South Gloucestershire Dementia Strategy

2017–2020

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South Gloucestershire Council

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Welcome

Older people are an important and growing population in South Gloucestershire. We celebrate the fact that we are living longer. To maintain good health and to stay well we need to work together as a community to provide care and support both when people are well and when their health is not so good.

In South Gloucestershire we want to make real change for older people and are jointly developing strategies on three issues that significantly impact on older people's wellbeing: dementia services, falls prevention and support for carers. Some younger carers care for older people, and many are older people also care for each other.

These matters do not affect anyone in isolation. All three can be part of an individual's daily life and it makes sense to develop them together.

In South Gloucestershire there are approximately 3,300 people with dementia and this is set to increase to 5,200 by 2025. We know that as well as changing the life of the person with dementia, dementia has a significant impact on the lives of relatives, friends and neighbours who often take on caring roles.

We want people with dementia and their carers to live well and be supported to do so throughout the progression of the disease. They will know about and be able to access the right support and services at the right time. We want dementia to become everyone's business. This means that we need to ensure everyone knows about dementia and that people can live well with dementia, throughout the progression of the disease, in South Gloucestershire.

This strategy and action plan sets out how South Gloucestershire Council and South Gloucestershire Clinical Commissioning Group and partners will work together to improve the lives of people with dementia and their carers and we hope that you will support and join us in this challenge.

PHOTOS

Matthew Riddle – Health and Wellbeing Board – Chair

Jane Gibbs – Health and Wellbeing Board – Vice Chair

Introduction

There are high human and economic costs associated with dementia. These costs include impact on the health and wellbeing of the person with dementia and people close to them, as well as the cost to society of their services and support.

In recent years there has been an increased focus on dementia both nationally and locally because the population is ageing, and this has led to increasing numbers of people with dementia.

This strategy has been developed by South Gloucestershire Council and South Gloucestershire Clinical Commissioning Group in conjunction with local partners from the statutory and voluntary sector, as well as through talking to people with dementia and their carers about their experiences in South Gloucestershire.

The main purpose of the strategy and action plan is to provide a framework for commissioning and service delivery which ensures that people in South Gloucestershire with dementia and their carers are able to live well and are supported to do so throughout the progression of the disease. This will be achieved by enabling access to the right support and services at the right time, whether that be from their local community or health and care services.

We recognise that minimising people's risk of developing dementia is also important for the population as a whole and the strategy also describes ways in which we will raise awareness of the healthy lifestyle choices people can make to reduce their risk of dementia, and stay fit, well and independent as they get older.

Dementia is everyone's business; looking after our personal health and to support people with dementia and their carers in South Gloucestershire is not just the reserve of specialist care services.

The South Gloucestershire Dementia strategy and action plan will:

- set out the vision for what we want to achieve
- help co-ordinate the excellent work that is already ongoing
- identify key priorities for what needs to improve
- maximise opportunities for identifying synergy and potential for cross-agency working
- engage local people in discussion on what works best for them

Ensure that we keep people living with dementia central to everything we do.

Why we need better care

Local health and care system do not always work well for the people using them. It can be complicated and difficult to move from one service to the next. Health and care professionals often work independently of each other, rather than together, when looking after people. Some services which are currently delivered in hospitals would be better delivered in the community, close to people's homes.

At the same time, the demand for health and care services is rising. We have an ageing population and a growing number of elderly people needing more intensive care and support. It is clear that we need to work differently to deliver the care that we will need, now and in the future.

Our aim

That people in South Gloucestershire with dementia and their carers are able to live well and are supported to do so throughout the progression of the disease.

What we want to achieve

Our vision is for joined-up health and care service with support that has the individual at the centre and empowers them to remain independent and well for as long as possible.

Better coordinated support that focuses on a person's well-being, health and care needs, can reduce their dependency on services in the long run and reduce or prevent hospital admissions. We want to provide more care in the community so that people can be supported to live safely and independently at home for as long as they wish. We also want to make sure that services work together more effectively to support people and their families, while helping people to access the voluntary social networks that are available in their communities.

