Joint Mental Health Strategy –Implementation Plan for Adults and Older People 2014-2016
(NHS Richmond CCG & London Borough of Richmond)

1. Purpose

This Mental Health Implementation Plan sets out the priorities for mental health services over the next 2-3 years to secure improved outcomes in the mental health of the population of Richmond borough.

The Implementation Plan is the basis for a refresh of the Mental Health Strategies for adults and for older people 2010-2015. The strategies are concerned with establishing more preventative and recovery based models of care and underpinned by evidence based pathways. Stronger integration is central- between primary and secondary care, and between health and social care and wider recovery and community support services.

The plan will ensure that the important improvements in mental health services achieved over the last few years are sustained. These improvements include increased access to psychological therapies through the Richmond Wellbeing Service, better rehabilitation in the community through the establishment of an integrated rehabilitation team, and developments in dementia care including support to carers.

The plan will also ensure outstanding challenges are addressed, taking account of changes both local and national developments, particularly the tight economic constraints.

The Implementation Plan enables all key stakeholders (health and local authority commissioners, providers, service users and carers and voluntary and community organisations) to monitor progress and to be held to account for delivery of defined commitments within governance frameworks.

2. Context

The Mental Health Implementation Plan takes account of important changes in policy, evidence and commissioning arrangements both nationally and locally.

Important national drivers include:

- The national mental health strategy- No Health without Mental Health (2011)
- The national Outcomes Frameworks for the NHS, Public Health and Social Care
- The Prime Minister's Challenge on Dementia (2012)
- The NHS Commissioning Board Mandate to achieve parity of esteem between mental and physical health (2013)

The Implementation Plan is aligned to a number of related joint strategies that are helping to deliver improved outcomes for people with mental health care needs and their carers and families. These local strategies include:

- SW London Out of Hospital Care Strategy and draft Richmond Out of Hospital Strategy
- Health and Wellbeing Strategy
- Substance Misuse Strategy
- Richmond Carers Strategy

Richmond CCG and Richmond borough Council are subject to financial challenges. The Implementation Plan brings together commissioning commitments on mental health within the resource framework.

Kingston CCG, on behalf of the 7 CCGs in SW London, takes the lead for mental health contracting. This ensures in Richmond and across SW London we can work effectively with our providers and also have robust performance monitoring in place.

3. The mental health profile of the residents of Richmond borough

There are a number of major concerns relating to the pattern of mental health among the Richmond population.

- More people with depression and anxiety, particularly older people and people with long term chronic conditions, could benefit from access to psychologies therapies in primary care.

- Many people have multiple long term physical and mental health problems that impact on their quality of life and health. People with serious and complex mental health problems die on average 15 years earlier than people without mental illness. Smoking, diabetes, high blood pressures and obesity are the main factors that cause these early deaths.

- Significant numbers of people with mental health problems also have substance misuse problems (alcohol and drugs) and a large number of acute hospital admissions are alcohol related.

- The rate of hospital admissions for acute conditions (schizophrenia and other psychotic disorders) is higher for Richmond than the average for England (2009/10 to 2011/12) and similar to most other boroughs in London. Early intervention, crisis and home treatment services are critical to avoiding inappropriate hospital admissions, along with other community services that enable
- The number of people with dementia living in the borough will increase, driven by the aging profile of the Richmond population. In Richmond, as nationally only about 50% of people with dementia currently receive a formally diagnosis. We know that timely diagnosis of dementia can have benefits for individuals and carers.

- People with dementia are high users of acute hospitals due to physical illness. A considerable number of unplanned acute admissions could be avoided through alternative provision in community settings.

- There are significant numbers of carers (around 16000 people (census 2011)) who are vulnerable to physical and mental health problems.

4. Objectives and priorities

Five overarching priority objectives will be the focus of delivery programmes for both adults and older people. These are:

Strengthening the role of service users and carers

To ensure services users and carers are fully involved in decision making within commissioning and delivery of care

Prevention and early intervention

- To ensure that there is targeted prevention for people at risk of mental ill health and early intervention for people with symptoms of mental illness

Acute care and crisis intervention

- To ensure that people experiencing a crisis and acute distress have quick access to high quality and safe care in the most appropriate setting

Recovery and independent living

- To deliver a multi-professional and multi-agency approach that enables people with mental health care needs to live independently

Mainstreaming mental health services

- To ensure that integrated approaches are in place that address the physical health needs of people with mental health conditions, and also the mental health needs of people with long term physical conditions.

5. Expected outcomes

The Plan will help achieve over the long term the following outcomes:

- More people have access to and benefit from psychological therapies
- Fewer people with serious mental illness die prematurely
- More people receive a formal diagnosis of dementia as a proportion of people estimated to have dementia
- People can access mental health services quickly and easily when needed
- Post diagnosis care for people with dementia is effective in sustaining independence and improving quality of life
- More people with mental illness are in sustained employment
- More people with mental illness say that services have made them feel safe and secure.

2014-16 ADULT and OLDER PERSONS MENTAL HEALTH COMMISSIONING ACTION PLAN

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
1		**PRIORITY : STRENGTHENING USER AND CARER INVOLVEMENT**				**Nov-14**	**Jun-15**
OP	**1.1**	**CREATE MORE OPPORTUNITIES FOR USER INVOLVEMENT**	Recommission service user platforms to enable mental health service users and carers to be active partners in the planning and delivery of services.	(a)Specification for new mental health service user group developed by June 2014.	JCC, MH Commissioner CCG, Engagement Manager	Discussions /meetings have taken place with the Alzheimers Society London and Innovations in Dementia to find an effective way to ensure people with dementia can be active partners in palnning and delivery of services . Work will continue to establish service enagement in the next 6 months. - MHC, JCC	A new leaflet about assitive devices and technolgy has been produced by the JCC with the LA and the assistance of a person with dementia and their carer supported by innovations in dementia. The online version can be found here. http://www.richmond.gov.uk/home/services/health_conditions/dementia/dementia_gadgets.htm . Additionally people with dementia have been consulted on outcomes that are important to them to inform the Out Comes based commissioning model that RCCG are leading on. Cobic led on this work and interviewed people at Woodville and in a local care home. (AJ-8/5/15)
					CCG, Engagement Manager	Initial meeting with Bruno Meekings (Community Involvement Coordinator) to identify gaps in current Service User/Carer engagement activity. Further mapping and reviewing of good practice to inform a network approach to be discussed with local groups in January 2015. (JCC-MHC, 9/12/14)	
				(b)Service commissioned by April 2015.	JCC, MH Commissioner		The JCC are leading on developing a business case to create a dementia stratgey. Service user enagement will be included in the stratgey both to contribute to and consider how to support SUs. (AJ-8/5/15)
					CCG, Engagement Manager		
OP			Commission training programme to enable MH service users and carers to participate effectively in service evaluation and planning	(c)Include within specification for 1.1	JCC, MH Commissioner	Draft service specification for training programme based on good practice initiatives (see above) by January 2015. (JCC-MHC, 9/12/14)	Initial investigation & scoping of training needs of MH service users has commenced with visits to London Cyrenian supported accomodation.
					CCG, Engagement Manager		
OP	**1.2**	**SUPPORT CARERS OF PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS**	Implement relevant key actions arising from implementation of the Carers Strategy	(a)Carers Strategy implementation reviewed by Dec 2015	see Carers Strategy Action Plan	RBMind contributes via the Carers Strategy Action plan. - RBM 3/11/14	
OP	**1.3**	**ENABLE SERVICE USERS AND CARERS TO PROVIDE REAL TIME FEEDBACK ON SERVICE QUALITY**	Apply the "Friends and Family Test" to mental health services.	(a)Information on service quality derived from Friends and Family Tests available by December 2014	SWLStG, Service Director	SWLSTG plan to have in place by this financial year. ●Technical Patient FFT systems implementation (Q2). ●Achieve a response rate (to be defined by future national guidance) by 31 October 2014 (Q2). ●Achieve a response rate (to be defined by future national guidance) by 31 January 2015 (Q3). ●Submit a year-end report including examples of action plans based on feedback received in response to FFT follow-up question. Real Time Feedback is the Trust's local method of collecting Feedback for improvement (CQUIN indicators). Involves collecting feedback from service users, carers family & friends using a range of devices (Kiosk, Tablets and online).	
					RWS, Clinical Lead/Service Manager	RWS offers regular service user meetings (every 6 weeks in the evening) to gather feedback, these are publicised in our waiting areas and in our clinical rooms. RWS asks for service user feedback at the beginning, middle and end of treatment which patients either submit electronically or by hand if they prefer. RWS has regular clinical quality meetings when feedback and complaints are discussed and learning objectives agreed. RWS has a complaints procedure which is publicised on their website and in their waiting rooms (RWS Nov14)	
OP	**1.4**	**CARER SUPPORT FOR PEOPLE WITH DEMENTIA**	provide support to carers of people with dementia, specific services include the Caring Café, Homelink day respite and support groups through the Alzheimer's Society	(a)Evidence of activities and take up of activies related to this project	Homelink, Chief Executive	The new Homelink centre due to be open in January 2015 plans to offer carers a variety of different relaxation therapies, one to one sessions and support meetings.-Homelink 14/10/14	Homelink moved into its new BREAAM Excellent purpose-built Dementia care centre in January 2015. This new centre has been designed in collaboration with the King's Fund and is built to the highest possible specifications to cater for people suffering with dementia. This is turn enables us to better support local carers, caring for a family member, friend or loved one with a mental health diagnosis. All Homelink staff now hold the Dementia Care Level 3 certificate and all staff and volunteers are now Dementia Friends. We are extending the Dementia Friends training to our carers and this training is due to take place in June 2015. (11/5/15)
						See carers strategy action plan	
					Carers Hub Service, Chief Executive	CARERS HUB SERVICE August 13 - July 14 - 1. Caring Café 24 Cafes; 54 individual carers attended. Second café launched 01/08/14 for delivery at Whitton (Homelink premises). 2. Homelink - 27 carers x weekly respite care breaks x 49 weeks per year. 3. Alzeimers Society - delivered Specialist information and advice, informal emotional support (116 carers x individual sessions and 55 support groups) to unpaid carers. 4. Crossroads Care Richmond and Kingston - delivery of 1232 respite care sessions at home (with high percentage with dementia related care needs). NOTE : Alzeimers Society , Crossroads and Homelink provide additional services/support to carers caring for someone living with dementia not funded through the Carers Hub Service. Carers have also accessed univeral services delivered by Richmond Carers Centre and others within the Carers Hub Service - including informal emotional support, breaks and leisure activities, information and advice, debt and money advice, young carers support service, training. Alzheimer's Society Carer Support Service reviewed at end of Year 2 of Carers Hub Contract to include Carers Information Programme (CRISP) as well as continuing with community carer support groups, informal emotional support and leisure breaks . Attendance at the carers support groups within the Caring Cafe remains most popular due to the availability of respite. The evening support group continues to build and the quarterly introductory meetings to support are in high demand. - Carers Hub 16/10/14	CARERS HUB SERVICE August 14 - April 15 - 1. Caring Café 18 Cafes; Average 30 individual carers attended. Cafe running twice a month with monthly session at Sheen Lane and second session at Homelink premises (Whitton). 2. Homelink - 27 carers x weekly respite care breaks x 49 weeks per year. To date delivered 864 session 3. Alzeimers Society - delivered Specialist information and advice, informal emotional support (66 carers x individual sessions and 54 support groups) to unpaid carers. 4. Crossroads Care Richmond and Kingston - delivery of 908 respite care sessions at home (with high percentage with dementia related care needs). NOTE : Alzeimers Society , Crossroads and Homelink provide additional services/support to carers caring for someone living with dementia not funded through the Carers Hub Service. Carers have also accessed univeral services delivered by Richmond Carers Centre (RCC) and other organisations within the Carers Hub Service - including informal emotional support, breaks and leisure activities, information and advice, debt and money advice, young carers support service, training. Approximately 25% of carers registered with RCC have indicated they care for an older person living with dementia. Alzheimer's Society Carer Support Service reviewed at end of Year 2 of Carers Hub Contract to include Carers Information Programme (CRISP) as well as continuing with community carer support groups, informal emotional support and leisure breaks . 1 of 2 Crisp programmes delivered with 12 carers (maximum capacity) attending. Attendance at the carers support groups within the Caring Cafe remains very popular due to the availability of respite. Demand continues to outstrip capacity. Group numbers are very high with limited group facilitation capacity and space issues. . - Carers Hub 30/06/15
					Alzheimers Society, Service Manager	Alzheimer's Society Carer Support Service reviewed at end of Year 2 of Carers Hub Contract to include Carers Information Programme (CRISP) (funded outside this contract last year and as well received) as well as continuing with community carer support groups reported on through Carers Hub quarterly performance monitoring . Attendance at the carers support groups within the Caring Cafe remains most popular due to the availability of respite. The evening support group continues to build and the quarterly introductory meetings to support are in high demand. - Alzheimer's Society 16/10/14	Alzheimer's Society Carer Support Service is currently in year 3 of Carers Hub Contract, providing 14 hours Dementia Support, which includes running various carer support groups and providing outreach support to carers in the community. In addition, 2 x Carers Information Programme (CRISP) are being funded through the contract (the second to run in July 2015, and a CrISP 2 programme (funded outside the Carers Hub contract) later in 2015. The community carer support groups reported through Carers Hub quarterly performance monitoring are continuing and enjoying a high level of attendance. Attendance at the carers support groups within the Caring Cafe remains most popular due to the availability of respite and have been maintained despite splitting between Homelink and Sheen Lane Day Centre. The evening support group continues to build and the quarterly introductory meetings to support are in high demand. - Alzheimer's Society 22 June 2015

