Story of Change for People and the System through the West Glamorgan Regional Partnership

Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

Reporting Period: Quarter 4 Cumulative 2022-23 Financial Year

Programme Overview

TITLE: West Glamorgan Dementia Programme

The West Glamorgan Dementia Programme forms part of the wider Emotional Wellbeing and Mental Health programme, which was re-launched in April 2022.

The purpose of the Dementia Programme is to oversee the implementation of Regional Dementia Strategy and the Regional implementation of the all-Wales Dementia Care Pathway of Standards and subsequent Action Plan to improve dementia support and services.

A predominant focus for this year has been preparedness, to ensure that as a region we are in a strong position to deliver the all-Wales Dementia Standards and Action Plan. We have established the governance around this which mirrors the national structure and ensured we have the right people across the region involved in the 5 workstreams sub-groups membership. An initial engagement event was held towards the end of the financial year, feedback from which has confirmed that whilst partners across the region have achieved a lot, there is still a lot to be done, especially in relation to early diagnosis and supporting people to live at home for as long as possible.

RBA Performance Accountability

SECTION GUIDANCE NOTE:
This section of the report focusses on the performance accountability of the RBA methodology (delivery of programmes). It should demonstrate the activities enabled by RIF funding/programmes, and demonstrate how person-centred outcomes are being achieved. You can copy and paste infographics, etc. from the excel tool to add to the reporting and include person/project case studies as supporting evidence/sharing of good practice.

Quantitative Measures

There are **16 projects** delivered by Third Sector organisations across the region, approximately **7750** people living with dementia and/or their carers have been supported. These have been grouped into **5 themes** which support the **Models of Care 'Placed Based Care – 'Prevention and Community Coordination' and 'Promoting Good Emotional Health and Wellbeing'** as outlined below:

Prevention and Community Co-ordination:

1) Information, Advice and Support
2) Providing support to living independently

Promoting Good Emotional Health and Wellbeing

3) Community Respite
4) Community Wellbeing
5) Post diagnosis support/treatment

The total investment of Dementia Projects is £1,169,624

Please refer to attached infographics which provides a summary of the performance measures for all the carers projects.

<u>Prevention and Community Co-ordination:</u>

Theme 1 – Information, Advice & Assistance
A key priority for the region is to support people living with dementia to live at home, independently, for as long as possible. In order to achieve this those living with dementia and their carers need to be fully aware of the options available to them and empowered to make decisions about their lives at

every stage of their dementia journey. **3 projects provide Information, Advice and Support** to people living with Dementia across the region. **3633** people supported in this financial year, projects in this theme have provided **54** awareness raising sessions and **482** Wellbeing Support sessions for adults with dementia or their carers. These projects allow carers to successfully navigate the pathway to diagnosis, how and when to access service which can provide support and assist in identifying how they can remain as independent in their community for as long as possible.

300 people have received support from **'Dementia Connect'** ~~aim to~~ supporting people waiting to be seen by the Memory Assessment Service through an established pathway dementia support, so that those worried about their memory, and those needing guidance through the diagnosis journey have access to information, advice and required support. The Dementia Connect project provides a simple, single point of access which works hand in hand with clinical care. It connects People Living with Dementia (including Carers) with vital practical support which empowers them to independently manage their condition and remain active within their community. Anyone affected by dementia can be referred pre or post diagnosis into the service by their GP, Social Services, Carer, Family member or they can self-refer.
98% of those who made a referral into the service were contacted within 3-5 working days, with **100%** of those referred to the service receiving support which met at least one identified outcome.