Our priorities for action

1. Increase awareness and understanding of dementia amongst professionals and the public
2. Improve diagnosis rates and ensure a timely diagnosis for those with dementia. Ensure high quality information about dementia, local services and support is available to all those with a dementia diagnosis and their carers
3. Develop care and support to meet the needs of individuals with dementia and their families and other carers, to maintain independence and avoid crisis
4. Recognise the contribution of carers, and encourage and enable them to look after their own health and wellbeing as well as those they care for
5. Improve provision for people who can no longer live at home, supporting care homes to meet the needs of people with dementia and developing alternatives
6. High quality hospital care for people with dementia, including pathways to ensure appropriate and timely discharge.
7. High quality end of life care

Common themes across these work streams

- Safeguarding is everybody's business
- Planning and service provision based on evidence and intelligence about local need
- The benefits of a healthy lifestyle in reducing the risk of dementia and slowing its progression
- Services and support are available near to people's homes and in community settings
- The Five Year Forward View for Mental Health NHS Plan and complementary initiatives in social care, housing and the wider voluntary sector

- Working with people with dementia, their families, other carers and providers of mainstream and specialist dementia services and support to meet their need
- Strategic partnerships with colleagues in Bristol and the local universities through the Dementia Health Integration Team (HIT) of Bristol Health Partners and the Strategic Clinical Network's South West-wide Dementia Improvement Group (DIG)

Background information about dementia can be found in the JSNA
http://edocs.southglos.gov.uk/completejsna/pages/adults/dementia/

People at risk of developing dementia

Age is considered the highest risk factor for dementia, and the percentage and numbers of older people in the population is increasing. There is evidence for mid-life healthy lifestyle approaches to delay or prevent onset of dementia; the potential impact on future prevalence and service demand is not yet fully understood.

Keeping one's mind active, being socially active, exercise, blood pressure control and other measures already known to reduce heart disease have been shown to reduce the risk of developing dementia. There is concern that due to the large areas of rural geography in South Gloucestershire, people may become socially isolated.

Dementia with learning difficulties

People with learning difficulties, particularly those with Down's syndrome, are at increased risk of developing dementia. About 1 in 5 people with a learning disability who are over the age of 65 will develop dementia. People with learning disabilities who develop dementia generally do so at a younger age. Studies have estimated that 1 in 50 people with Down syndrome develop dementia in their 30s, rising sharply to more than half of those who live to 60 or over. If a person with a learning disability develops dementia, they will face different and additional challenges to people who do not have a learning disability (Alzheimer's Society Factsheet).

Technology

Technology can be used to support people with dementia in many different ways. People with dementia and their carers already use various types of telecare to help them complete daily tasks and live safely. We are working with various partners to develop and pilot innovative ways to support people with dementia.

Where are we now?

National and local policy, legislation and guidance and key drivers

There are a number of national strategic drivers that have helped to shape the strategy. These include:

- The National Dementia Strategy, 'Living Well with Dementia' 2009 (Department of Health, 2009)
- Quality Outcomes for People with Dementia: Building on the Work of the National Dementia Strategy 2011 (Department of Health 2010)
- The Prime Minister's Challenge on Dementia 2020 – Delivering Major Improvements in Dementia Care and Research by 2015 (Department of Health, 2012)

More operationally, the 2016/17 NHS planning guidance expects services to achieve measurable improvement in all areas of the Prime Minister's challenge on dementia 2020, including:

- achieve and maintain a diagnosis rate of at least two thirds (67%)
- increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral
- improve quality of post-diagnosis treatment and support for people with dementia and their carers

Care Act, 2014

The Act has most relevance for people with dementia and their carers in these areas:

