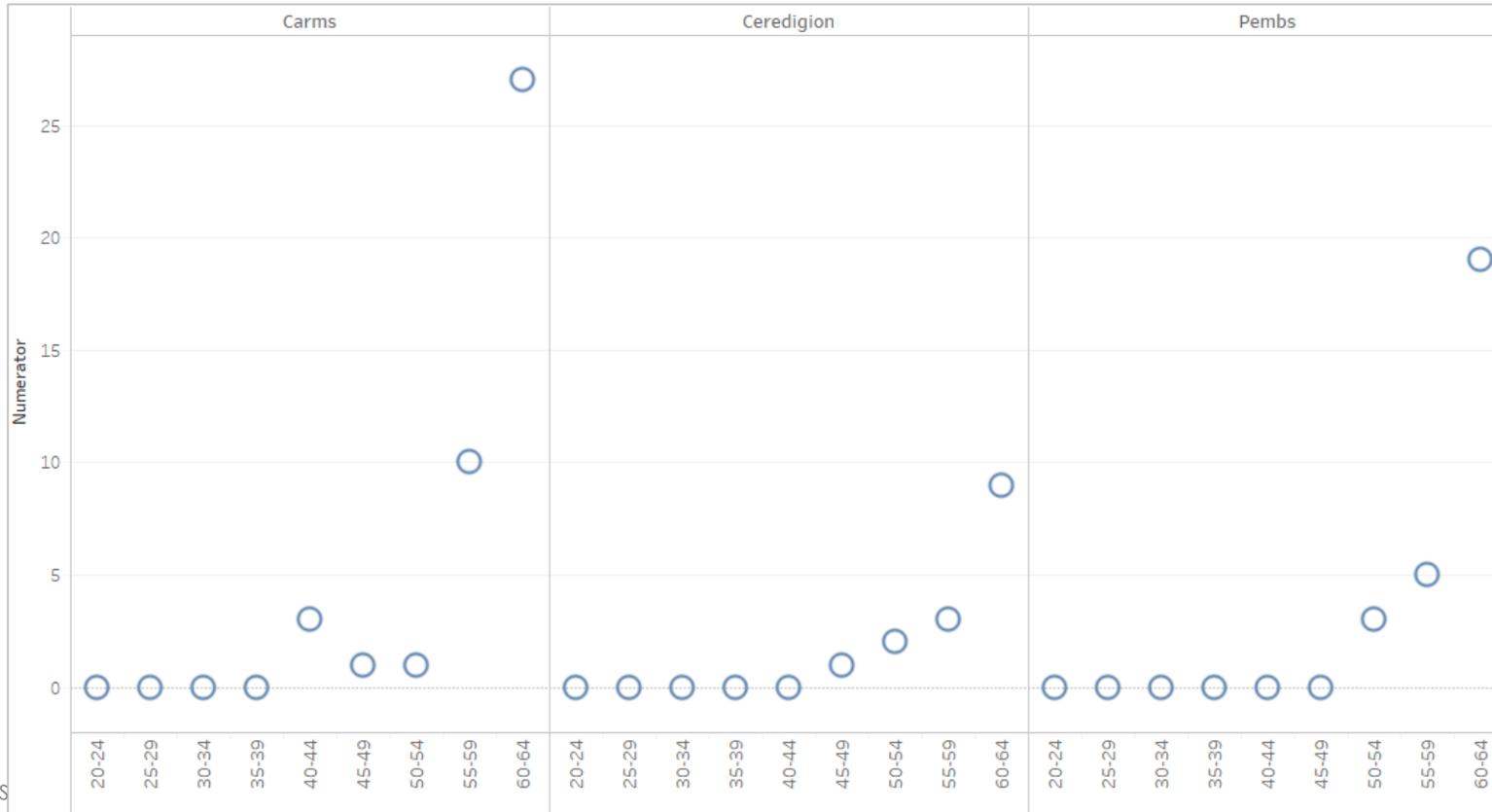


Young onset

Young onset dementia is the onset of dementia when a person is under 65 years old. Across West Wales there are 84 patients on the registers who are under 65 years old. Of those, 55 are in the 60-65 year age group. This gives West Wales a rate of 0.04% across the population in the adult population, which is very similar to the rate seen across Wales registers nationally.

