ST HELENS
BOROUGH COUNCIL

DEMENTIA STRATEGY

SEPTEMBER 2023

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FOREWORD

I am proud to present our Dementia Strategy for St Helens for 2023 - 2026. Within this document, we aim to enhance our approach to the prevention, onset, and management of dementia as well as the support available to the many caregivers across our Borough.

Communities within the Borough of St Helens have played a significant role in shaping our approach to dementia and we are committed to having an ongoing programme of engagement to enhance this relationship further. Indeed, to build and shape our action plans, we will pay close attention to the opinions of the local population, especially those who are impacted by and living with dementia. This will also play close attention to the role of caregivers' physical and emotional needs, including addiction and mental health issues.

We want St Helens to be a community where everyone, including those with dementia and those who care for them, may have a healthy and full life. We want the people who live in our Borough to know that their community is a place where those who are caring for individuals who have dementia are heard and given the support they require. Additionally, we hope that everyone will have access to the care and assistance they need to live comfortably at home for as long as possible and pass away with the respect they deserve.

The evolution of this document has been influenced by several national policy declarations, pieces of legislation, and stakeholder engagement studies, some of which are included below:

- The Prime Minister's Challenge on Dementia in 2020
- Live Well with Dementia a National Dementia Strategy February 2009
- NHS Long Term Plan
- The Care Act 2014
- Dementia 'A state of the nation report on dementia care and support in England
- Alzheimer's Society reports: 'Worst hit – Dementia during coronavirus.
- Dementia diagnosis to end of life.
- Ethnic minorities increasing access to Dementia Strategy 2022-2027 6 diagnosis,
- Hospital and care homes- increasing access to diagnostics; Report on regional variations and access to diagnostics

The creation of Dementia Friendly Communities is our long-term goal. To achieve this, it is necessary for attitudes and behaviours about dementia to shift at all levels of society to reflect the difficulties associated with an ageing population, longer lifespans, and the effects of dementia. We also acknowledge the relevance of leading a healthy lifestyle in preventing dementia and that the setting in which someone lives, works, and socialises has an impact on how well they manage their dementia.

M. M. Quinn.

Councillor Marlene Quinn
Cabinet Member -
Integrated Health & Care

1. INTRODUCTION AND CONTEXT

1.1. DEMENTIA AND OUR COMMUNITIES

This document outlines the overall framework for lowering the risk of dementia and promoting healthy ageing in St Helens.

Dementia is a general word used to describe the signs and symptoms of disorders that affect the brain. These could be brought on by a variety of conditions that lead to progressive deterioration, including memory loss, loss of cognitive ability, loss of communication, and loss of everyday functioning.

Dementia is not merely an old-age condition. More than 5% of those with dementia are under the age of 65, and they are frequently referred to as 'younger people with dementia' or 'early-onset dementia'. We also acknowledge that patients with dementia frequently also have other medical issues.

1.2. DEMENTIA IN ST HELENS

Approximately 2,554 people in St Helens have dementia (as at 2020), with 60% of them being women. By 2035, this total figure is expected to rise to almost 4,000, representing a 67% increase in 15 years.

Clearly, therefore, how we meet current needs whilst ensuring a longer-term approach will be crucial. The following table shows the number of people predicted to have dementia in St Helens 2017 to 2035:

Age	2017		2020		2025		2030		2035	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65-69	78	56	74	52	78	54	89	62	86	62
70-74	146	125	155	134	140	120	149	125	174	144
75-79	163	247	184	260	224	332	204	293	219	312
80-84	224	372	255	399	296	439	367	572	347	505
85-89	184	355	217	377	267	466	334	533	434	688
90+	112	307	140	307	195	368	279	491	363	614
Total by gender	907	1,462	1,024	1,530	1,200	1,779	1,422	2,075	1,622	2,326
Total	**2,369**		**2,554**		**2,979**		**3,497**		**3,948**	

Source: POPPI

1.4. OUR COMMITMENT

Our goal is to see dementia services significantly improved. We want to work, in partnership, to create a system where all people with dementia have access to the care and assistance they need. This would be a system in which both the public and experts are well-informed, in which the stigma and fear related to dementia have been reduced, and in which the myths that dementia is an inevitable part of ageing and that nothing can be done have been disproved. We also want to ensure that dementia-affected families are aware of where to turn for assistance, what services to anticipate, and where high-quality care is available no matter where they may reside.