2860 people have visited the service provided by the **Dementia Hwb** either by attending the shop or by contacting the telephone Hwb**.** This project is based in Swansea City Centre and is open to the public 7 days a week, from 11:00 – 15:00. The Dementia Hwb provides vital support and information to enable people to find out what is available to them and their family, with information available for every stage of the dementia journey. The Hwb provides support to individuals via self-referrals or to family members seeking advice and support. The staff and volunteers at the Hwb are made up of former carers and professionals from local organisations who support those living with dementia and their carers. In addition to the Hwb's 'shop front', there are back rooms/ spaces which offer a safe haven in the City Centre for people living with dementia to come to whilst they are shopping, enabling carers a time limited 'drop-off' to have a short respite, provide a safe resting place for those alone and enable Hwb staff to register people for South Wales Police Keep Safe Cymru and complete the Herbert Protocol information. The back-office space also enables discreet conversations around personal finances, counselling sessions the possibility for memory assessments to take place. **37%** of people who made contact with the service were identified as people caring for a loved one living with dementia, and **17%** of people who made contact with the service were requesting information on behalf of someone else. **97%** of visitors to the Hwb reported that they were pleased with the service with **2%** reporting that they were 'somewhat pleased'. **100%** of visitors to the Hwb have stated that they would recommend the service to someone in a similar situation to themselves.

Theme 2 - Providing Support to Living Independently
1177 people have received services delivered by 4 projects which specialise in supporting people to live as independently as possible, As a region we recognise that nobody wants to live in residential care as a first option. People want to remain at home, in their own homes for as long as possible. People also want to retain as much independence as possible whilst living at home, but also if they enter a residential care setting.

332 people accessed the **Pre-Memory Assessment Support Project**. **64** x referrals received, **168** x support to carers via telephone, **70** x professionals advised/ supported, and **30** x 3rd sector workers supported/ advised. This project is to expand and align the team across the 3 Primary Care Clusters by establishing specialist Dementia Support Workers who provide a dedicated and specialist support to individuals whilst they wait for a diagnosis of dementia. They will provide support by developing an integrated support plan and coordinate practical and emotional support to enable people to maintain their independence, improve their sense of well-being and take control of their own lives. The role of the Dementia Support Workers is to also liaise with and escalate concerns with individuals awaiting diagnosis with GPs and Virtual Wards.
Of the **64** referrals received**:**

- **47** people were referred on for a diagnosis of dementia,
- **64** people were triaged by the team and offered support services,
- **46** specialist assessments were completed,

- **59** were signposted to other services (in some cases in addition to receiving support from this service).

Another project aimed at providing support to live independently is the **Dementia Pathfinder Service**. This project will help newly diagnosed people to:

- Develop a person-centred support plan that will provide a pathway to local services that the client and their unpaid carers need to live well and independently for as long as possible, whilst delaying the need for statutory intervention.
- Have advance planning in place and adhere to it when patients loose cognitive ability (Lasting Power of Attorney)
- Avoid unnecessary hospital/ nursing home admissions and/or being 'lost in the system' following dementia diagnosis.
- Delay the need to access statutory services by ensuring each patient has a Person-Centred Support Plan.

The new **Dementia Pathfinder Service** will aim to reduce the number of people receiving a late diagnosis of Dementia among older people in West Glamorgan by working collaboratively with local NHS services, GP surgeries, local voluntary services, and the older generation in communities, to raise awareness of dementia, memory clinics and to support timely diagnosis. The project aimed to support 200 people but has reported supporting **274** people with developing Person-Centred Support Plans, personalised to their needs and requirements. **100%** of contacts into the service were dealt with within the required timeframe with **100%** of contacts receiving a service.

<u>Promoting Good Emotional Health and Wellbeing</u>

Theme Three – Community Respite

In order to ensure that people living with dementia can remain living at home for as long as possible, we need to ensure that there are sufficient support services in place which can provide support to those who care for the person with dementia. Caring for a loved one, whilst rewarding can be extremely challenging. We have recognised the need to provide carers of those living with dementia with respite opportunities which enable them to take a break. The **'Marie Curie Dementia Care and Respite Service'** project is aimed at providing additional care and respite support for the growing number of people in West Glamorgan who are living with dementia to enable them to remain at home for as long as possible by providing support to their carers to help prevent escalation of need and crisis. The project works as part of the Swansea Bay Multi-Disciplinary Team to support the Virtual Wards, Community Resource Teams and existing dementia support services to prevent hospital and care home admissions and enable safe and timely discharge from hospital.