There are 5 patients on the GP registers who are under 50 years old. There are under 30 in Wales as a whole (with a formal, GP registered diagnosis). Again, the prevalence rates across West Wales are higher than that of Wales (around 0.0025%)

Young Onset Dementia by age and cluster



10. Appendix 2: Feedback From Initial Structured Interviews

Stakeholder Engagement

The first phase of the development of this strategy took place January through to May 2021. Attain were initially commissioned by Carmarthenshire County Council on behalf of the WWCP to carry out a review of the ICF Dementia Investment Plan along side the development of a high – level dementia strategy vision and service model pathway across the West Wales region. The initial work was well supported by WWCP who worked with Attain to codesign a high-level draft dementia strategy. Stakeholders from across the region worked very hard to provide local knowledge and insight, through structured stakeholder discussions. The themes stemming from the initial interviews have been summarised where possible on the following pages. Theme form the second phase of work is summarised earlier on in the strategy.

Many thanks to those who engaged in this first phase of work:

| Name | Title | Additional Staff |
|-----------------|--|---|
| Rhian Dawson | Hywel Dda UHB & Carmarthenshire County Council - County Director Carmarthenshire | Emails sent 25/03 and 12/04 |
| Jina Hawkes | Hywel Dda Health Board - General Manager Community Primary Care - Ceredigion | |
| Sonia Hay | Hywel Dda UHB - General Manager Community & Primary Care -Pembrokeshire | Charlotte Duhig, Ceri Griffiths plus 2 others |
| Rebecca Jones | WWCP Programme Manager for Workforce development | |
| Sue Leonard | CEO PAVS | Cherry Evans Sophie Buckley |
| Elaine Lorton | Hywel Dda UHB County Director Pembrokeshire | |
| Peter Skitt | Hywel Dda UHB - County Director Ceredigion | |
| Alex Williams | Head of Integrated services Carms | Plus Carms colleagues |
| Neil Mason | Hywel Dda UHB - Service Manager Older Adults Mental Health | Plus Admiral Nurse |
| Graham O'Connor | (Hywel Dda UHB - Consultant Psychiatrist) | |
| Donna Pritchard | Head of Adults Ceredigion Council | Ellen James, Sian Howys, Nerys Lewis |
| Claire Sims | Hywel Dda UHB - Head of Occupational Therapy | Plus Karen Shearsmith-Farthing |
| Becca Stilwell | Clinical Psychologist | Email sent 15/04/21 |

The themes stemming from the interviews with stakeholders have influenced the development of the service model pathway and the recommendations within this report.

| Main themes | What works Well | What could be improved | What elements are missing | Joined up services |
|---|--|---|---|--|
| A clear regional strategy, vision and service model is needed and long term funding to deliver the services is needed | 3 rd sector dementia connector role has brought together other dementia focused roles now operating as an MDT | Consultants trained to be able to support people with dementia | Informal carers getting exhausted - could be prevented if they have the right support | Dementia is so wide - it is across the whole community and it really needs to be part of day to day planning and development |
| The overarching thing not addressed is base line wrap around the person, a co-ordinator throughout their journey | New Admiral Nurse service sitting with social care - providing support, bringing other professionals in team around the person | There is a need for all GPs to take the responsibility for onward prescribing of dementia | No centralised overview of GP dementia registers | Organisations now need to play their part to form a joined up integrated approach - not easy for West Wales |
| There is no coherent pathway and a lack of person centred care/understanding of dementia | Some good examples – Delta Connect, fulfilled lives - person centred domiciliary care, Ceredigion - come up with good solutions - real team feel | GPs/AHPs could be making straight forward diagnosis. MH team should be focusing on specialist diagnosis | Programme management of West Wales dementia services through the WWCP, service evaluation and performance reporting | Lots of handovers between services - difficulty with the long term care - where does dementia sit? No one service has the capacity to manage this large cohort |
| Attribution that dementia is a MH issue so if someone presents with challenging behaviour they call MH | Alzheimer's provide pre-diagnostic support following referral - people go directly to face to face support rather than a call centre. | National system feedback on hospital care can be adapted for PLWD and their carers to provide feedback on all our services | Requirement to have EoL conversations earlier. Some professionals reluctant to enter in ACP conversations | The service vision and model needs to ensure that services are easy to access and joined up |