Our commitment, therefore, is in line with the above and intends to ensure:

- **Emphasis on prevention -** To ensure that individuals are informed as soon as possible about measures to avoid dementia, more focus must be placed on prevention and details will be provided through more rigorous engagement and planning with our communities
- **Support is easy to access -** The degree and nature of support available to carers will be increased
- **Creating a pathway of treatment and care starting at diagnosis -** Too many of our residents feel that services lack a coordinated approach, which frequently makes them feel ignored or unsupported. We will ensure that people do not fall between the gaps between different services by ensuring a clear and coordinated care pathway at the time of diagnosis.

1.5. WORKING TOGETHER

How we deliver the above commitments, will be contained within the action plan associated with this document. However, this is not a singular Strategy and is created, influenced, and delivered through our numerous partnerships, service providers and communities which includes:

- Leaders of Integrated Care Boards, local authorities, and health partners
- Service providers for social services, health care, social and physical environment
- Health, social, and community service commissioners
- The community and voluntary sector

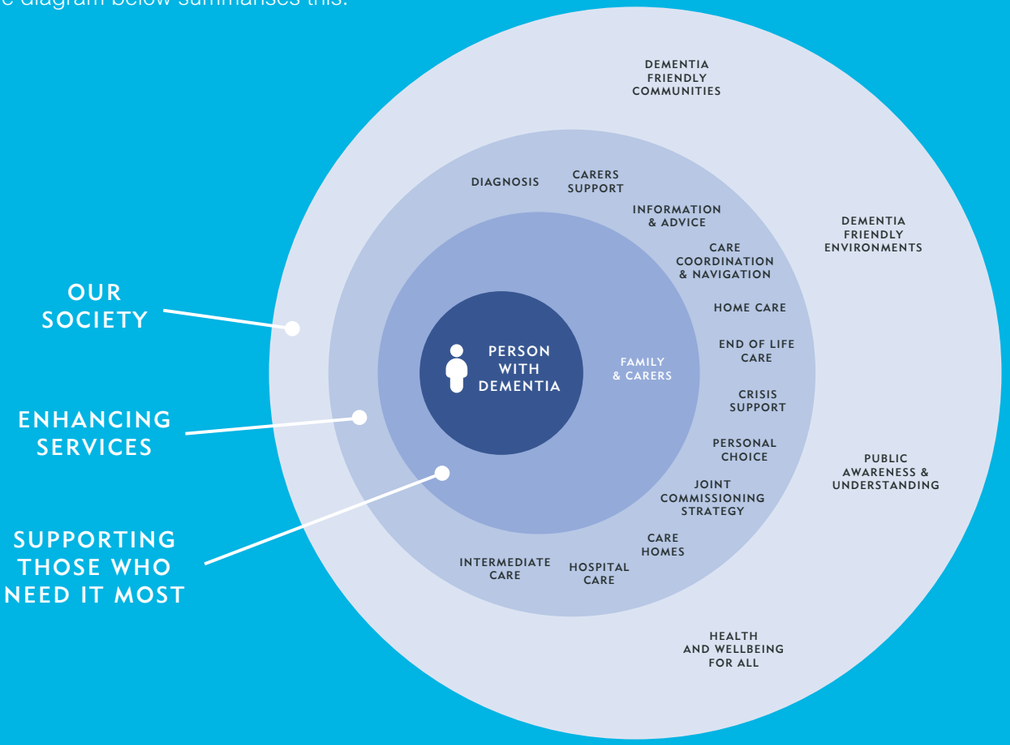
The delivery of coordinated and seamless services to help people, including those with learning disabilities and autistic people, live healthy, independent, and dignified lives increases with the integration of health and social care, which also improves results for the population as a whole.

2. VISION AND OBJECTIVES

2.1. WHAT WE ARE TRYING TO ACHIEVE

We want to ensure that people with dementia and their family and carers have the help and support they require as the disease progresses, allowing them to live the best lives they can and live well with dementia. At the same time, we will develop a longer-term approach, focusing on health, wellbeing and societal changes.