- general responsibilities of local authorities
- determining who is entitled to care and support
- charging for care and financial assessment – personal budgets
- integration and partnership working between health, social care and housing
- information, advice and advocacy
- adult safeguarding

Five Year Forward View 2015

This plan for the NHS is far ranging and gives priority to:

- helping people to lead healthier lives
- giving people more control of their own care
- more integrated treatment and care, across health and social care, primary and secondary care and physical and mental health ('Parity of Esteem')
- care provided in a uninstitutional setting as possible
- stronger partnership between NHS, councils and local communities

Expanding the Options Service Review 2015

South Gloucestershire Clinical Commissioning Group commissioned a dementia services review (Expanding options for people living with dementia, by Trevor Eardley of Organi Consulting, 2015) which found that service users and their carers feel that there is a lack of coordination of support across agencies. This is a particular problem for those with complex needs. Another problem identified is that the majority of support is only accessible between normal office hours and the availability of emergency respite is limited and difficult to access.

Most of the recommendations in the 'Expanding options for people living with dementia' report relate directly to services, but the three below are about how we plan these services and support:

- The dementia strategy should be fully costed and be underpinned by a detailed implementation plan, the delivery of which should be regularly monitored and reported on (recommendation no 1)
- There is a detailed mapping exercise which plots high levels of dementia in the population, ward by ward, against the location of current services (recommendation no 2)
- A project management discipline should be adopted for the delivery of projects and initiatives within an overall programme dictated by the dementia strategy (recommendation no 3)

Asset Based Community Development (ABCD)

Building on existing resources, recognising the unique contribution of:

- people with dementia themselves and their potential to live well
- families and friends capacity to support them to live well
- neighbours and local communities welcoming people living with dementia
- voluntary sector capacity building, community development and advocacy
- public sector funding person centred services, infrastructure and support
- private sector welcoming people living with dementia as customers
- partnerships to combine above strengths to help people with dementia live well

Safeguarding is everyone's business

It is important to recognise that people with dementia and their carers may be vulnerable and at risk of abuse and neglect. The largest proportion of abuse happens in people's homes, but can happen wherever they live. Unintentional abuse can occur at any time. Abuse and neglect can take many different forms including physical, medical or emotional neglect, physical or psychological abuse, financial or sexual abuse. There is evidence to show that abuse is higher than average among people with dementia and that people with dementia can be particularly vulnerable to abuse.

Current service provision in South Gloucestershire

Improving care and support for people with dementia is a priority and features in a number of work streams including the Better Care Fund programme and Urgent Care and includes:

- Dementia Action Alliance and Dementia Friendly initiatives
- Dementia advisors
- improving diagnostic pathways
- preventing unplanned hospital admissions
- improving hospital care
- reducing delayed transfers of care
- support for care homes and end of life care planning

More strategically the Dementia Health Improvement Team (HIT) work together and have developed action plans for five work streams:

- transforming care
- dementia friendly
- patient and public involvement
- workforce
- research

A key theme of all this work is a change in focus toward risk reduction, early intervention and community based support, thereby delaying the point where a person's care needs become more serious. Since 2015 South Gloucestershire Council, South Gloucestershire Clinical Commissioning Group, Avon and Wiltshire Partnership and other partners have been increasingly working together in clusters of GP practices through their multi-disciplinary team meetings.

The largest asset in dementia care is unpaid carers, families, friends and informal community support mechanisms around the person with dementia. We need to continue to raise awareness about dementia across our communities enabling carers and communities to support individuals as the disease progresses.

There are a range of services and sources of support available to people with dementia and their carers in South Gloucestershire. The diagram below describes the assets and services available. It illustrates the potential 'circle of support' around people with dementia and their families and other carers in South Gloucestershire.