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
2	**PRIORITY: PREVENTION AND EARLY INTERVENTION**						
OP	**2.1**	**DEVELOP COMPREHENSIVE, ACCESSIBLE AND EFFECTIVE MEMORY SERVICES**	Improve the detection, diagnosis and recording of dementia in primary care.	(a)Achieve a local diagnosis rate of 66% by March 2015. Through continued education of GPs and implementing the HRCH CQUIN which focuses on training district nurses to detect dementia and refer to the Memory Service. Increased referrals to Memory Service from the Liaison Psychiatric Service (LPS) at Kingston Hospital and the proposed LPS for West Middlesex Hospital.	JCC, OPMH Commissioner	Dementia diagnosis working group: A dementia diagnosis working group has been established meeting approximately quarterly to consider new initiatives that may influence diagnosis rates. The core members include the CCG Chief Nurse, The GP Mental Health lead (now a governing member CCG GP), Medicines management and the Commissioning Manager. a)The Commissioning manager and Lead MH GP have worked with Hounslow and Richmond Community Healthcare NHS Trust and SWLSTG to launched a three month pilot to enable nursing staff to identify and refer patients with cognition and memory problems to the Richmond Community Mental Health Memory service provide by SWLSTG. The pilot will be evaluated and agreement will be reached re the future of this referral pathway . b) CCG Governing Body GPs: In June 2014 a letter was sent from Dr Graham Lewis Chair of the CCG to all GP Governing body members asking them to lead by example to increase the dementia diagnosis rate in Richmond. c) The Vice Clincal Chair of the CCG and Commissioning manager led a presentation to the CCG GP Membership meeting on the importance of a diagnosis and evidence of the diagnosis rate for each GP practice from NHS England was included for discussion . 4 GP practices have achieved above the 67% diagnosis ambition. d) The GP Practice Nurses have completed a dementia training session , this included recognsiing the symptons, the importance of diagnosis and an understanding of the impact of dementia. e) See also entry under West Middlesex University Hospital Liaison Psychiatric Service (OPMHC, JCC 10/10/14)	In January 2015 through NHSE funding, RCCG employed a GP with special interest in dementia to complete a list validation exercise in GP surgeries and to assess residents of care and nursing homes in the borough where the staff had concerns about Cognitive impairment of people not yet diagnosed. Through this 7 week project RCCG increased the dementia diagnosis rate from 54.8 - 63.6%. RCCG is expecting this to increase to 67% by June 30th as the remaining people currently being assessed in the Memory Clinic receive a diagnosis. (AJ-8/5/15)
					SWLStG, Service Director	SWLSTG are currently working with Commissioners in the development of a pilot to explore opportunities for increasing referrals to the memory Assessment Service. ● Pilot commenced for 6 months from Sept 2014. There have been 12 referrals received to date. SWLStG,14/10/14	
					HRCH, Service Director		Pathway established with SWLSG for direct referral to memory service by inpatients unit, RRT and community nursing. HRCH engagement in National dementia CQUIN. (HRCH-21/7/15)
OP			Ensure that an effective range of interventions are provided following diagnosis, including for carers	(b)Wide range of face to face and group sessions available to service users and carers for information, support and therapy by April 2014	SWLStG, Service Director	SWLSTG have revised the SLA with the Alzheimer's Society (AS) ● New performance metrics have been developed for the AS to report on in the future ● Group work in place with membership from both SWLSTG staff and AS. ● Set Qtrly performance review mtg in place, with attendance from CCG. SWLStG,14/10/14	
					Carers Hub Service, Chief Executive	as above (1.4a) re Alzheimer's Society for specialist support through Carers Hub Service. Carers have also accessed univeral services delivered by Richmond Carers Centre and others within the Carers Hub Service.Alzheimer's Society have a range of support services for people with dementia and carers appropriate for people with different needs and at different stages. - Carers Hub 16/10/16	as above (1.4a) re Alzheimer's Society for specialist support through Carers Hub Service. Carers have also accessed univeral services delivered by Richmond Carers Centre and other organisations within the Carers Hub Service.Alzheimer's Society have a range of support services for people with dementia and carers appropriate for people with different needs and at different stages. Within the Caring Cafe (delivered by Crossroads with support from Alzheimers Society to facilitate group activity and provide information and advice) the number of carers wanting to participate in group support/discussions is increasing significantly. Facilitator of group is needing to consider appropriate options to ensure group/s are effective and purposeful and meet carers needs. Resource issues re need for additional groups/group facilitators. - Carers Hub 30/06/15
					Alzheimers Society, Service Manager	Alzheimer's Society have a range of support services for people with dementia and carers appropriate for people with different needs and at different stages. The support available includes a Dementia Adviser and a Dementia Support Worker available for Carers Support including signposting and referring to all other sources of support . Alzheimer's Society are integrated with the Carers Hub, Memory clinic and CiIs to improve access to relevant support services for carers of people with dementia at different stages . All service user and carer support activity is closely monitored through quarterly reporting mechanisms. Through the Dementia Friendly Community Project we have worked with a number of local organisations and have created sustainable dementia friendly activities such as share a book at the library, talk and draw at Orleans House. - Alzheimer's Society 16/10/14	Alzheimer's Society have a range of support services for people with dementia and carers appropriate for people with different needs and at different stages. The support available includes a Dementia Adviser who works with the 2 x Memory clinics in the Borough, and Dementia Support Workers who are available for support for People with Dementia and Carers Support, both services include signposting and referring to all other sources of support as well as on to one outreach support. Alzheimer's Society are integrated with the Carers Hub, Memory clinic/CMHT and CiLS contract to improve access to relevant support services for people with dementia and carers of people with dementia at different stages . All service user and carer support activity is closely monitored through quarterly reporting mechanisms. Our Dementia Support Workers and Dementia Adviser all refer into the CiLS dementia friendly activities and Carers hub services to ensure interevention is provided following diagnosis. Following the Dementia Friendly Community Project, many acitvities have successfully transferred into the CiLS servcie and Alzheimer's Society continues to work with a number of local organisations and have created sustainable dementia friendly activities such as share a book at the library, talk and draw at Orleans House and so on. The Dementia Support Service also has a number of posts funded by local trusts to ensure people with dementia and carers are supported following their diagnosis - Alzheimer's Society 22 June 2015
					CILS : INS	Community Partnership - INS (covering Richmond, Kew, Ham and Petersham): Specialist Information Navigator based within Alzheimer's Society to provide targeted information and support to those affected by dementia and memory loss, providing a fast and direct referral pathway for those seeing advice and information. All Information Navigators are to access Dementia Friends training. -INS 17/10/14	In January 2015 INS sub-contracted our Information Navigation Service to Richmond AID to provide a single point of contact across the two Community Partnership localities. There have also been a number of changes to the staff providing Information Navigation, but all completed Dementia Friends training before the changes came into effect. Alzheimer's Society still take the lead in coordinating specialist advice about dementia across the Community Partnership. We have worked closely with Bluebird Care (Care Provider) and Richmond Adult Community College (RACC) to start delivering Dementia Friends sessions at RACC - the first of which was hosted on 22nd May 2015. CILS INS 1/7/2015
					CILS : RAID	Community Partnership - Richmond AID (covering Teddington and The Hamptons)Specialist Information Navigator based within Alzheimer's Society to provide targeted information and support to those affected by dementia and memory loss, providing a fast and direct referral pathway for those seeing advice and information. All Information Navigators are to access Dementia Friends training. Info Navigators role is to support people to access services preventing crisis. Social centres provide social inclusion activities for people with low level dementia and their carers. CILS RAID 6/11/14	Community Partnership Information Navigation team have specialist Dementia Information Navigator to provide information and support to those affected with Alzheimer's, dementia and memory loss and their carers. Outreach service in local communith provides awareness raising and pathways for early detection. Activities in the Teddington and Hamptons area includes weekly dementia peer group, walking groups, supper club and a mental health group. (LB 3/7/15)