The service launched in October 2022, due to a period of recruitment was not in flight until December 2022. In the final quarter of the financial year the project has received:

- **60** referrals,
- **47** households have been supported (including 45 patients diagnosed with dementia),
- **1,824** rostered Healthcare Assistant staff hours have been used,
- **252** Registered Nurse hours have been used.
- **5** volunteers were recruited and trained,
- **15** referrals to receive support from volunteer Dementia Helper's,
- **20** visits undertaken by Dementia Helpers.
- **92%** of referrals received support from the service,
- **100%** of service users describe the service as 'very good'.
- The Dementia Helper element has recruited and retained **100%** of volunteers.

Theme Four – Community Wellbeing

This theme focusses of promoting the wellbeing of those living with dementia and those who care for them. The 6 projects have supported **3356 people**. Each of these projects offer support within the community, enabling those living with dementia and their carers to reduce isolation, improve the sense of community, enjoy taking part in appropriate activities and connect with other people living similar experiences. **3094 people** with dementia and their carers reported a positive experience after attending activities offered by these projects. **2797 adults** with dementia and their carers reported an improvement in their emotional wellbeing and mental health.

One of the **'Wellbeing'** projects is **'Osprey's in the Community Sporting Memories'**, is a project which has been running since 2019. The project utilises Wales's passion for sport and rich history, to help tackle some of the biggest issues in the local area namely dementia isolation and loneliness. The project has grown rapidly from six people in Dunvant RFC in 2019 to over **300 participants weekly** across **seven** local rugby clubs with an **estimated social return of circa. £3million**. Using the familiar community facilities to host the clubs, a friendly, sociable and relaxed environment is achieved where people can build friendship and share experiences. Attendees can reminisce to talk about sport, maybe a game they once played in, a great match they have witnessed, or even meeting a famous sports star from the past.
In the last 12 months the project has delivered:

- **481** group sessions
- **2414** unique engagements
- **398** hours of delivery
- **7,420** session attendees (these are not 7,420 individual people as most members attend on a weekly basis however there are a few who attend more than one session per week as they benefit so significantly from it)
- **25** registered volunteers
- **640** quizzes and games
- **471** lives changed
- **6,936** cups of tea
- **6** external agencies have been engaged in the project such as Mid & west Wales Fire and Rescue Fire Safety Team, Dementia Hwb, Age Cymru West Glamorgan. **35** individuals sought help from those external agencies with 100% receiving the help and support they needed.

Another project supporting the **'Wellbeing'** theme is **'Me, Myself & I Community Hub'**, this project provides a community hub that is attractive and welcoming to people of all ages. The aim of the Hub is to provide support to people on their journey, provide opportunity for people to maintain their independence, remain in the community for longer and help to prevent social isolation and loneliness. The Hub provides emotional support, reassurance and opportunities for people living with dementia and their families to socialise in a relaxed and friendly setting. The Hub also offers companionship along with a variety of activities such as Art, music, singing, sports/ exercise, tabletop games, quizzes and cooking. The project provides this support in two forms:

- Day Care Service which provides a full day at the Me, Myself and I venue which includes hot/cold meals, drinks and activities to take part in throughout the day, and
- Social Afternoons/ Friendship Groups which run every morning and afternoon Tuesday – Friday 10:30-12:30 or 14:00-16:00

The project has supported **1059** people via the Day Care Service and **1098** people utilising the Social Afternoons (this does not account for people returning and using the service more than once). **30** people per week (**1560 over the year**) have been engaged in physical or meaningful activity; there have been **51 new referrals** for 22-23; **155** people have accessed advice, guidance, information and support from various resources provided by the service; **172** people have been signposted to additional services. **1059** People with an approved assessment for complex day services joined the day care sessions within 4 weeks of their approval, which meets the project's target. **1059** people joining the complex day care services have an individualised care and support plan within 5 working days of their 1st session, which meets the project's target; **1098** of Social Afternoon guests have a care and support plan in place; all people accessing the services provided by the project are reassessed as continuing support annually; **293** people accessing the Hub have had a follow up correspondence **within 3 months** of engagement to ascertain if further support is requested.