The themes stemming from the interviews with stakeholders have influenced the development of the service model pathway and the recommendations within this report.

Communication

How people are diagnosed

How people access services

Workforce and Training

Use of technology

| | | | | |
|--|---|---|---|---|
| <p>Dementia wellbeing in the acute hospitals supporting reasonable adjustments for those admitted. Part of the ward MDT – about to be evaluated</p> | <p>Local Authority carers assessment is not dependant on a diagnosis but you still hear of it</p> | <p>Social care domiciliary care, respite care - harder to access and less secure postcode lottery going on to access</p> | <p>The regional dementia wellbeing team about to be launched will provide training to upskill staff and a specialist MDT approach for complex cases</p> | <p>In alignment with best practice, the use of technology should be central to the delivery of dementia services</p> |
| <p>Currently too many handoffs not joined up in anyway - need to have some co-ordination and case management.</p> | <p>Need for earlier identification and diagnosis in primary care. Need to fast track dementia diagnosis in line with CHC assessments</p> | <p>Where do people lives sit? Holistic picture - need to include the needs of the carers collated within the record of the person living with dementia.</p> | <p>People providing care need to be able to spot dementia and have skills to support - regular training refreshers are needed</p> | <p>Delta connect trying develop care so the person can stay at home</p> |
| <p>Develop structure for services to communicate better with each other/to share information - what is available in the community - feels very fragmented.</p> | <p>Consider what is the purpose of the diagnosis? Treatment? Medication? Delaying the inevitable? Respite, carers support?</p> | <p>There is an opportunity for a central point of access through the Delta Wellbeing service which is provided regionally</p> | <p>GPs require training to detect the early signs of dementia and physical issues in the advanced stages. Trainee MH nurses need training in dementia</p> | <p>The Wellbeing Team is working with Delta connect - trying to skill up the crisis team to stop people having to go into hospital</p> |
| <p>FIRST OF ITS KIND - OT's are working in Scotland and are providing journey through dementia - protocol led interventions which will be evaluated</p> | <p>Belief that it can only take place in MAS setting - some patients get diagnosed in hospital. Need an MDT approach to diagnose in community</p> | <p>Need to review dementia navigators, community commentators, social prescribing type roles to avoid duplication and align them across the system</p> | <p>A lack of knowledge, confidence and skill in staff/services recognising that people with dementia and their carers use multiple services</p> | <p>The Wellbeing team is working with @learning Wales to make the training more accessible. Mindful that eLearning training doesn't give people tools</p> |

11. Appendix 3: Approach to managing the programme of work

| Project Requirement | Progress | Key Accomplishment |
|---|----------|--|
| Review existing regional governance to ensure robust, multi-agency ownership of the ICF Plan, its delivery and evaluation | ✓ | This report provides a suggested programme outline |

What does good programme management look like?