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
					CILS : Age UK	GoLocal - Age UK (covering Barnes, Mortlake, Sheen, Twickenham & Whitton). Information Navigator based at Alzheimer's Society to provide information and support to those affected by dementia and memory loss, providing a fast and direct referral pathway for those seeking advice and information. Activities to support service users and carers include: Caring Cafe, Retro Cafe, Orleans House Gallery Talk & Draw and Share A Book Group. (Age UK 24/11/14)	GoLocal - Age UK (covering Barnes, Mortlake, Sheen, Twickenham & Whitton). Information Navigator based at Alzheimer's Society to provide information and support to those affected by dementia and memory loss, providing a fast and direct referral pathway for those seeking advice and information. Activities to support service users and carers include: Retro Cafe, Orleans House Gallery Talk & Draw and Share A Book Group. (Age UK 17/6/15)
				(c)Launch a Dementia Action Alliance in March 2014	JCC, OPMH Commissioner	Richmond DAA has now been launched and has a total of 31 organisations/services that have signed up @ October 2014. We will be writing an evaluation including the successes and challenges of the DAA members in becoming dementia friendly. This report will be available in March 2015 to document the first year's progress. - Polly Sinclair 14/10/14	The DAA now has a total of 41 organisation/teams/services that have signed up to the alliance. A report detailing the successes of the DAA is being finalised and will be distributed shortly. We have secured funding for 2015-16 to take forward the DAA and are in the process of recruiting a Partnership Coordinator who will be working on taking forward the dementia friendly communities agenda for Richmond over the next year.(PS-13/7/15)
				(d)Develop "dementia friendly" facilities/services in partnership with the Alliance, The community Indepependent Living Hubs leisure and arts services by March 2015	CILS : INS	Community Partnership - INS (covering Richmond, Kew, Ham and Petersham): Seeking a commitment from all partners to be engaged with Dementia Friends and to be signed up to the Dementia Action Alliance. To explore developing new services such as supported activities at the Cambrian Centre to build on existing services and to meet un-supported needs locally. Exploring working in partnership with Older People's Mental Health Team, Bluebird Care, Alzheimer's Society and Richmond Adult Community College. Explore development of integrated services that involve people from mixed client groups such as Community Choir based at Woodville. - INS 17/10/14	We are encouraging our Partners to engage with Dementia Friends and to sign up to the DAA. After exploring the possibility of providing activities at the Cambrian Centre we recognised that this was not currently viable as the Centre requires additional funds to improve the facilites. We are still working with RACC and Nordoff-Robbins with the aim to develop a locally inclusive choir at Woodville. CILS 2/7/2015
					CILS : RAID	Community Partnership - Richmond AID (covering Teddington and The Hamptons) - running a range of dementia friendly activities and support including Bush Parking Walking Club, Strawberry Hill House Gardening club, dementia peer group in the Greenwood Centre. Also have the specialist dementia navigator and mental health navigator and we are raising awareness amongst all partners for dementia friendly activities and be engaged with Dementia Friends. Befriending available via Greenwood for housebound people. - CILS RAID 6/11/14	no further update
					CILS : Age UK	GoLocal - Age UK (covering barnes, Mortlake, Sheen, Twickenham & Whitton) - key staff and partners 'Dementia Friends' trained and signed up to DAA. (Age UK 24/11/14)	GoLocal - Age UK (covering Barnes, Mortlake, Sheen, Twickenham & Whitton) - key staff and partners 'Dementia Friends' trained and signed up to DAA. (Age UK 17/6/15)
OP			Integrate dementia within the NHS Health Checks Programme in line with Department of Health direction	(e)All over 65's attending a Health Check are given DH leaflet, dementia awareness signposting and advice by December 2014	LBRuT, Director of Public Health	a) NHS 40 + Health checks: Ensuring people with dementia are given a timely diagnosis is key to the National Dementia Strategy; To improve both prevention and diagnosis of dementia, all patients aged over 65 years attending a Health Check at a pharmacy or at an outreach event are being given dementia awareness, signposting and advice. Since the beginning of this financial year, public health data informs us that 309 people over the age of 65 have had a health check, however currently it is not possible to verify whether dementia advice was actually provided to all these patients. Public Health commissioners have requested that this information is recorded and Public Health has contacted the software provider to see if this level of data can be provided in the near future. (Aileen Jackson 10/10/14)	
OP	**2.2**	**RAISE AWARENESS OF COMMUNITY SERVICES AND IMPROVE USE OF TALKING THERAPIES and LIAISON SERVICES IN PRIMARY CARE**	Publicise and Encourage self-referral to Richmond Wellbeing and other services, improve take up by Older People, BME groups and those with long-term conditions or medically unexplained symptoms and enhance integrated response.	(a)Produce and disseminate leaflet about mental health services in Richmond by March 2014.	RWS, Clinical Lead/Service Manager	A service leaflet has been produced and delivered to all residents in Richmond. RWS has a well established a presence in the Community through locating their clinicianc in GP surgeries throughot the Borough, they also have clinicians working in Community settings such as in the Age UK office in Twickenham. RWS is piloting a therapy group specifically for older age adults. RWS offers a therapy group for LGBT service users, and has a long term conditions therapy group. RWS is developing an enhanced care programme which will offer treatment to patients who have MUS and other more complex presentations which can be treated in primary care. (RWS Nov 14) The service has updated the service leaflet and distributed across the Borough in all GP practices and other community venues. The service is currently working with the Community Pharmacists to support the work of the Richmond Integrated Partnership Group to further improve access to psychological services. The service is now based in Age UK in Twickenham one day per week and an Older Persons Group has been established. (RWS 14/1/15)	
					RB Mind, Chief Executive	RB Mind actively promotes Community Services through contracted element of RWS. - RBM 3/11/14	Staff have met with Crossways Pregnancy Service, Homelink, Age UK, local employers and other organisations. At end of 6 week group sessions patients advised about peer groups available in the community.30/6/15
				(b)Develop web-site by March 2014.	RWS, Clinical Lead/Service Manager	RWS website is fully functioning and service users can self refer via the website. RWS continues to develop its website to improve access to psychological therapies. (RWS Nov 14) The website has been developed and in operation since September 2014. Further work to provide testimonials from patients is scheduled before the the end of March. The service is also looking to develop podcasts to support the delivery of the service. (RWS 14/1/15)	
				(c)Improve take up among hard to reach groups by 20%	RWS, Clinical Lead/Service Manager	Survey sent out to 600 older age adults in community to identify how to improve older adult engagement in RWS. Analysis of survey underway and should be completed by January 2015 (RWS Nov 14) The service has developed a working relationship with AGE UK and is based on their building one day per week. The service is providing No Health Without Mental Health training to colleagues both in Richmond and Kingston. This involves professionals from numerous backgrounds i.e. social care, district nursing, third sector etc. (RWS 14/1/15)	
				(d)Enhance social care capacity.	RWS, Clinical Lead/Service Manager	RWS is in discussion with Commissioners with regard to employing a social worker on secondment to enhance RWS's social care capacity. RWS attends interface meetings regularly with Richmond CMHT and is a member of the local adult safeguarding improvement panel, the older people's mental health strategy group . (RWS Nov 14)	