Theme Four - Post Diagnosis Support and Treatment
There are **two projects** providing a range of support and/or treatment services to people who have been diagnosed with dementia, supporting 199 people who are living with dementia and / or their carers.

The first project is the **'Advanced Nurse Practitioner in Primary Care of OPMHS'**. This project is aimed at improving diagnostic capacity within the Memory Assessment Service by establishing an Advanced Nurse Practitioner/ Non-medical Prescriber leadership role. The Advanced Nurse Practitioner will both manage and clinically practice within the Memory Assessment Service in line with local, strategic and NICE guidance to differentiate and formulate diagnosis for people with suspected dementia, identifying suitable medical and psychosocial treatment pathways. The Advanced Nurse Practitioner are involved in clinical expose days across the health board. This project has only been in flight for the second half of the financial year and has supported **119** people.

The second project supporting the **'Post Diagnosis Support and Treatment'** theme is **'Speech & Language Therapy in the Memory Assessment Service'**. This project was established as there were no Speech and Language Therapists employed as part of the Memory Assessment Service for the general population across SBUHB. The purpose of this role is to provide specialist communication and dysphagia (swallowing difficulties) assessment, advice and support for people presenting with early cognitive and linguistic changes. This includes young onset dementia services as well as services for older adults.
The Project has received **80 referrals** of people living with dementia for support:

- **52** referrals for communication assessment and support
- **15** referrals for Dysphagia
- **12** referrals for Dysphagia and communication assessment and support

These referrals lead to:

- **29** people being diagnosed with communication impairment.
- **14** people being diagnosed with eating and drinking issues.
- **68** people being referred for further therapeutic input.

The project has delivered:

- **4** assessments were conducted in Welsh upon request.
- **101** Therapy sessions
- **12** Carer Consultation sessions
- **21** people were signposted to other services such as Audiology and Third Sector Services.
- **58%** of patients receiving assessment in less than a week from referral, with other referrals being seen under the Welsh Government target of 9 weeks
- **100%** of patients have been assessed at home.
- Training to **14** staff
- **41** sessions providing advice and support and awareness raising with professionals.

Most of the 16 projects are community lead and offer support and advice on topics and issues relevant to the individuals they are engaging with. Some of the examples include awareness raising organised by and with help of professionals. Others have the purpose of reducing dementia isolation and loneliness by promoting groups and Hubs where people can feel part of a community. There is a considerable amount of 'working together' across all of the projects, with a collective view to give those living with dementia the ability to remain at home, independently for as long as possible.

Although the above projects come under the primary Models of Care, 'Placed Based Care – Prevention and Community Coordination' and 'Promoting Good Emotional Health and Wellbeing' the projects will support other models of care as they can also keep families together for longer and enable those living with dementia to be discharged home from hospital rather than into care.

Qualitative Indicators

Prevention and Community Co-ordination:

Theme 1 - Information, Advice and Assistance:

The difference the **Dementia Connects Project** has made to people living with dementia has been noticeable as **270 people referred have reported that their needs were met or exceeded by the service.** The increase in referrals to the Dementia Connect project has reduced demand on the Memory Assessment Service, they made 138 referrals as this project would better suit the needs of the service user, by providing the right support at the right time. Whilst the Memory Assessment

Service have made the highest number of referrals into the project, 102 referrals came directly from those who wished to access the service for themselves, and 42 came from GPs across the region which indicates a rising awareness of the different support services available across the region and a shift from referring individuals in traditional ways.