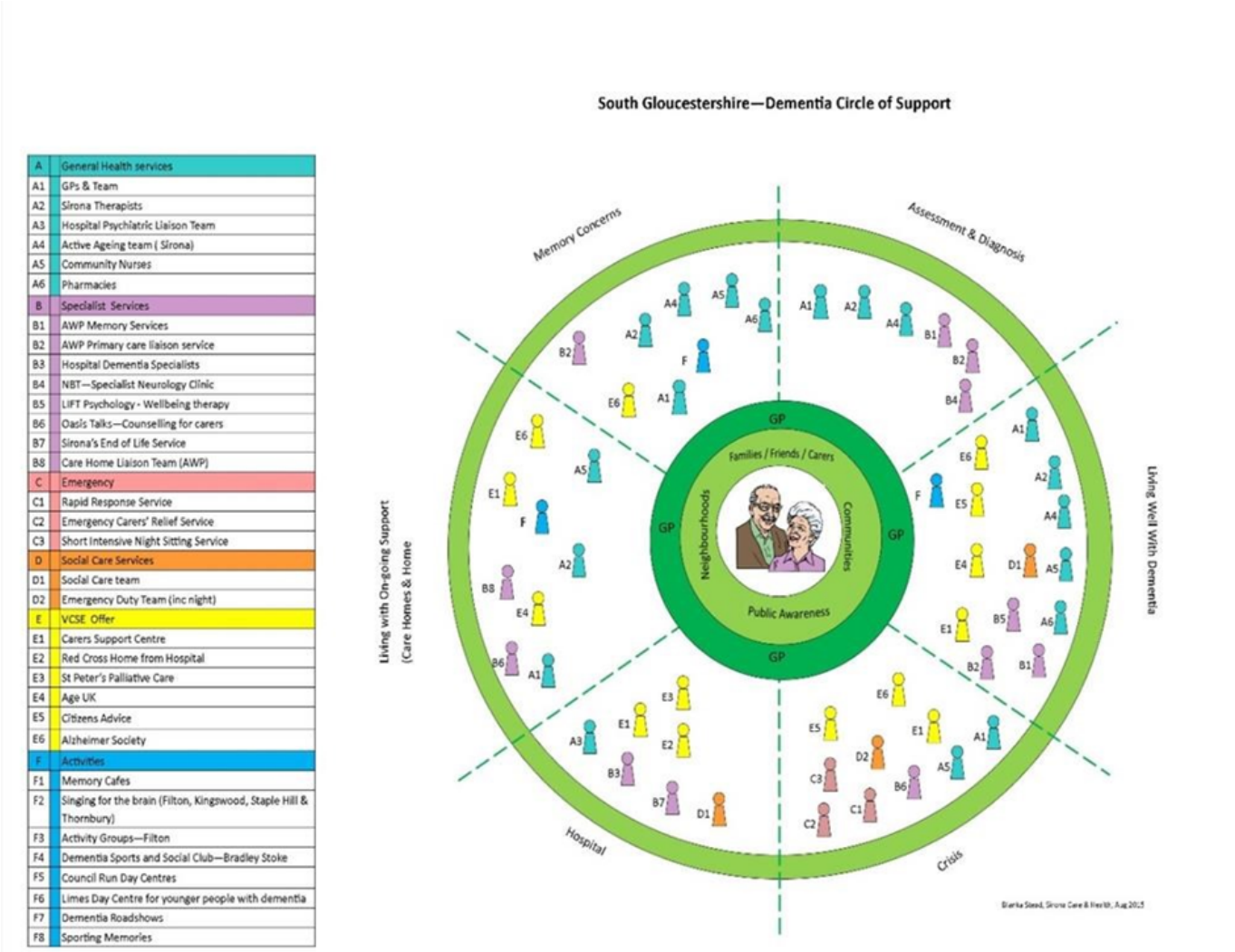
GPs in South Gloucestershire have been instrumental in raising the proportion of people with dementia who have a diagnosis. Since 2012 the proportion of people estimated to have a confirmed diagnosis has increased from 37% to 60%. Our challenge now is to achieve the 67% national aspiration. It is estimated that over 40% of all medical admissions, aged 70 years or over, have dementia but only half have a confirmed diagnosis (NICE, 2006).