As such, our overall approach is multi-faceted and will be delivered across different levels. The diagram below summarises this:



2.2. OUR OBJECTIVES

WE HAVE IDENTIFIED A NUMBER OF OBJECTIVES TO DELIVER WHAT WE ARE TRYING TO ACHIEVE. THESE ARE NOTED IN THE PREVIOUS DIAGRAM BUT CONSIDERED IN MORE DETAIL IN THE FOLLOWING SECTION. THESE HAVE BEEN DEVELOPED THROUGH OUR ONGOING WORK WITH OUR PARTNERS AND COMMUNITIES.

OBJECTIVE 1: IMPROVING PUBLIC AND PROFESSIONAL AWARENESS AND UNDERSTANDING OF DEMENTIA

To improve dementia care and reduce the stigma surrounding it, St Helens residents and professionals must be more knowledgeable about dementia. We will work to spread awareness in our communities about the advantages of prompt diagnosis and treatment, encourage dementia prevention, and lessen social exclusion and discrimination.

OBJECTIVE 2: GOOD-QUALITY EARLY DIAGNOSIS AND INTERVENTION FOR ALL

Every person with dementia should have access to a care pathway that includes: a quick and competent professional evaluation; an accurate diagnosis that is sensitively conveyed to the person with dementia and their carers; and treatment, care, and support offered as needed after the diagnosis. The system must be able to detect any new dementia cases that arise locally.

OBJECTIVE 3: GOOD-QUALITY INFORMATION FOR THOSE WITH DIAGNOSED DEMENTIA AND THEIR CARERS

At the time of diagnosis and throughout their care, dementia patients and their caregivers should have access to reliable information about the disease and the services that are offered.

OBECTIVE 4: ENABLING EASY ACCESS TO CARE, SUPPORT AND ADVICE FOLLOWING DIAGNOSIS

To develop several dementia adviser roles to make it simple for people with dementia and their carers to receive the right care, support, and advice.

OBJECTIVE 5: DEVELOPMENT OF STRUCTURED PEER SUPPORT AND LEARNING NETWORKS

By creating and maintaining these networks, people with dementia and their carers will have access to immediate local peer support. Additionally, it will make it possible for people with dementia and those who care for them to actively participate in the planning and prioritisation of local services.

OBJECTIVE 6: IMPROVED COMMUNITY PERSONAL SUPPORT SERVICES

Provide a suitable range of services to help carers and people with dementia who live at home. Access to dependable, adaptable services that are responsive to each person's unique needs and preferences and consider their larger family situation, from early intervention through specialised home care services which are accessible to people who pay for their care individually, through personal budgets, or through local authorities that have arranged services.

OBECTIVE 7: IMPLEMENTING THE CARERS' STRATEGY

The most crucial resource accessible for those with dementia is their family carers. To guarantee that the Carers' Strategy's provisions are accessible to carers of people with dementia, active engagement is required. To assist the crucial role that carers play in the care of the person living with dementia, carers have a right to an assessment of their requirements and can get support through a mutually agreed-upon plan. This will feature individualised breaks. Additionally, steps should be taken to protect the unique needs of children who are in caring roles by strengthening support for them.

OBJECTIVE 8: IMPROVED QUALITY OF CARE FOR PEOPLE WITH DEMENTIA IN GENERAL HOSPITALS

Identifying leadership for dementia care in general hospitals, outlining the dementia care pathway there, and establishing specialised liaison teams for older people's mental health to work in general hospitals.

OBECTIVE 9: IMPLEMENTING THE CARERS' STRATEGY

Improved intermediate care for people with dementia.

OBECTIVE 10: CONSIDERING THE POTENTIAL FOR HOUSING SUPPORT, HOUSING-RELATED SERVICES, AND TELECARE TO SUPPORT PEOPLE WITH DEMENTIA AND THEIR CARERS

The creation of housing alternatives, assistive technologies, and telecare should take the needs of people with dementia and their carers into consideration. As more information becomes available, commissioners should think about offering ways to prolong independent living and postpone the need for more intensive services.

OBJECTIVE 11: LIVING WELL WITH DEMENTIA IN CARE HOMES

The establishment of explicit dementia leadership within care homes, the defining of the care pathway there, the commissioning of specialised in-reach services from community mental health teams, and through inspection processes will all improve the quality of care provided to people with dementia in nursing homes.