Dementia Hwb: Since the start of the project the footfall at the Hwb has been consistent and the staff have been able to provide information, advice, and support to people in many ways. One example is the help that was provided to a visitor called 'Jane', and the subsequent help that was put in place:
Jane came into the Hwb in a distressed state with no recollection of how she had got to the city centre. Jane was unable to recall her name, address or where she was going. She was well dressed and had been shopping prior to her visit at the Hwb. Staff working at the Hwb were able to locate her bus pass with her name printed on it. The Hwb calmed Jane down and offered her some tea. The staff and the Hwb made contact with the emergency duty social services team, to see if we could find Jane on their system but there was no match found. The Police were then contacted to understand if anyone had reported her missing, or if she was known to them. A PCSO arrived at the Hwb and worked with staff to support Jane. Eventually the PCSO and staff were able to discover the name of Jane's husband and roughly where she lived. The PCSO made contact with Jane's husband, explained what happened and took Jane home equipped with information from the Hwb for her husband as this has never happened to Jane before. As a follow up, a member of the Hwb tracked done Jane's GP via the GP lead for Dementia, to make them aware of the issue, meaning they can respond appropriately at her next GP visit. Jane and her husband came in to thank the Hwb team who had helped her. They notified us that the Herbert Protocol form would be filled out, and that Jane was feeling better.

Theme 2 - Providing Support to Living Independently

The **Pre-Memory Assessment Support Project** has recorded successes. 100% of carers that have accessed the service report being happy with the support offered. Telephone enquiries are dealt with on the same day or within 24hrs. 50% of staff have received training (this is due to staff turnover and further training has been scheduled for new staff). A Feelings and Wellbeing questionnaire has been created to be implemented in 23-24 to capture feedback more accurately.

The **Dementia Pathfinder Service** has reported that, where possible those who had been supported had been surveyed for feedback and the responses were:

- **225** reported receiving the right information and advice when needed.
- **225** reported feeling more involved in decisions about care and support.
- **218** rated the service as good/ excellent.
- **225** reported the service helped them get the right dementia care/ support as early as possible.
- **234** reported that they were treated with respect.
- **144** said that the Dementia Support Plan mapping local support, care/ support and home safety/ adaption advice, information and contacts was extremely useful
- **134** reported feeling like they had someone on their side
- **134** reported feeling better able to continue caring for a loved one
- **95** reported being able to provide better care for their loved one.

The service has also reported securing **£19,219** in previously unclaimed benefits for service users with **63** reporting the project has improved their personal finances.

<u>Promoting Good Emotional Health and Wellbeing</u>

Theme Three – Community Respite

The **'Marie Curie Dementia Care and Respite Service'** has been providing a service for the last quarter of the 22-23 financial year. During this time **6** carers have reported that they feel more able to access respite, **100%** of carers have stated that they have benefited directly from the service and said that as a result their well-being and mental health had improved as they were enabled to take a break. **100%** of those who used the Dementia Helper Volunteer stated that they have benefitted from

the service noticing an improvement to their mental health. **100%** of volunteers say they feel confident in supporting people living with dementia and their carers.

Theme Four – Community Wellbeing

The **'Osprey's in the Community Sporting Memories'** project is considered one of the Region's great successes as it improves the lives so significantly for those who attend, with an estimated social return circa. £3million. Some testimonies from attendees:

- "*My mental health would not have survived caring for my father if we hadn't had the opportunity to attend these groups. Long may this continue*".
- "*This is a lifeline for us, it has changed everything*".
- *"These clubs are amazing, the only day of the week that my partner will get out of bed. I regard all the staff as friends. I work full time as well as care for my partner, I request a Wednesday as a non-working day so I can attend with him*".