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				(e)Pilot therapy on-line and at community and faith venues	RWS, Clinical Lead/Service Manager	RWS offers live on-line therapy and support through Big White Wall , and also has the capacity to offer therapy through skype. RWS is undertaking the development of on line psychoeducational resources by developing a podcast for their Introductory Seminar . RWS is developing their outreach programme to distribute leaflets in local faith centres and local BME community venues. (RWS Nov 14)	
				(f)Pilot SUN project for those with mild/moderate personality disorder.	SWLStG, Service Director	SWLSTG - currently reviewing the roll out of the SUN project, plan to integrate with local PD. SWLStG,14/10/14	
	2.3	**HELP PEOPLE TO STAY HEALTHY**	Identify risk factors and support individuals to avoid health problems linked to unhealthy lifestyles which contribute to excess morbidity and mortality among people with mental health problems	(a)Continued development of the Livewell Richmond service - enabling people to make lifestyle changes including more physical activity, reduce alcohol /consumption, stop smoking and managing stress and anxiety	Homelink, Chief Executive	The new Homelink centre due to be open in January 2015 plans to work in parrtnership with other statutory and voluntary organisations to provide a variety of oppertunities for carers to promote well being.- Homelink 14/10/14	Homelink are looking to work together with other local statutory and voluntary organisations to use our facility to its full potential. The new centre will allow us to extend our services for the carers of those with dementia. The additional spaces will enable us to offer carer support meetings, training sesions, chiropody, massage and other services that benefit the health of both clients and carers. (11/5/15)
					HRCH, Service Director	Work has taken place to maximise the numbers of goals set by clients of health trainers. (HRCH 26/11/14)	Work underway to build the dementia case finding question into all new health checks offer by Live Well Richmond (healthy living services), to maximise our screening potential. Targetted and tailored training in development for Q2 15-16 for Health & Wellbeing team. (HRCH, 20/07/15)
					RB Mind, Chief Executive	RB Mind runs Ecotherapy groups using Resilience Model of 5 ways to wellbeing. RB Mind is developing project to run Wellbeing Sessions for Young people (14-25) in schools, colleges and youth settings from Spring 2015. Currently recruiting volunteers. - RBM 3/11/14	RBMind's Mindkit project has 4 trained peer volunteers and has presented wellbeing sessions to over 1000 Richmond students in first 3 months. Second tranche of volunteers being recruited. 30/6/15
OP	2.4	**SELF- HARM AND SUICIDE PREVENTION**	Develop a Joint Self-Harm and Suicide Prevention strategy	(a)Undertake needs assessment and suicide audit by June 2014.	LBRuT, Director of Public Health	Undertaken suicide and self harm audit. Outline framework for suicide and self harm strategy development discussed at workshop in September 2014. Draft framework planned to be circulated for comment November 2014- AK 20/10/14	
				(b)Publish Self Harm and Suicide Prevention Strategy by March 2015	LBRuT, Director of Public Health		
OP	2.5	**DEVELOP PLAN FOR PROMOTING MENTAL WELLBEING**	Scope opportunities to enhance mental health resilience, working in partnership with range of bodies and organisations including employers, registered housing providers and the voluntary sector	(a)Undertake mental wellbeing needs assessment by September 2014	LBRuT, Director of Public Health	Initial work on policy review of mental wellbeing completed, including some needs analysis- AK 20/10/14	
				(b)Map services and opportunities and agree priorities including training and education of range of professional and non-professional staff about mental health/ identification of mental illness; promoting mental health among employees, reducing social isolation among vulnerable groups & older people by Dec 2014	LBRuT, Director of Public Health	Brief for mapping of services being prepared by ealry November+B71 - AK 20/10/14	
					RB Mind, Chief Executive	RB Mind offers stress management workshops, MH Awareness for employers, and anti-stigma sessions.-RBM 3/11/14	Several voluntary orgs, college and local employers have accessed the MH Awareness training. Motivational Interviewing training now added to portfoliio of training 30/6/15
					Paragon	40 Paragon staff scheduled to attend the No Health without Mental Health training on offer from Richmond Wellbeing Services. Review of Paragon's sheltered housing service resulted in the development of roles that have specific reponsibility for reduction in social isolation - LW 09/01/2015	40 Paragon staff attended the No Health without Mental Health training on offer from Richmond Wellbeing Services. Review of Paragon's sheltered housing service resulted in the development of roles that have specific reponsibility for reduction in social isolation - BS 30/06/2015
OP	2.6	**PROMOTE SOCIAL INCLUSION AND REDUCE SOCIAL ISOLATION, PARTICULARLY AMONG OLDER PEOPLE**	Encourage meaningful activiites in the community to reduce isolation and loneliness and associated depression.	(a)Evidence of activities and take up of activities in the community (and linked to 2.1, 2.5, 4.1)	CILS : INS	CILS have instigated Community Choir in Ham loaclity and have liaised with Woodville Centre to accommodate. - INS 17/10/14	This is still in the development phase and dependant on the lead provided by Nordoff-Robbins. CILS 2/7/2015
					CILS : RAID	Community Partnership- RAID (Teddington and Hampton area). 45 activites running regularly. Q2 had 5477 attendances. - CILS RAID 6/11/14	no further update
					CILS : Age UK	GoLocal - Age UK (covering Barnes, Mortlake, Sheen, Twickenham & Whitton). Wide range of activities delivered from a number of locations including Age UK Social Centres in Barnes, Twickenham & Whitton. Activities include exercise, arts & crafts, wellbeing and social events. Older People's Programme = 71 activities & 5269 attendances across 2 localities (Q2). (AgeUK 24/11/14)	GoLocal - Age UK (covering Barnes, Mortlake, Sheen, Twickenham & Whitton). Wide range of activities delivered from a number of locations including Age UK Social Centres in Barnes, Twickenham & Whitton. Activities include exercise, arts & crafts, wellbeing and social events. Older People's Programme = 112 activities & 8,033 attendances across 2 localities (Q4). (AgeUK 17/6/15)
					RB Mind, Chief Executive	RB Mind runs around 10 Peer groups in the community for adults, including older adults with MH problems and provides Information Navigation under CILS. RB Mind runs Ecotherapy groups using Resilience Model of 5 ways to wellbeing. - RBM 3/11/14	7 Peer led groups currently running. Model revisited to include 'subject expert' volunteer alongside peer volunteers. 30/6/15
OP	2.7	**STRENGTHEN DUAL DIAGNOSIS PATHWAYS**	Ensure that providers/professionals are aware of/and implement pathways for those with co-morbid substance misuse and mental health problems	(a)Recommisioning of Richmond adult substance misuse treatment services (led by PH) ensures effective linkage with mental health services (Oct 2014)	LBRuT, Director of Public Health	New substance misuse service established 1 October (RIRS . Dual diagnosis policy being considered by clinical team and mental health service	
				(b)Develop and agree substance misuse and mental health pathway document by Dec 2014	LBRuT, Director of Public Health	Pathway documents amended for end of March 2015	
	2.8	**COMMISSION LOCAL DIAGNOSTIC PATHWAYS FOR ADHD**	Ensure that good quality diagnostic service is implemented following completion of pilot project	(a)Specification revised by February 2014 and service re-launched by April 2014	SWLStG, Service Director	ADHD service in place, reviewing demand to service and impact on service delivery. SWLStG,14/10/14	
					JCC, MH Commissioner	Revised contract signed & implemented. (JCC-MHC, 9/12/14)	Contract continues in place. Decision to join main block SWLStG contract will be made in year. (GN 10/7/15)
OP	2.9	**PROMOTE INDEPENDENCE AND QUALITY OF LIFE FOR PEOPLE WITH DEMENTIA AND THEIR CARERS**	To consider benefits and risks of developing an intergrated primary Mental health , physical health and social care community health and social care service for Older people with mental health diagnosis	(a)Scope and develop business case to look and benefits risks and costs	JCC, Head of JCC	Issue raised with PWC who are leading on the Community Health Outcomes Based Commissioning programme	