OBJECTIVE 12: IMPROVED END OF LIFE CARE FOR PEOPLE WITH DEMENTIA

Dementia sufferers and their carers should be involved in the planning of end-of-life care that considers the guidelines set in the Department of Health End-of-Life Care Strategy. Local work to take dementia into account in the End-of-Life Care Strategy.

OBJECTIVE 13: AN INFORMED AND EFFECTIVE WORKFORCE FOR PEOPLE WITH DEMENTIA

To deliver the highest level of care in the positions and environments in which they work, health and social care professionals who are involved in the care of people who may have dementia must possess the essential skills. To be accomplished by efficient basic education and ongoing professional and occupational training in dementia.

OBECTIVE 14: A JOINT COMMISSIONING STRATEGY FOR DEMENTIA

Identifying the services required for those with dementia and their caregivers and determining a way to address those requirements will need the establishment of local commissioning and planning procedures. The World Class Commissioning for Dementia guidance created to support this Strategy should be a guide for these commissioning strategies.

OBJECTIVE 15: IMPROVED ASSESSMENT AND REGULATION OF HEALTH AND CARE SERVICES AND OF HOW SYSTEMS ARE WORKING FOR PEOPLE WITH DEMENTIA AND THEIR CARERS

Enhance inspection procedures for nursing homes and other services that improve the standard of dementia care.

OBJECTIVE 16: A CLEAR PICTURE OF RESEARCH EVIDENCE AND NEEDS

Evidence must be made available on the UK's current dementia research base and any gaps that need to be rectified.

OBJECTIVE 17: EFFECTIVE NATIONAL AND REGIONAL SUPPORT FOR IMPLEMENTATION OF THE STRATEGY

The Strategy should have the proper national and regional support to guide and aid local implementation. The development of dementia services should be covered in high-quality information, including data from assessments and demonstrator locations.

2.3. WHAT SUCCESS LOOKS LIKE

To deliver the above objectives, a significant and varied amount of work is required. This means that if we are to understand whether we are achieving what we set out to do, we will need a targeted set of measures that provide a clear indication of success. These are set out as follows:

- Targeted campaigns to raise awareness for people with dementia.
- Commissioning of good quality provision for early diagnosis and intervention in dementia
- Development of dementia advisers in order that people have a single point of contact
- Development of local peer support and learning networks for people with dementia and their carers
- Implement the Putting People First personalisation changes
- Ensure that breaks are commissioned that benefit people with dementia and their carers
- Identification of a senior clinician within acute care to ensure high quality and seamless pathways of care
- Development of different models of housing including extra care

3. DELIVERING THIS STRATEGY

Through our commitments, objectives, and measures of success, we have set out what we want to achieve and an indication of how we will know if we are on the right path. Delivering this, though, takes a holistic approach and one that encompasses a range of provision, partners, and people. The following section provides an overview of the key elements of this

3.1. MEETING RISING DEMAND

Although this Strategy, and associated action, will assist in slowing down rising demand, it will not be enough to stop the trend completely. As noted in Section 1.2, current predictions suggest a 67% increase in the number of people with dementia over the next fifteen years. In addition, the Real Living Wage (NLW), has put pressure on social care providers and commissioners to maintain high-quality, cost-effective services which has also resulted in cost increases in recent years. In combination, this creates huge financial challenges that must be met, illustrated by the table included in Appendix 1.

Having acknowledged these fiscal pressures, the Government has set aside more monies for the upcoming three years in a variety of distinct financing streams. These will be accessed through a partnership approach. The transition to an Integrated Care System across Cheshire and Merseyside provides us with a stronger platform to do just this and ensures that the objectives contained within this Strategy are shared by all who can impact them.

3.2. MARKET SUPPORT, STIMULATION & MANAGEMENT

As is the case across several Boroughs, there are challenges in ensuring market diversity, workforce stability and growth, and sustainable service delivery, especially in light of the present economic environment. Our market has some more susceptible areas than others due to service gaps and high costs.

To sustain high-quality services in the right volumes to meet demand, all at an acceptable cost of care, ongoing efforts will be enhanced in order to maintain a balance of market support, stimulation, and management.

3.3. CO-PRODUCTION AND CO-DESIGN

The goal of community-based services is to help or empower people to live independently at home as opposed to being admitted to a long-term residential or nursing home. The needs of individuals and their families call for adaptable community services that can meet those specific and varied needs. They must also consider how they will entice and meet the unique needs of their workforce.