In addition to the standard sessions the project runs additional activities for example:

- The project has a pool of 12 smart watches that are loaned to members on a weekly basis to encourage them to stay active and count their steps. 25 people have accessed the watches and have returned with positive feedback of how the watches challenged them to be aware of how much activity they were doing. This built up to an activity in October 2022 where 100 members took part in the initiative and in total walked 6,871,753 steps. As a project the members arrived virtually at the North Pole just in time for Christmas.
- In celebration of International Day of Happiness members were issued with planting pots and packets of Sweet Pea seeds to grow at home. The 140 members that have taken part have become quite competitive.

The **'Me, Myself & I Hub'** is a very popular service. Of **840** people who took part in a quarterly evaluation process reported improved wellbeing from their attendance at the hub. **689** of people who took part in a quarterly evaluation reported feeling less isolated and reduced feelings of loneliness from their attendance at the hub. **1361** people over year have reported feeling more connected to a community. **1680** people over the year have reported benefiting from engaging in mentally stimulating activities and/or improved mobility from physical activity.
Some feedback received from people who use these services are:

- *"When I come to club my daughter can go and have her hair done, I love it here and I'm happy, she's happy too. that's what matters to me!"*
- *"I look forward to Thursday's I get to see my friends and I love the homemade cakes we have."*
- *"This is a testimonial for Me, Myself & I, brilliant place to take my mother for support with her dementia, really helpful staff and gave me a bit of time to myself to do the shopping."*
- *"I love this club as all my friends are here. I feel part of something special and it has given me a confidence I haven't had for a very long time. I greet new guests into the club and tell them don't worry you will enjoy it here as we are all friends."*

Theme Four - Post Diagnosis Support and Treatment

Patient centred outcomes have improved since commencing the **'Advanced Nurse Practitioner in Primary Care of OPMHS'** project as of the **119** people supported**. 100%** stated that they preferred having one person to communicate with from the point of referral to diagnosis and any subsequent follow up appointments. Professionals have reported reduced waiting times, delivery of diagnosis has been easier with the support of the ANP, there has been a consistent and efficient approach and patients outcomes have been improved.

The **'Speech & Language Therapy in the Memory Assessment Service'** has reported a reduction in the impact of undiagnosed communication impairments e.g. behavioural changes, social skills, interpersonal relationships, self-confidence and self-esteem. More timely and responsive interventions have been reported by professionals as a more seamless assessment process has been developed.
Stakeholder feedback indicates:

- **75%** of patients rather the service as excellent
- **80%** of carers rated the service as excellent.
- **98%** of carers report a better understanding of the nature of the communication and/or swallowing difficulty of the person they are supporting.
- **86%** of carers report to feeling more confident in using augmentative communication systems with the person they are supporting
- **91%** of carers report a greater understanding of the importance of optimising the communication environment and the impact their own communication styes and approaches have on individuals with communication impairments.
- **95%** of the multidisciplinary team rated the service as excellent.

Some feedback received from Team Managers are:
"Your support has been so valuable to the MDT Team – improvement in communication and updating us of new changes and developments in your service. You have been present at assessments which has reduced waiting times in improved the accuracy of the patient's diagnosis. This can only mean a more efficient and effective way of working for us all".

"The new provision of Speech and Language Therapists within our service has been a very welcomed and beneficial addition to the team. Despite having many years' experience of working with older adults/ people with dementia, I did not realise the extent of how a speech and language therapist can work with a patient with dementia to provide better patient outcomes and to assist with the dementia screening process".

"I have personally found it very reassuring to know that if someone I have visited/assessed has communication issues, word finding difficulties etc. I can now refer on to SALT and the person will then receive a thorough assessment, support and advice. Previously before SALT was in-situ in the team, the person would have received no further support for any communication issues. Since SALT have been with us, I have also increased my own knowledge in issues surrounding communication – they are always happy and willing to share their knowledge and offer advice. Over the past few months, I have referred several people to SALT – recently I have referred 2 patients who have been referred by a neurologist".

RBA Population Accountability

SECTION GUIDANCE NOTE:
This section of the report focusses on the population accountability of the RBA methodology (delivery of system change and wider system performance enabled by the programme/regional Model of Care – demonstrating contribution and learning to inform national models).
For Q4 reporting system level indicators have not been agreed, therefore, please reference any data you consider appropriate to aid identification of population indicators/system measures as part of the intended reflection exercise, and for future testing at Q1.