ExtraCare Housing enables individuals to live in self-contained flats or chalets within an

environment that promotes privacy, comfort, support and companionship. It is an important component of housing designed to meet the needs of an ageing population where care and support needs can be focussed into individual housing developments as required. We have an aspiration to develop an Extracare facility which will be a life time home for someone with dementia. Enabling people with dementia to become resident during the early phase of the disease through to supporting them as the disease progresses and an advanced stage with the appropriate levels of care and support.

There is a range of both statutory and non-statutory community based services available, however, an increasing number of people may require a stay in hospital or respite, reablement or permanent care in residential and nursing accommodation.

We work with our health partners on effective patient flows, including supported discharges from acute hospital trusts but the demand for home care and care home beds, particularly affordable care home beds, continues to outstrip demand across South Gloucestershire, its neighbouring areas and across the country itself. Care home bed placements with higher demand and increased costs for providers, indicate that costs to local authorities and health partners are set to continue to rise.



Where we want to be

We aim to deliver this strategy within existing funding commitments. Any changes to delivery will be achieved by redesigning services and will use existing funding differently to achieve the required aims.

By delivering the priorities and actions set-out in this strategy we aim to ensure that people with dementia and their carers are treated as individuals and are able to access the right support and care, at the right time so that they can continue to live well with dementia within supportive and understanding communities. Our vision for South Gloucestershire involves every member of the community. We will work with local communities to support, understand and include people with dementia so that they can live well as active and valued members of our society.

For those living with dementia we will ensure that there is an appropriate diagnosis pathway and that services are joined up so that it is easy for people to access the support and care and that they need, to avoid crisis, without falling in to gaps between services.

We will take a proactive approach to supporting people to stay within their home and community wherever possible through the provision of care and support so that they can live well on a daily basis. At difficult times, such as crisis or illness, if people do need to travel to health or care services that cannot be delivered within their community, e.g. acute hospitals and/or specialist inpatient hospitals, this will be for as short a time as possible, with the aim to get the person back to their home as soon as possible.

We would like to review the ways in which we offer hospital care for people with dementia. We will investigate and develop a range of options and community facilities to offer range of care and support to meet the various and sometimes complex and challenging behaviours of people with dementia. This will prevent and reduce hospital admission and therefore reducing acute care costs.

When people with dementia need to be in hospital we need to ensure that appropriate care is available in the community to so that they can be discharged at an appropriate time and that their length of stay is not unduly extended.

Wherever possible, South Gloucestershire Council and South Gloucestershire Clinical Commissioning Group will work with these organisations to co-produce new service developments to complement existing service provision and strategic approaches.

Our priorities – 1. Increase awareness and understanding of dementia amongst

professionals and the public

Context

Increasing awareness and understanding of dementia is important to:

- enable people to take steps to reduce their risk of dementia
- encourage people with symptoms to access support
- enable communities to support people with dementia and recognise symptoms in friends and family
- promote professional understanding

There is growing evidence indicating that certain medical conditions such as high blood pressure, diabetes and obesity may increase the risk of dementia, whereas a healthy lifestyle may reduce the risk. We recognise that minimising people's risk of developing dementia is also important for the population as a whole.

Ongoing work

There are a range of local initiatives encouraging older people to have active and healthy lifestyles. We will continue to raise awareness using national public health initiatives promoting healthy lifestyles. Encouraging them to make choices to reduce their risk of dementia, and stay fit, well and independent as they get older.

South Gloucestershire Dementia Action Alliance will continue to work with Dementia Friends and other partners to increase understanding of dementia and build community support for people with dementia.

We will continue to offer the local 'Living Well with Dementia' roadshows and new dementia guide to services.

Future plans

Continue raising awareness of dementia amongst minority communities.

Investigate and develop mix of roadshows, delivering them in GP surgeries as well as in large community facilities.