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
Op			Ensure responsible GP for over 75s gives improved outcomes for people with a mental health diagnosis	(b)Extract and analyse data from the proposed Locally Commissioned Service for adults at risk of being admitted to hospital as an emergency admissio. This LCS will include a Mental Health element	JCC, Primary Care Commissioner	LCS to be implemented in Qtr 3 to 4 during 2014/15 and continue into 2015/16. Qtrly payment submission will collect data on referrals to CILS and Memory Clinic for each practice. (Raksha Kaduda 13/10/14)	
Op			Pilot one year occupational therapy Valuing Active Life in Dementia (VALID) Research Project. Proposal for OT to be based within the SWLSTGt memory service. VALID aims to promote independence, meaningful activity and quality of life for people with dementia and their family carers living in the community	(c)To support and advise carers and people with dementia; to prevent hospital admissions and enable people to live independently for longer.	SWLStG, Service Director	The National Research Study (Valid project) timeframe has been delayed until Jan15 (this dictates the local project) ● SWLSTG had planned on time line of research training to be completed by August 2014. ● Data collection to begin from September 2014 onwards. Both of the above will be vised to be realigned to new launch. SWLStG,14/10/14	
					JCC, OPMH Commissioner	Work has begun to design a telecare leaflet for people with dementia who are early in their diagnosis. - OPMHC 10/10/14	Telecare leaflet has been completed; http://www.richmond.gov.uk/home/services/health_conditions/dementia/dementia_gadgets.htm (AJ-8/5/15)
OP	2.10	**SUPPORT AND ADVICE FOR PEOPLE WITH EARLY ONSET DEMENTIA AND THEIR CARERS**	An early onset (younger than 64 years) pilot support service is being set up by the Alzheimer's Society. Learning form this pilot will inform future commissioning.	(a)Evidence of activities and take up of activies related to this project	Alzheimers Society, Service Manager	The project began in March 2014 and there are already 24 active clients. Following user group consultation a peer support group for people with dementia has started with 9 members and is almost at capacity (10 people). The clients have also through introduction to this project have accessed additional sources of support such as dementia friendly activities. - Alzheimer's Society 16/10/14	This project has been extended to end March 2016 and has also recently had a change of staff who are developing the project and support further within the time allocated, with 7 hours per week being allocated to the project by a specialist DSW . At March 2015 there were over 40 clients who had been supported within the project (carers and people with dementia), and 8 people regularly attended the weekly dementia support group specifcally aimed at issues affecting younger people with a diagnosis, and a regular group of 15 aattending the quarterly meeting for people with dementia and their carers. Some clients prefer some one to one support and this has been offered to some people who fall in theis age category. Due to the progress of dementia and spaces arising in the groups, the new team are working to fill spaces from a waiting list and develop a robust programme to support people in the upcoming year. Alzheimer's Society 22/06/15
3	**PRIORITY : ACUTE CARE AND CRISIS INTERVENTION**						
OP	**3.1**	**PROVIDE GOOD QUALITY COMMUNITY AND CRISIS SERVICES FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS WHICH PREVENT HOSPITAL ADMISSION WHENEVER POSSIBLE**	Implement remodelled care pathways for severely mentally ill people aged 18-75 by reconfiguring Community Mental HealthTeams (CMHTs)	(a)Following consultation and agreement to revised care pathways, implementation programme completed by April 2014	SWLStG, Service Director	SWLSTG has completed a mapping exercise. ● Service users have been allocated within appropriate care pathway team. ● Initial agreement is in place ● Final stages of implementation currently being rolled out. SWLStG,14/10/14	
			Continue to reduce inappropriate acute and emergency hospital admissions by further enhancement of Crisis Resolution and Home Treatment services (CRHT) available on a 24 hour basis	(b)Ensure that additional investment enables provision of 24 x 7 cover by March 2014.	SWLStG, Director of Operations	● HTT provides 24/7 service. ● Night time is provided but is not funded. SWLStG,14/10/14	
				(c)Staffing levels raised to London average by June 2014	SWLStG, Director of Operations	Staff levels are currently under review as part of the Trust directive. SWLStG,14/10/14	
OP			Develop approach for ensuring high quality End of Life Care for people with dementia, based on findings of pilot of an end of life service being provided by Princess Alice Hospice.	(d) the team consists of 3 staff: (1)Specialist Nurse – works with GP practices to identify patients in the last year of life, supports advanced care planning with patients and carers, clinicians providing palliative care management and provides a rapid response service to those patients whose conditions are deteriorating rapidly and supports out of hospital care; (2)Psychosocial Worker – provides psychosocial support and counselling for patients their families and carers. She oversees volunteers from the local community, visits and supports patients and their carers; (3)Benefits advisor – supports patients and families on benefits	JCC, Commissioning Project Manager, Community Ward	The end of life care project has come to an end. Elements have been incorporated in the DES and LCS projects. (Linda Balzanella 13/10/14)	The Richmond project was focused on identifying patients in the last year of life and providing psychosocial support and rapid response - not primarily for Dementia patients (PAH 16/6/15)
					PAH, Service Manager		Princess Alice Hospice supports patients with mental health illness provided they fulfil the criteria for referral. PAH serves the population of part of Surrey and West London; it has a reputation for quality care and plays a significant contribution to healthcare for patients at the end of their life either directly through its own clinical services or indirectly via education and support to NHS and other colleagues. (PAH 16/6/15)
OP			Implement outcomes of review of Liaison Psychiatry and CRHT services for Adults at Kingston Hospital , particularly in relation to frequent users of Accident and Emergency services.	(e)(1) Identify frequent attendees at A&E services and review care plans .	SWLStG, Service Director	● Kingston Hospital - have performance metrics which incorporates identifying frequent attendees at A&E ● SWLSTG - Liaison Psychiatry services have ability to extract data and review cases SWLStG,14/10/14	
			Consider joining commissioning arrangement for Laison Psychaitry for West Mid	(e)(2)Present benefits and risks of existing West Mid Hospital (CNWL) commissioned contract to provide Psychiatric laision	JCC, MH Commissioner	RCCG Approved funding for LPS at WMUH September 2015 Liaison Psychiatric Service West Mid RCCG September 2015 This LPS provides a 24/7 365 days a year service, and includes identifying people with dementia and staff training. The LPS can refer directly into the Richmond Memory Service. This LPS has only recently been awarded funding by RCCG and Commissioners are working with the service provider WLMHT to ensure the pathways are in place for Memory Clinic referral and to other Richmond based vol , statutory and health based services monitor all the KPIs.	The LPS at WMUH: RCCG has agreeed funding 2015/16 through the BCF. The LPS manager is scheduled to attend the OPMHS meeting in May. Establishing good connections with stakeholders is key to ensuring a local pathway is established, this work is ongoing. (AJ-8/5/15)
					WLMHT, LPS Team Manager		added May 2015
				(f)Evidence outcomes of Kingston Hospital psychiatric laison service (SWLSTG) for older people by September 2014.	SWLStG, Service Director	Older people Liaison team are based within the A&E department of Kingston Hospital. This team works closely with the A&E team and Older Adults service to enhance patient care. SWLStG 14/10/14	
			Manage cross-border and specialist Mental Health contracts: *West London Mental Health Trust *South London and Maudsley Mental Health Trust	(g)Establish regular performance monitoring meetings by April 2014.	JCC, MH Commissioner	Regular performance monotoring meetings established. (JCC-MHC, 9/12/14)	Regular performance meetings held with providers.
				(h)Promote referral pathways to GPs and providers by May 2014	JCC, MH Commissioner		Project was reviewed by CCG MH Clinical Lead and CCG Chair and concluded that remodelling was not feasible due to geographical constraints on reffering GPs.

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
OP	3.2	**PROVIDE HIGH QUALITY INPATIENT SERVICES FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS**	Ensure that high standards of care and safety are achieved for all Richmond patients on psychiatric wards.	(a)Older Peoples' ward refurbished and re-equipped to high standards by April 2014.	SWLStG, Service Director	• All Richmond Patients were legally detained with good evidence of scrutiny. • Care records demonstrated that individual risk assessments were documented and regularly reviewed. • All patients physically health was assessed on admission and regularly reviewed • Patients reported that they felt they were safe on the ward, were involved in the care planning process and had regular access to advocates. • Staff had good understanding of safe guarding procedures. • The Older adult ward will move in the autumn to a newly refurbished ward. SWLStG,14/10/14	
				(b)Enhanced staffing levels for qualified nurses on all wards implemented by June 2014.	SWLStG, Service Director	Performance management process in place - daily assurances that the wards are staffed to meet the needs of the patients. SWLStG,14/10/14	
OP	3.3	**DEVELOP VIABLE ALTERNATIVES TO OLDER PEOPLE ACUTE MENTAL HEALTH HOSPITAL ADMISSION**	Explore options with relevant stakeholders including carers.	(a)To present a business case for change if applicable.	JCC, OPMH Commissioner	SWLSTG Estates modernisation Consulation is underway . Commsioners will await outcome and decision prior to emabarking to look at alternatives to acute MH admissions. (Aileen Jackson 10/10/14)	
OP	3.4	**IMPROVE SERVICES FOR CARERS OF SEVERELY MENTALLY ILL PEOPLE**	Continue to develop partnership working with carers in line with the borough Carers Strategy including recognising carers as expert partners in care.	(a)Evaluate outcomes achieved by the acute carers recovery worker post by September 2015.	RB Mind, Chief Executive	RB Mind contributes via Carers Strategy. RBM 3/11/14	Initial evaluation report submitted to CommissionersJune 15
				(b)Undertake respite survey of needs of carers of adult mental health service users by September 2014.	RB Mind, Chief Executive	RB Mind contributes via Carers Strategy. - RBM 3/11/14	Initial evaluation report submitted to CommissionersJune 15
				(c)Evaluate outcomes of the Shared Lives dementia scheme respite programme by December 2014	LBRuT, Shared Lives Manager	Evaluation due to be published January 2015	Shared Lives evaluation is now complete. The LA Departmental Management Team have agreed to the service being continued. The service is key to providing respite choice and flexiblity to carers of people with dementia. The SL manager will publicise the scheme by attending team meetings, carers meetings at Woodville and other carers meetings. The SL Manager will be attending a meeting at the carers centre on 13th July to explain our service to the team. The Manager will revisit the marketing plan at the beginning of the pilot and complete a new plan to market the service further. (CG-1July15)
OP	3.5	**IMPROVE THE PHYSICAL WELLBEING OF SEVERELY MENTALLY ILL PEOPLE**	Ensure that physical health examinations are carried out a minimum of annually in primary care and within 48 hours of admission to a psychiatric secondary care bed.	(a)Review available data to assess CCG and Trust performance by September 2014	SWLStG, Service Director	In regards to a PHA being carried out within 48hrs of admission to a psychiatric secondary care bed: ● CQC June 2014 reported that all patients are having their physical health assessed within 48 hours of admission. ● This is closely monitored within the Trusts internal performance management processes. SWLStG,14/10/14	
				(b)Implement recommendations to ensure 95% compliance rate by April 2015	SWLStG, Service Director	This is closely monitored within the Trusts internal performance management processes. SWLStG,14/10/14	
			Audit sample of physical health exams of those with SMI and subsequent health promotion responses.	(c)Audit completed by December 2015	SWLStG, Service Director	Audit will be monitored through Clinical Governance SWLStG,14/10/14	
OP			Encourage service users to quit smoking, take exercise and eat sensibly.	(d)Target Health Promotion initiatives on MH service users by December 2014	SWLStG, Service Director	This is closely monitored within the Trusts internal performance management processes. SWLStG,14/10/14	
					LBRuT, Director of Public Health	To be considered in reprocurement of Prevention Services+G98 - AK 20/10/14	
					RB Mind, Chief Executive	RB Mind supports this work with quitting smoking, healthy eating and exercise sessions in the Wellbeing Centre. - RBM 3/11/14	Initial evaluation report submitted to CommissionersJune 15
OP			Improve physical healthcare on Older Peoples wards by implementing the "safety thermometer".	(e)Improvement programmes put in place to respond to harms caused by falls, pressure ulcers etc.	SWLStG, Service Director	● Falls champions are ensuring that the new falls policy is disseminated and implemented by all staff and audits relating to falls. ● Falls policy discussed in the Trust Physical Health Training sessions and wards meetings ● All patients over 65 have a falls risk assessment on admission. SWLStG,14/10/14	
				(f)Provide performance report based on monthly audits required by 2013/14 CQUIN by March 2014	SWLStG, Service Director	2013/14 CQUIN report can be Trust Information Team. SWLStG,14/10/14	
			Community Health dementia and co-morbidities	(g) Develop the New Dementia Clinical Specialist Role	HRCH - Director of Quality & Clinical Excellence		HRCH community dementia clinical specialist roles (2.0wte) now recruited to. These will play a key role in supporting early diagnosis, management and appropriate referral on to specialist services, as well as supporting patient journey across care settings (HRCH 20/07/15)
OP			Reduce the extent of low dose anti-psychotic prescribing to people with dementia, including those in residential care.	(g)Monitor and evidence reduction in low dose prescribing by April 2015	CCG, Medicines Management	With ref to receiving the appropriate medication in the most appropriate setting there are sometimes shared care issues etc related to prescribing of medication that need resolving; we aspire to smooth this potential gap across the interface through collaborative work with the other 4 CCGs that commission, mainly from SWLStG MHT in the SWL interface prescribing forum. This is chaired by the KCCG chief pharmacist as RCCG commission the support from the CSU who outsource it to KCCG but also has the trust members there – specifically Dianne Adams (who was the previous chief pharmacist of R&TPCT). - MedMgmt (ER) 20/10/14	We continue to work collaboratively with the other 4 CCGs that commission mainly from SWLStG MHT in the SWL mental health interface prescribing forum on any prescribing issues that arise. There has been a slight fall from in low dose antipsychotic ADQ usage (Q4 13/14: 47.19, Q1 14/15 46.74, Q2 14/15: 47.02, Q3 14/15: 46.03) but we are still higher than national and South London averages. We intend to continue monitoring prescribing levels during 2015/16. Our ePACT data can not distinguish between the indications for prescribing and a recent practice audit suggests that prescribing of low dose antipsychotics is not always linked to dementia related indications. The audit showed that percentage of reported patients with dementia who are also on an antipsychotic (without a psychiatric diagnosis) has decreased from 14.6% in 2011/12 to 11.4% in 2012/13. Contact MedOpt if further information is required. - MedOpt (SQ) 24/04/15
					CCG, Medicines Management	There has been a slight fall from in low dose antispsychotic ADQ usage but we are still higher than national and South London averages. Our ePACT data can not distinguish between the indications for prescribing and a recent practice audit suggests that prescribing of low dose antipsychotics is not always linked to dementia related indications. The audit showed that percentage of reported patients with dementia who are also on an antipsychotic (without a psychiatric diagnosis) has decreased from 14.6% in 2011/12 to 11.4% in 2012/13. Contact MedMgmt if further information is required. - MedMgmt (SQ) 21/10/14	as above - MedOpt (SQ) 24/04/15