The components of a good programme (1)

| | Vision, Leadership & Culture | Programme Governance | Stakeholder Management and Communication | Planning and resourcing |
|----------------------|---|--|---|---|
| What good looks like | <ul style="list-style-type: none"> • Clear shared vision owned by all partners • Joined up leadership fully engaged • Vision and strategy are aligned with partners' organisational strategies and relevant regional / national strategies | <ul style="list-style-type: none"> • Clear governance structure in place that includes input at the right level for decision making and managing risks/issues • Clear process in place for escalating risks, issues and opportunities • Lean structure; time is used effectively, with a balance between discussion and action • Programme team have a clear understanding of roles and responsibilities • Patient / public engagement embedded in programme governance • Clinical leadership embedded in programme governance | <ul style="list-style-type: none"> • Stakeholder mapping and communications plans in place • Key stakeholder relationships are managed proactively • External communications are targeted at relevant audiences and accessible language / communication formats are used • Internal communications to keep programme team informed, support team dynamics • Successes are celebrated internally and all areas of the programme contribute to case studies and good news stories for external use | <ul style="list-style-type: none"> • Robust overall business case for the programme in place and agreed by partners, with review points in place to establish ongoing viability • Each workstream has a clear plan, setting out what will be delivered, how and when • Interdependencies have been mapped • Resources required to deliver the programme have been mapped and investment agreed • OD requirements mapped and strategy in place for coordinated delivery |
| Tools and products | <ul style="list-style-type: none"> • Vision / mission / values statement • Memorandum of Understanding / partnership agreement • Outline Business Case | <ul style="list-style-type: none"> • Programme Governance Structure Chart(s) • Terms of Reference • Meetings forward plan • Programme team organisation chart • Roles / responsibilities matrix • Reporting and risk/issue escalation processes • Templates for meeting agendas, notes and actions, highlight reports | <ul style="list-style-type: none"> • Programme Communications & Engagement Strategy / Action Plan • Stakeholder mapping tool • Internal communications process • Equality Impact Assessment process and documentation • Core set of programme documentation / presentations / branded templates for use with a range of audiences • Engagement tracker | <ul style="list-style-type: none"> • High level programme plan with milestones and critical dependencies • Detailed programme plan • PMO work plan • Recruitment and resourcing tracker (programme team) • Business case process, template and guidance • Financial plan |

The components of a good programme (2)

| | Outcomes and Benefit Tracking | Risk and Management | Programme Support | Financial Management |
|----------------------|---|--|--|---|
| What good looks like | <ul style="list-style-type: none"> Financial and non-financial benefits of the programme have been clearly articulated (covering activity shift, clinical quality and patient experience) and tested out with key stakeholders Robust methodology in place to track benefits across all work streams Baseline data captured Outcome measures are targeted to enable monitoring of specific interventions – to see whether a change is effective Existing data sets and reporting are utilised wherever possible to minimise reporting burden (lean approach) | <ul style="list-style-type: none"> Key risks to delivery of the programme have been mapped and mitigating actions identified Clear processes are in place for identifying and tracking risks, with levels of escalation Robust, consistent documentation used across the programme to support proactive risk management and provide an audit trail Programme risk register is maintained and reviewed regularly with evidence of following up mitigating actions recorded and followed through | <ul style="list-style-type: none"> Information is well managed and easy to find, e.g. contact list, filing structure, protocols in place for maintaining an audit trail Change control in place for core documents/tools PMO team is able to support operational staff / work streams by reducing the documentation burden PMO advises and supports programme team / delivery leads; skills development, quality improvement Quality assurance is in place for key deliverables | <ul style="list-style-type: none"> Budget agreed for programme resourcing Robust mechanisms in place for management of programme budget – budget setting, change control, monitoring, accounts payable, procurement |
| Tools and products | <ul style="list-style-type: none"> Business Case/ Investment Appraisal Benefits/outcomes framework, capturing key performance indicators, outcome measures, metrics etc) Benefits realisation plan and tracking tool | <ul style="list-style-type: none"> Programme risk and issue register Risk management process and guidance | <ul style="list-style-type: none"> Programme contact list Information Management protocols and filing structure Shared programme calendar / inbox | <ul style="list-style-type: none"> Programme Financial management process / control Programme budget |