Ensure that health and care staff are aware of and promote the importance of healthy lifestyles.

Through the Dementia HIT link up health, social care and hospitals to create generic dementia training. Enabling the workforce to move between sectors without needing to take additional training.

2. Improve diagnosis rates and ensure a timely diagnosis for those with dementia

Context

Timely diagnosis for those with dementia, their carers and families will promote choice, allow them to plan for the life changes they will experience, and access support needed to maintain independence.

GP education and awareness raising has been a key focus in South Gloucestershire over recent years and diagnosis rates have increased. However more needs to be done to make people aware of the signs and symptoms of dementia and the help available, to encourage them to seek help and get access to timely treatment and support.

Ongoing work

Supporting GP practices to ensure that all people with memory concerns have a timely assessment, and diagnosis if appropriate.

Working with Avon and Wiltshire Partnership and other partners in the Strategic Clinical Network's Dementia Improvement Group to enable us to demonstrate that people referred to the Memory Service for assessment receive their diagnosis within six weeks.

The Care Home Liaison service is developing its offer to care homes, a combination of support with the management of individual residents and training tailored to the needs of their staff.

We use the DLD dementia screening tool to establish a baseline and monitor people with Down Syndrome. For other learning difficulties we use the same assessment, but gain a baseline when changes are already indicated. We maintain a local data base to ensure that repeat DLDs are completed in a timely way and all changes are recorded to ensure people are supported through the dementia pathway.

Future plans

Build on the current GP knowledge base to improve the recognition of cognitive decline and normal changes with age.

Consider a self-referral clinic for people worried about their cognition.

Improve diagnosis pathway for younger people with dementia to ensure a timely diagnosis.

Investigate the feasibility of ongoing monitoring of people that have had a diagnosis of mild

cognitive impairment for potential progression to a dementia diagnosis.

Ensure collaboration between different services so that they are aware when someone may have a diagnosis of dementia (because the person with dementia may not remember this).

Ensure that undiagnosed cognitive impairment in secondary care or social care is reported back to the GP to investigate.

Continue to develop the message to the public that there are positive aspects to having a diagnosis including remaining 'in charge' of decisions by making and appointing a Lasting Power Of Attorney.

South Gloucestershire Clinical Commissioning Group will support GP practices to be recognised as 'Dementia Friendly Surgeries'.

Sirona and other providers of community health and voluntary sector services will ensure that people with cognition concerns are offered screening tests and referral to their GP where appropriate.

3. Ensure high quality information about dementia, local services and support is available to all those with a dementia diagnosis and their carers

Context

Everyone needs good quality information to enable them to make the right choices to plan their future, make the best decisions possible in relation to their care and support needs and to make decisions for a time in the future when they may not be able to make those decisions themselves. This is particularly important to the people with dementia and their carers.

Ongoing Work

The 'Living Well with Dementia' roadshows will continue in 2017/18. We will investigate piloting of 'mini roadshows' in GP practices to compliment the roadshows.

The Avon and Wiltshire Partnership Memory Service offers post-diagnostic support to all people with dementia diagnosis and their carers.

We continue to improve information about services and support for people living with dementia available on the Well Aware website and telephone helpline.

A new, more accessible 'Dementia Guide to Services' has been developed and is available to

replace the Information Prescription.

The Alzheimer's Society offer a local and national information and advice helpline, a range of factsheets, carers groups and social activities to support people with dementia and their carers.

The Community Learning Difficulties Team has a range of accessible information about having a learning difficulty and dementia which includes where you can get support and who might give you that support, information for people who may be more likely to get dementia and the various tests and treatments you might expect if you are being investigated or treated for dementia and have a learning difficulty.

We are piloting Dementia Advisors, a partnership between the Alzheimer's Society and Sirona, to be the main contact to enable people with dementia and their carers to access information and services to meet the needs of the person with dementia generally and when in crisis. Ensuring that they can access the right support and services at the right time.