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
OP			Establish a model to improve care management in care homes to reduce unplanned hospital admissions of people with dementia	(h)Evaluate outcomes of pilot project led by clinical nurse specialist to reduce hospital admissions of people with dementia in care homes by Dec 2014	JCC, Commissioning Project Manager, Community Ward	The care home pilot project is due to finish, and a decision has not yet been made re the evaluation. I am not sure that care home patients with dementia have been recorded as the aim of the project was to reduce hospital admissions for all care home patients and was not specific. Elements have been incorporated in the DES and LCS projects. (Linda Balzanella 13/10/14)	
	3.6	**IMPROVE SERVICES FOR PEOPLE WITH EATING AND OTHER COMPLEX PSYCHOLOGICAL DISORDERS**	Review care pathways for people with eating and personality disorders	(a)Project brief agreed bySept 2014	JCC, MH Commissioner		RCCG has had initial meeting with Kingston CCG to review a common approach to personality disorder pathway.
					NHS ENGLAND		
					SWLStG, Director of Operations		
				(b)Review completed by April 2015	JCC, MH Commissioner		
					NHS ENGLAND		
					SWLStG, Director of Operations		
				(c)Results implemented by Dec 2015	JCC, MH Commissioner		
					NHS ENGLAND		
					SWLStG, Director of Operations		
OP	3.7	**ENSURE THAT SEVERELY MENTALLY ILL PEOPLE HAVE A VOICE DURING THEIR TREATMENT**	Ensure that good quality independent and general advocacy services are available as required.	(a)Evidence outcomes and increased take up of IMHA and IMCA services by Sept 2014	KAG, Service Manager		
4	**PRIORITY : ACHIEVE RECOVERY and INDEPENDENT LIVING**						
OP	4.1	**COMMISSION EFFECTIVE REHABILITATION SERVICES**	Ensure that short term care and support is available to assist people to recover their health and wellbeing	(a)Ensure that care pathways to the newly commissioned Richmond Response and Rehabilitation Team enable the provision of integrated and seamless support to people with dementia and other non acute MH conditions and their carers whenever appropriate	HRCH, Service Director	RRRT are involved in the dementia training programme within HRCH. RRRT have met with community mental health colleagues to develop and build relationships to ensure that they support patients with dementia and other non acute mental health conditions and their carers. Community service pathways currently being reviewed with the CCG (HRCH 26/11/14)	RRRT continuing to work with both acute and community mental health colleagues in the effective management of discharge to the community from Tolworth Hospital and referral to Memory Services. Staff trained in Foundation level dementia awareness and skills, and will participate in targetted Level 2 training in Q2-3. (HRCH 20/07/15)
				(b)Ensure there is effective joint working with housing providers when there are early indications of re-emerging mental illness and tenancies may be at risk	SWLStG, Service Director	Joint review meeting with Housing providers to ensure service provision is within agreed care plans SWLStG,14/10/14	
					All Housing Providers	L&Q have an excellent working relationship with many of the local CMHT team. We actively liaise with them in relation to concerns that are raised about specific residents. We also attend the monthly Supported Housing Allocations Panel to ensure that we are taking collorative responsibility for new residents in our homes. Our policies and procedures heavily stipulate the necessity to liaise with support providers where a resident's tenancy is at risk. - L&Q 7/11/14	L&Q have an excellent working relationship with the local CMHT team. We actively liaise with them in relation to concerns about specific residents, in order to maximise the outcome for those individuals. We also attend the monthly Supported Housing Allocations Panel, where we strengthen our working relationships with Metropolitan Care & Support who are also in attendance, to ensure that we are taking collorative responsibility for new residents in our homes. Our policies and procedures heavily stipulate the necessity to liaise with support providers where a resident's tenancy is at risk. - L&Q 30/06/15
					RHP		RHP provides support to customers who's tenancy maybe at risk through the Customer Support Team and for customers living in Retirement Housing through the Scheme Managers. Both services offer a regular reviews of support plan which identify any changes in need or health and wellbeing. RHP will then signpost accordingly to external agencies and partners for additionally support including GP referrals. As well as signposting RHP will carry out regular home visits and welfare checks, these visits may increase if a customers need require this. RHP has also signed up to the LBRuT joint Mental Health and Housing Protocol and are participating in the training and raising awareness to improve services to local people. (RHP 16/6/15)
					Paragon	Paragon has a Tenancy Support service which enables intensive 1-1 support to be provided to households at risk of losing their tenancy. This level of support enables our Tenancy Support Officers to develop relationships with relevant statutory and voluntary agencies LW 09/12/2014.	Paragon has a Tenancy Support service which enables intensive 1-1 support to be provided to households at risk of losing their tenancy. This level of support enables our Tenancy Support Officers to develop relationships with relevant statutory and voluntary agencies LW 09/12/2014.
					Metropolitan Housing, Service Manager		Metropolitan works closely with CMHT care co-ordinators to actively encourage appropriate referrals. We also liaise with other healthcare professionals, social workers and other agencies to ensure a collaborative approach. We attend the Housing Support Panel meetings with Richmond and other colleagues to discuss potentional referrals to ensure we allocate the most appropriate accommodation. (CS-1/7/15)
			Promote independent living and prevent hospital re-admission for mental health service users on the rehabilitation care pathway	(c)Newly commissioned rehabilitation service for people recovering from severe mental illness, fully staffed by March 2014	SWLStG, Service Director	SWLSTG - reviewed provision of rehabilitation service, with improvement being currently being rolled out. SWLStG,14/10/14	
				(d)All placements have been successfully reviewed and discharge plans developed by June 2014.	SWLStG, Service Director	Currently in plan and part of the teams remit SWLStG,14/10/14	
OP			Ensure that people recovering from mental illness are provided with opportunities for community participation via a Community Independent Living Hub	(e)Evidence of good levels of engagement with mental health service users, including people with dementia, with services initiated by Community Independent Living Hubs by Dec 2015	CILS : RAID	Teddington and Hampton CILS have a range of partners and services in this hub that support older people with mental health; social centres Elleray Hall and Linden Hall and support groups run by the Alzheimer's society. Community Partnership - Richmond AID (covering Teddington and The Hamptons) - running a range of dementia friendly activities and support including Bush Parking Walking Club, Strawberry Hill House Gardening club, dementia peer group in the Greenwood Centre. RB Mind have peer groups supporting people with mental health including; Creative Minds art group; Fun Football Thursdays; Ready, Steady, Bake & cook; the Gap (LGBT group) and Women's Group. Befriending support from Greenwood Centre for housebound clients. More than 440 people have accessed CILS service; 61% are over 65. - CILS RAID 6/11/14	no further update
					CILS : Age UK	GoLocal's single point of access provides an holistic service including an Info Navigator providing general information and signposting and where necessary and apppriate one-to-one complex case work. GoLocal's Community Mental Health Development Worker has a specific focus on developing community activities such as a Community Choir and taster sessions to explore new interests and activities. The CMHDW supports individuals to identify services and enable them to access them either through signposting, referring or support. The aim is to reduce social isolation and to re-engage with the community - GoLocal 21/11/14.	GoLocal's single point of access provides an holistic service including an Info Navigator providing general information and signposting and where necessary and appropriate one-to-one complex case work. GoLocal's Community Mental Health Development Worker has a specific focus on developing community activities such as a Community Choir and taster sessions to explore new interests and activities. The CMHDW supports individuals to identify services and enable them to access them either through signposting, referring or support. The aim is to reduce social isolation and to re-engage with the community - GoLocal 17/6/15.