Therefore, in many cases, we work to delay or prevent the need for ongoing Adult Social Care services to help people with dementia maintain their level of independence. We want to actively engage with and listen to communities as equal partners to make a difference. By actively participating in developing strategies for how we may build stronger communities now and, in the future, as well as by leveraging local working and existing networks and good practice, we can help people understand their role in maintaining fitness and health and reducing reliance on services.

3.4. ENHANCED INFORMATION AND ADVICE

Linked to the above, the 'St Helens Information and Advice Service' will be re-launched, and we'll make sure that it improves people's lives by educating, counselling, and promoting self-help and self-management so that they can keep their healthy independence.

As part of this, more people will be made aware of the price of that support and encouraged to buy their own through a Direct Payment. Adults will be able to fully self-regulate from social care-managed support care packages, which will lessen the need for more costly interventions. To ensure that everyone who can receive funding in paying for their own support is helped, we will also review our Direct Payment Assistance Programme.

3.5. LEARNING FROM BEST PRACTICE

Building on what has been successful over the past ten years, dementia services in St Helens will learn from residents and other Boroughs about what else could be done more effectively.

4. MONITORING, REVIEW AND CONTINUOUS IMPROVEMENT

Monitoring and evaluating the impacts of this Strategy, and the objectives contained within, is vital in ensuring that our efforts continue to be focused on the cared-for and carer experiences. This, in turn, needs to feed into every commissioning decision that we take.

As such, we are developing an action plan for the whole of Adult Social Care to ensure that we understand progress, tackle any issues that arise and focus on continually improving the services we commission and provide. There are two levels of effectiveness for monitoring this:

LEVEL ONE - GUIDING PRINCIPLES

These principles work to prioritise the needs of the people we support and ensure that the assistance they get will both achieve the desired outcomes and manage any risks:

- **The right people:** those who require assistance are identified and given top priority
- **The right time:** to prevent things from getting worse, to increase resilience, and to encourage independence
- **The best location:** Depending on the need and the most cost efficient solution, at home, in the community, or in a specialised environment
- **The correct support:** Just enough to keep everyone safe while also preventing, minimising, or delaying the need for long-term support, supplied by the appropriate individuals with the appropriate skills
- **Improved coordination and cost-effective support:** Provided through working more effectively with individuals, their friends and families, as well as in partnership with other organisations.

LEVEL TWO - PERFORMANCE REPORTING

To determine whether services for those with learning disabilities are achieving the necessary strategic results, the overall organisation and coherence of those services will be tracked and evaluated. Performance indicators (PIs), regular critical appraisals, satisfaction surveys, and the departmental index of complaints will all serve as guidelines for the reporting structure.

To support the above, we will routinely gather and compile data from a range of sources which will include:

- Employing regional and national performance metrics to compare our performance to that of other local authorities and assess the development of certain goals
- Continually evaluating our actions considering past, present, and projected requirements in strategic and performance management frameworks to ensure that we have enough capacity to meet any changes in service user demand
- To accelerate the implementation of innovative thinking that support the essential elements of the vision, we modified our strategy to take advantage of the most recent best practice.

APPENDIX 1 - RISING COSTS OF CARE

Average Package Costs Per Annum (2015-2021)							
Primary Support Reason	Average Annual Care Package						% Change
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	
	£	£	£	£	£	£	
Physical & Frail 65+	12,018	13,176	13,587	13,808	14,454	14,760	23%
Physical/sensory - All ages	15,921	17,413	19,141	18,942	19,909	22,530	42%
Memory & Cognition - All ages	22,903	24,885	27,083	28,850	34,971	33,084	44%
LD - All Ages	25,197	25,843	27,661	32,270	31,801	34,011	35%
MH - All Ages	19,913	20,473	24,936	28,380	26,678	25,543	28%
Residential	31,760	34,587	36,974	38,430	37,871	39,333	24%
Nursing	30,144	34,424	37,090	39,076	43,359	42,420	41%
Supported Living - All Cohorts	46,771	47,353	54,526	60,549	63,781	64,482	38%
Domiciliary Care	7,099	7,403	7,570	8,196	8,379	8,068	18%
Direct Payments	12,196	13,058	13,800	15,456	17,458	20,281	56%

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