Transformation: Changes to System

Emotional Health and Wellbeing
1. People are better supported to take control over their own lives and well-being
2. People have improved skills, knowledge and confidence to be independent in recognising their own well-being needs

Dementia sits within the wider Emotional Wellbeing and Mental Health programme in the West Glamorgan partnership. The Emotional Wellbeing and Mental Health programme is currently in the process of finalising its new Strategy. The Emotional Wellbeing and Mental Health Strategy, which has been coproduced with people affected by emotional wellbeing and mental health issues, is due to be published in June 2023. The next step will be to develop an Action Plan and start implementing it with our regional partners. Early indication is that this strategy will focus heavily on Prevention (how to prevent or delay the need for any services using community interventions), and early intervention (to ensure that needs are met quickly and efficiently at an early stage to prevent escalation of need/demand on services).

	In addition to this a new regional Dementia Strategy is being developed. This Strategy will tie in with the All-Wales Dementia Care Pathway of Standards but will also reflect any regional requirements which are not reflected in the national agenda. This Strategy will be implemented within the region linking partners working within Dementia Services and Older People's Mental Health across the Region. The Strategy will be developed collaboratively with partners and coproduced with those living with dementia and their carers. As a Region we recognise the importance of working together and overcoming the barriers already existing like lack of information sharing, lack of knowledge about services that are available, lack of joined up working between all partners and lack of awareness about impact a good, healthy lifestyle can have on our mental health, reducing the risk of dementia. Although Dementia supports two primary Models of Care, all six will be considered during the development of the Strategy. There is currently a mapping exercise underway across the region to allow better understanding of existing services, easier signposting and to identify any gaps in services provision to better inform future decision making. This mapping will also feed into the Strategy. Future planning in region needs to reflect the rising number of ethnic minorities, the cultural and language requirements of these communities will need to be planned for to ensure all residents can access the best possible care and treatment. Ensuring we provide the right services throughout the continuum of need is essential. Providing people with the right support at an early stage will promote independent living for as long as possible. Nobody wants to move into residential care and therefore the aim of the region needs to be strengthening services which promote independence and remaining at home for as long as possible. Once there is need for assisted living, services offered need to be innovative and focussed on the needs and requirements of those living with dementia. Traditional care homes are not always suitable. Increasing awareness of mental health issues and factors which could influence emotional wellbeing within workforce will improve the knowledge about how to better support staff emotional health and wellbeing. This should reduce referrals rate to the public sector as staff will receive support at the earliest opportunity. Furthermore, their knowledge will be shared with family members and friends, which should have a positive impact on the number of referrals made to the primary care sector as support will be found within community settings. Developing and enhancing mental health links into the cluster networks will increase community support and solutions for lower tier mental health services. The same will increase peer support, social prescribing, community groups to improve emotional wellbeing and mental health. In end effect more people will be supported within communities, having access to the right supported at the right time.

RIF Financial Accountability	**Financial and Economic Data**
	Ensuring we provide the right services throughout the continuum of need is essential. Providing people with the right support at an early stage will promote independent living for as long as possible. Nobody wants to move into residential care and therefore the aim of the region needs to be strengthening services which promote independence and remaining at home for as long as possible. Once there is need for assisted living, services offered need to be innovative and focussed on the needs and requirements of those living with dementia. Traditional care homes are not always suitable and more often people want to stay in their homes. The average cost of a care home is as follows: Average cost of dementia residential home – weekly cost - £800 Average cost of dementia nursing home – weekly cost - £1,083 Average cost of dementia residential home – weekly cost - £41,600 Average cost of dementia nursing home – weekly cost - £56,316 By providing services that promote independence not only supports the person to remain in their own homes for longer, but it also has significant cost avoidance savings.