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
					CILS : INS	CILS (Richmond, Kew, Ham and Petersham) provide a range of services which are delivered by partnership working, many of which are shared with Teddington & Hampton CILS. The Avenue Club in Kew provides a rich social support network for older people and the wider community, and have excellent links with local neighbourhood care groups. Specific support groups are provided by Alzheimer's Society and Richmond Borough Mind including: Richmond Walking Groups (Richmond Tow Path and Bushy Park), InMind at the Royal Academy, Caring Café, Support Group for People with Dementia, Supper Club, Richmond Gate Hotel Coffee Mornings, Life After Diagnosis, Creative Minds. Richmond Adult College is also providing a range of courses to adults around maintaining well-being and are offering free taster sessions to the local community. We have a team of Information Navigators providing general information and sign-posting along with complex case work relevant to their particular specialism including mental health, dementia, physical and sensory impairments, neurological conditions and learning disability.	These services are still on-going under our CILS partnership. 2/72015
					RB Mind, Chief Executive	RB Mind contracted to CILS to offer Information Navigation and Peer Groups now subsumed into this. - RBM 3/11/14	Initial evaluation report submitted to CommissionersJune 15
OP	4.2	**EMPOWER INDIVIDUALS TO LIVE INDEPENDENTLY AND TO SOCIALLY INTEGRATE**	To performance monitor the S75 indicators	(a)Quarterly updates of the delivery of the S75 performace indicators	SWLStG, Service Director	Process in place for the review and monitoring of S75 indicators SWLStG,14/10/14	
					LBRuT, Head of Performance & Quality Services, Adult & Community Services		
			All care plans should include a minimum of 2 recovery outcomes agreed with the service user and support to achieve them provided	(b)80% of Care Plans to include recovery goals by April 2015	SWLStG, Service Director	SWLSTG - AD of Social Work, currently working with other partners in the joint working of providing and implementing considerations of dementia provision in the development of new housing. SWLStG,14/10/14	
					RB Mind, Chief Executive	RB Mind Wellbeing Centre referral protocols revised in Oct 15, to work with CMHTs to progress recovery goals in Care Plans. - RBM 3/11/14	SWLStG restructuring now completed we are now revisiting the comms protocols with the CMHT 30/6/15
OP			To develop a telecare leaflet for people to receive on diagnosis through the Memory Clinic.	(c)Design and print leaflet; distribute to Memory Clinic.	JCC, OPMH Commissioner	Work has begun to design a telecare leaflet for people with dementia who are early in their diagnosis. - OPMHC JCC 2/12/14	
					LBRuT, Telecare Manager, Adult & Community Services		
	4.3	**PROMOTE RECOVERY THROUGH HOUSING, DAY AND EMPLOYMENT SERVICES**	To improve the number and quality of MH supported housing units in the borough	(a)7 additional tenancies for high support needs in borough and 7 low support tenancies by October 2014 .	JCC, MH Commissioner	4.3 (a) – 'additional 7 tenancies for high support needs' is on schedule. Building works are completed and referrals are being assessed currently.-JackWainwright 29/5	Project is complete.
					JCC, MH Commissioner	7 new Supported Housing Units developed by Paragon Housing group are on schedule to complete by 28th October 2014. (Housing Development 16/10/14)).	Project is complete.
					JCC, MH Commissioner	There has been a further delay to the completion of the low support units and handover to Paragon is due for 20th November, with subsequent handover to Metropolitan on 21st November. (NS - Housing, 20/11/14)	Project is complete.
					Paragon	Handover of 7 units from Paragon to Metropolitan completed on 28/11/2014. Occupation commenced from 08/12/2014 - LW 09/01/2015	Handover of 7 units from Paragon to Metropolitan completed on 28/11/2014. Occupation commenced from 08/12/2014 - LW 09/01/2015
				(b) Low supoprt tenancies (Kew Road) to ensure effective communication with local community and support mechanims for tenant s are in place	Metropolitan Housing, Service Manager	Handover delayed. New tenants assessed and due to sign up on 8 December 2014. - (CarolSmith 21/11/14)	All property now let. Each tenant has a support plan in place and a named key worker. Neighbours contacted and provided with contact number. (CS - 1/7/15)
OP			Implement the Housing Strategy 2013 – 2017 (to be agreed at Cabinet in January 2014) which outlines the Council's commitment to work with housing associations to ensure they consider the	(c)Evidence partnership with housing providers to implement dementia friendly specifications by Dec 2015	LBRuT, Policy & Planning Manager, Adult and Community Services	The Housing Strategy 2013-2017 was agreed at Cabinet in January 2014. This year there has been no extra care schemes in the pipeline so we have not been able to work with Registered providers in ensuring specifications are dementia friendly. (Dan Butler 13/10/14)	On 11th March 2014 Steve Hinds from PRP Architects gave a presentation to the Housing Association Forum (the main housing association developers in the Borough). This included design / access issues for older people including HAPPI principles and issues around dementia friendly environments. (DB 5/6/15)
					JCC, OPMH Commissioner	Commissioners will work with housing colleagues if new Extra care housing schemes emerge /are approved	
				(d)Evidence improved joint working between CMHTs and Registered Housing Providers by March 2015	SWLStG, Service Director	As above (4.2b) - part of the joint working & development of plan and progress updates. SWLStG,14/10/14	
					LBRuT, Policy & Planning Manager, Adult and Community Services	The development of joint working protocols on information sharing and hospital discharge is underway; these aim to facilitate better joint working around mental health and housing. They focus specifically on mental health, homelessness and ASB. Key organisations (Mental Health Services, Registered Providers, Housing Operations and SPEAR) have contributed to early development through providing shadowing for the project manager, and key organisations will attend the first steering group for this project on 27/11/14. The steering group will continue to provide expertise to the development of the protocols, with a target end date for this project of March 2015. The intention is then to embed the protocols within organisations through joint training between housing and mental health staff. (DanButler/BethanyPepper-21/11/14)	The Draft Protocols for Out of Hospital Discharge and Information sharing have been completed (March 2015). The strategic overview for the protocols will be monitored via the Tenant's Champion quarterly meetings. Work on joint training to embed the protocols and allow staff from mental health and housing to better understand roles and pressures will take place at least twice a year with the first event planned for June 2015. (DB 5/6/15)
OP			Commission day respite service via new purpose-built premises for older people with dementia or other mental health coditions	(e)New build in partnership with Homelink completed Nov 2014.	Homelink, Chief Executive	Due to be completed November 2014 to open January 2015. - Homelink 16/10/14	The new centre was opening in January 2015 and the official Grand Opening/Launch will take place on 12th September 2015. (11/5/15)
				(f)Service launched Jan 2015	Homelink, Chief Executive	All on target to open 5 January 2015. - Homelink 16/10/14	Centre opened January 2015 (11/5/15)
			Increase the effectiveness of employment and training services.	(g)Evidence outcomes of the commissioned Employment services ie: number of adults in secondary mental health care in employment increased by 10% by Sept 2015	Remploy, Service Manager		
OP	4.4	**PROVIDE MEANINGFUL ACTIVITIES FOR OLDER PEOPLE WITH DEMENTIA AND MENTAL HEALTH**	Provide meaningful activities through Council run centres for people who meet Fair Access to Care (FACS) eligibility criteria.	(a)Monitor attendance and effectiveness of Woodville and Sheen Lane day centres.	LBRuT, Day & Community Services Manager, Adult & Community Services, LBRuT	Sheen lane Day Centre is open 5 days a week and the average weekly attendance (25) is in line with the capacity of the day centre. While the Woodville Centre is open 7 days a week and the average weekly attendance (35 Monday to Friday and 15 at Weekends) is in line with the capacity for the centre.	no further update
				(b)Woodville to complete process of signing up to Dementia Pledge.	LBRuT, Day & Community Services Manager, Adult & Community Services, LBRuT	Sign up to the Dementia Pledge is complete	no further update
	4.5	**ENSURE THAT RELEVANT SECTIONS OF THE HALTH AND SOCIAL CARE ACT ARE IMPLEMENTED**	Prepare and agree plan and schedule for implementation of key provisions of the Care Act 2014	(a)Implementation plan issued for consultation and agreement with key partners by September 2014	LBRuT, Head of Performance & Quality Services, Adult & Community Services	Information on the implementation of the care act is published here http://www.richmond.gov.uk/home/services/adult_social_care/adult_social_care_policy/the_care_act/the_care_act_in_richmond.htm	
5	**PRIORITY : MAINSTREAMING MENTAL HEALTH AND REDUCING STIGMA**						
OP	5.1	**BUILD GREATER UNDERSTANDING OF MENTAL HEALTH ISSUES AMONG PROFESSIONAL AND**	All organisations to ensure staff / volunteers are trained to required level to deliver mental health services.	(a)Evidence training completed.	Homelink, Chief Executive	All Homelink nursing staff now hold a level 3 diploma in dementia care and all volunteers have recieved dementia training and the majority are now dementia friends.- Homelink 14/10/14	All staff and volunteers are now Dementia Friends. We are extending the Dementia Friends training to our carers and this training is due to take place in June 2015. (11/5/15)