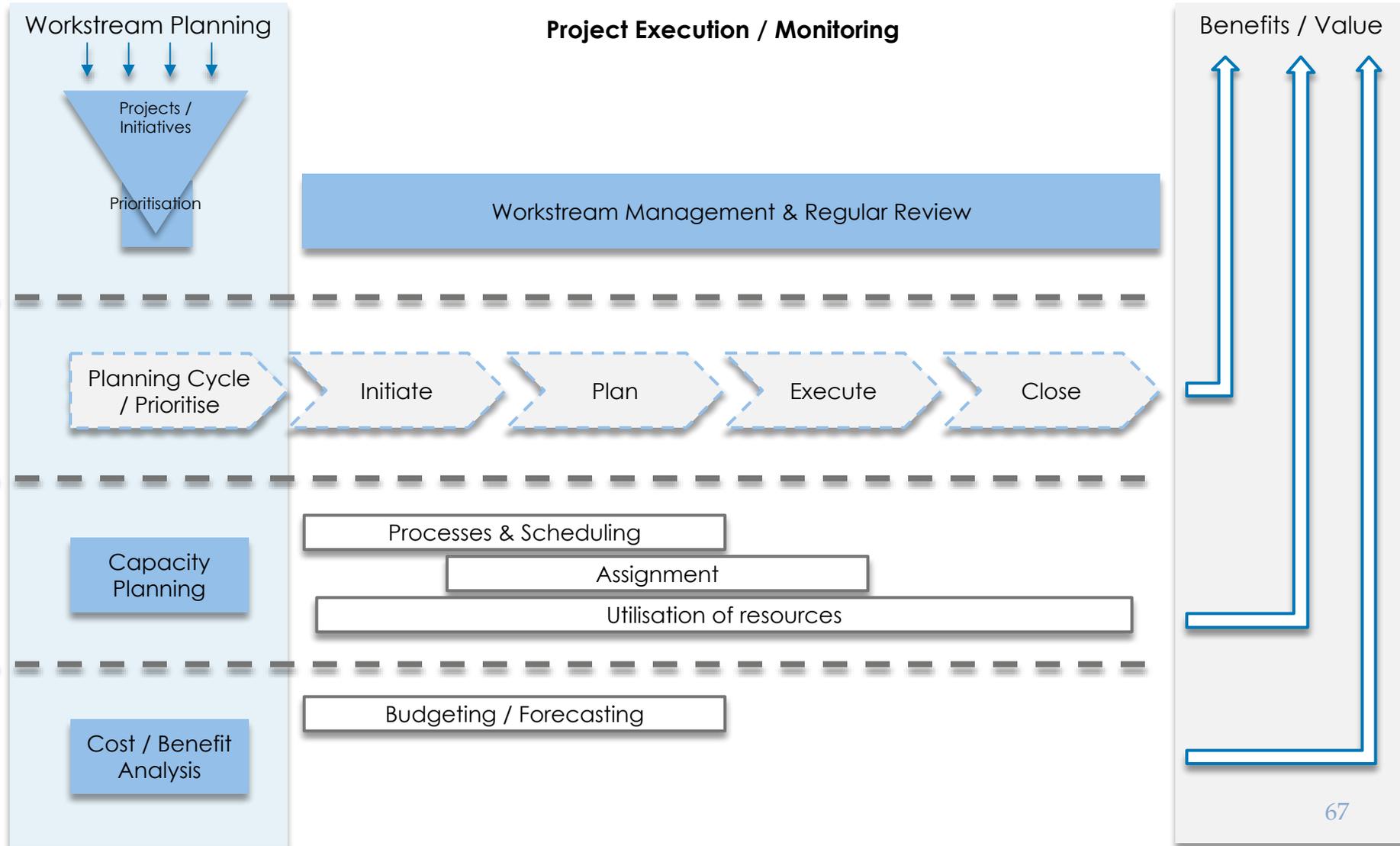
Proposed Delivery Approach: Programme Workstream Management

Workstream Management

Project Management

Resource Management

Financial Management



Contacts

| | | |
|------------------|--|--------------|
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