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
					SWLStG, Service Director	• All new staff and Volunteers attend Trust Induction which provide the basic training. • Then mandatory training covers more specific learning needs based on job role. • Specialised training is provide on an individual basic. SWLStG,14/10/14	
					HRCH, Service Director	Staff made aware and can access all relevent training (HRCH 26/11/14)	Internal Foundation level dementia awareness training in place. Access to 'No health without mental health' training advertised and made accessible to all staff (HRCH 20/07/15)
					CILS : INS	INS ensure that all relevant training for our staff team is promoted, and that staff are available to attend to develop their knowledge of mental health. - INS 17/10/14	Information Navigators are now managed by Richmond AID but we had ensured all were trained as Dementia Friends. We have Information Navigators based in RB Mind and Alzheimer's Society who provide the lead on mental health/dementia.
					CILS : Age UK	5.1a:GoLocal's Community Mental Health Development Worker and Info Navigator have promoted the service extensively across the borough e.g. meetings with Social Workers, CMHT. All staff have completed Mental Health & Well-being training. The CMHDW is a qualified social worker and has additional training around mental health, and other training is attended as identified and appropriate - GoLocal 21/11/14	5.1a:GoLocal's Community Mental Health Development Worker and Info Navigator have promoted the service extensively across the borough e.g. meetings with Social Workers, CMHT. All staff have completed Mental Health & Well-being training. The CMHDW has additional training around mental health, and other training is attended as identified and appropriate - GoLocal 17/6/15
					RB Mind, Chief Executive	RB Mind recruits appropriately qualified frontline staff. All staff undertake Safeguarding training. Office staff undertake training to deal with MH presentations over the phone. Other specialised training given as required. - RBM 3/11/14	As before. RBMind offers MH awareness training and participates in Time to Change Initiatives. Actively engaging local employers to introduce MH awareness in the workplace. VF 30/6/15
					all organisations	As part of our learning and development programme, all resident facing staff are required to undertake training in relation to mental health. We provide our own in-house training, regularly attend legal training in relation to mental health issues that is presented to us by our partnering solicitor firms, and we also liaise with the various local authorities that we engage with who provide their own training to staff working in the borough. In Richmond specifically, the Neighbourhood Services Officers and Team Leader has enrolled onto a training course provided by the Richmond Wellbeing Service. - L&Q 7/11/14	HRCH - Access to 'No health without mental health' training advertised and made accessible to all staff (HRCH 20/07/15)
					Metropolitan Housing, Service Manager		**Metropolitan** has a comprehensive Learning and Development Programme and all staff are required to follow the approrpriate learning pathrway to enable them to confidently support our customers. On-line modules, specific courses around mental health and bespoke training form part of this programme. Our service development leads are available to offer their expertise in identifying and delivering appropriate training in order that our team can meet the changing needs of specific individuals. Additionally we attend relevant training provided by Richmond Wellbeing. (CS 1/7/15)
					RB Mind, Chief Executive		**RBMind** offers MH awareness training and participates in Time to Change Initiatives. Actively engaging local employers to introduce MH awareness in the workplace. VF 30/6/15
					PAH, Service Manager		All PAH staff are trained in communication bespoke to their level of expertise. Social workers are trained counsellors to level 3All staff are trained in safeguarding, DoLS and are able to escalate to mental health teams as appropriate (16/6/15)
					RHP		All RHP employees that work in the Customer Support and Retirement Housing teams have received safeguarding eLearning and Level 1 training. One of our scheme managers has sucessfully acheived trian the trained for safeguarding. In addition all have attended "no health without mental health" and Dementia awareness and recently became Dementia friends. The team delivers a number of awareness training to other front facing teams including caretakers and repairs operatives which is planned for Q2. (RHP 16/6/15)
					Paragon	Paragon actively supports and encourages training for front line officers in mental health training and as such has extensively taken up training opportunities provided by Richmond Wellbeing Service. Paragon also has 2 Dementia Champions who have responsibilty for delivering Dementia Friends information sessions across the different services within the organisation LW 09/01/2015	Paragon actively supports and encourages training for front line officers in mental health training and as such has extensively taken up training opportunities provided by Richmond Wellbeing Service. Paragon also has 2 Dementia Champions who have responsibilty for delivering Dementia Friends information sessions across the different services within the organisation LW 09/01/2015
					L&Q Group	As part of our learning and development programme, all resident facing staff are required to undertake training in relation to mental health. We provide our own in-house training, regularly attend legal training in relation to mental health issues that is presented to us by our partnering solicitor firms, and we also liaise with the various local authorities that we engage with who provide their own training to staff working in the borough. In Richmond specifically, the Neighbourhood Services Officers and Team Leader has enrolled onto a training course provided by the Richmond Wellbeing Service. - L&Q 7/11/14	As part of our learning and development programme, all resident facing staff are required to undertake training in relation to mental health. We provide our own in-house training, regularly attend legal training in relation to mental health issues that is presented to us by our partnering solicitor firms, and we also liaise with the various local authorities that we engage with who provide their own training to staff working in the borough. In Richmond specifically, the Neighbourhood Services Officers and Team Leader has enrolled onto a training course provided by the Richmond Wellbeing Service. Additionally to this Sarah Atkinson, the Neighbourhood Services Team Leader, has been working on the project group whose aim is to develop and provide training around the new inter-agency joint working protocols that have been devised to strengthen the way in which housing providers and CMHT staff work together to maximise the outcomes for residents with mental health issues. L&Q 30/06/15
			Commission training and education (eg "Mental Health First Aid") to develop competence in recognition of signs and symptoms of mental illness, to include dementia, among frontline staff in a range of health, housing, social care and other	(b)See 2.5	JCC, Commissioning Manager	The JCC have been successful in a bid to Heath Education South london (HESL) The workforce development award is specifically aimed at educating the Health and Social care and Service Users workforce across all sectors in No Health without Mental health . The ambition is to provide this training to 400 + participants. Commissioning Manager, JCC 10/10/14	The No Health Without Mental Health training is on target to reach 400+ participants by end of July 2015. The JCC are waiting to hear from HESL if the 3rd phase of the project (evaluation across 4 broughs) will be funded. (AJ-8/5/15)
					SWLStG, Service Director	• The SWLSTG - Recovery College provides' understanding MH ' courses that is available to all staff volunteers and service users. SWLStG,14/10/14	
					HRCH, Service Director	Dementia training for staff has been prioritised by the Trust. Four dementia trainers have been identified from within clinical services and they deliver the training to staff. Director of Quality and Clinical Nursing has led on dementia friendly training, open to all staff.(HRCH 26/11/14)	Ongoing delivery of dementia foundation level training. Dementia awareness now one of three HRCH quality priorities for 2015-16 (HRCH 20/07/15)
					LBRuT, Workforce Development Manager, Adult & Community Services		
OP			Richmond Council has signed up to a Dementia Compact in order to commit to improving the lives of people with dementia.	(d)Six monthly reporting required on committed outcomes.	JCC, OPMH Commissioner	The dementia commitment is updated 6 monthly and published on the LA website http://www.richmond.gov.uk/dementia_commitment. OPMHCM 10/10/14	
					Homelink, Chief Executive	Homelink has signed up to the Dementia Compact - Homelink 14/10/14	Homelink is also part of the Dementia Action Alliance (D.A.A.) The C.O.O. Sue Hodder was invited to talk about our new dementia care centre at their recent AGM and invited people to visit the centre which is a beacon of excellence in our community. (11/5/15)

		Objective	Task	Milestones *(targets)*	Lead	Evidence / Progress Report All leads to complete	Evidence / Progress Report All leads to complete
OP			Create a Dementia Action Alliance (DAA) with local businesses and organisations to enable businesses to learn how to become dementia friendly through training for their staff offered to DAA members	(e)Launch of DAA planned for March 2014 .	JCC, OPMH Commissioner	(see 2.1 above) Richmond DAA has now been launched and has a total of 31 organisations/services that have signed up @ October 2014. We will be writing an evaluation including the successes and challenges of the DAA members in becoming dementia friendly. This report will be available in March 2015 to document the first year's progress. - Polly Sinclair 14/10/14.	
						SWLSTG are members of the DAA since May 14. Through AS and the VALID projects, SWLSTG working with other organisations in the provisions services for DAA. SWLStG,14/10/14	
				(f)To be reviewed March 2015 (see 2.1)	LBRuT, Director of Public Health		
OP			Commission/provide further MH training for professional practitioners including GPs and specialist MH staff	(g)An online training for dementia awareness is being rolled out across 29 participating GP practices, all practices should be participating by April 2014.	LBRuT, Workforce Development Manager, Adult & Community Services		
				(h)ACS Adult workforce development to commission relevant MH Act training based on annual training needs analysis by Dec 2014. (see 2.2, 2.5, 5.1)	LBRuT, Workforce Development Manager, Adult & Community Services		
OP	5.2	**BUILD CAPACITY OF CARE HOMES TO PROVIDE HIGH QUALITY CARE FOR PEOPLE WITH DEMENTIA**	Undertake Care Home Pilot -with the aim of establishing a model for improving care management in care homes, improving coordination and quality of care ,early diagnosis, and reducing the number and length of unplanned hospital admissions among patients with dementia	(a)A clinical nurse specialist to lead multi-factorial intervention in care homes, initially starting where non-elective admission rates exceed the borough average in place by Sept 2014.	HRCH, Service Director	HRCH was not commissioned to undertake this pilot (HRCH 26/11/14)	HRCH community dementia clinical specialist roles (2.0wte) now recruited to. These will play a key role in supporting early diagnosis, management and appropriate referral on to specialist services, as well as supporting patient journey across care settings (HRCH 20/07/15)
				(b)Evaluation completed by Nov 2015.	HRCH, Service Director	N/A (HRCH 26/11/14)	N/A (HRCH 20/07/15)
OP			25 year contract with Care UK for the provision of residential and nursing care in three care homes in the Borough. 39 beds across the service portfolio are being reconfigured, allowing some current standard residential beds to be re-designated residential dementia and nursing dementia, supporting people with	(c)Availability of the reconfigured beds for people with higher support needs will be coming on line in phases in 2014. Necessary building alterations to enable the reconfiguration (for which the Council has a shared responsibility) will be carried out.	LBRuT, Assistant Director, Adult & Community Services	Completed 1.4.14 and incrementally implemented from that point. The building work was completed 1.8.14. Further work to model our bed requirements for people with enhanced needs going forward now sits with the JCC, which will inform any further recommissioning	
OP	5.3	**CARE HOMES AND QUALITY ASSURANCE**	The Council's Quality Assurance team to be actively involved with all 19 care homes in the borough.	(a)Hold quarterly forums to discuss various issues that affect the service, visit the homes to check performance and offering support to improve standards. Dementia awareness training and dementia best practice events to be made available to all cares homes operating in the borough	LBRuT, Head of Performance & Quality Services, Adult & Community Services		
	5.4	**ARMED FORCES**	To review activities being undertaken to	(a)To report on relevant MH aspects of the Armed Forces	Groundworks, Service Manager		