Community Connectors support individuals: to access a range of information and activities, to develop skills and develop strong local support networks. The aim is to improve individual wellbeing and self-care using social prescribing techniques. The Community Connectors project is a community led by volunteers who will be supported by paid staff, in each cluster.

Future plans

Ensure support and services are available for younger people with a diagnosis of dementia.

Develop the Dementia Advisors pilot into normal working practices.

4. Develop care and support to meet the needs of individuals with dementia, their families and other carers, to maintain independence and avoid crisis

Context

There is a range of different types of support available to people with dementia and their families. If the condition is advanced, some will need of health and care support straight away, while others may not have reached that point yet. However, everyone will need support, advice and help to understand what it means to have dementia, what they can do to live as well as possible with the condition and to enable them to plan for the future.

Ongoing work

South Gloucestershire Council, South Gloucestershire Clinical Commissioning Group, Sirona and

the Alzheimer's Society are collaborating to offer support specifically for people living with dementia in each cluster of GP practices. This service started in summer 2016 and will be provided by a mental health nurse in Cluster 5 and dementia advisor or the Alzheimer's Society in each of the clusters. The Alzheimer's Society will continue to work across South Gloucestershire. The dementia advisor posts are funded for a year, by the South Gloucestershire Clinical Commissioning Group. This collaboration means that people with dementia and their carers will have a named contact that they will be able to liaise with they need support in crisis.

Future plans

Collaboration between dementia advisors, Falls Service, community connectors, integrated care practitioners, Frailty Service and health champions to develop community resources in each cluster and enable individuals to access them and thereby reduce isolation.

Early experience of the dementia advisors will help shape future provision of support for people with dementia and carers with particular regard to:

- The scale of support people require, and the model
- How to meet the needs of different people e.g. younger people with dementia, people from black and other minority communities and advanced dementia
- The level of demand and potential benefit from non-pharmaceutical therapies including cognitive behavioural therapy (CBT), mindfulness and meaningful activities specifically for people with dementia

We have developed a day of specialist training for care home staff to support people with a learning difficulty and a dementia diagnosis. We are hoping to adapt this training and to roll it out to supported living providers and family carers.

We have an aspiration to develop an Extracare development which will be a life time home for someone with dementia. Enabling people with dementia to become resident during the early phase of the disease through to supporting them as the disease progresses and an advanced stage with the appropriate levels of care and support.

We should review commissioning arrangements for individuals living in the community. This should give providers discretion to deploy additional staff on a temporary basis to better manage crises, due either to changes in behaviour, or because of physical illness, thereby avoiding unnecessary hospital admissions. Any flexibility should be time limited, monitored closely and contribute towards the CCG's personalised care target (Expanding Options report recommendation no 4).

A dementia 'hub' should be developed which may include at its core extra care housing and/ or nursing care, day services and emergency respite. This new facility could provide a base for out of hours/ crisis response teams (Expanding Options report, recommendation no 13).

Commissioners should keep under review the need for a crisis response team that also works outside of normal working hours, specifically for people living with dementia which also operates out of normal working hours (Expanding Options report, recommendation no 19).

5. Recognise the contribution of carers, and encourage and enable them to look after their own health and wellbeing as well as those they care for

Context

Supporting carers should be an integral part of the care and support package for people with dementia. When carers are well supported, they can provide better care for the person with dementia, leading to better outcomes for all.

Ongoing work

A new 'Understanding and Supporting the Needs of Carers' strategy is out to consultation at the same time as this Dementia Strategy. It focuses on improving support for all carers including those caring for a family member or a friend with dementia.

The Alzheimer's Society and Carers Support Centre deliver training for carers, some specifically for carers of people with dementia, but their capacity to do so is limited.

The Alzheimer's Society offer a local and national information and advice helpline and a range of factsheets to support people with dementia and their carers.

Both local acute trusts (North Bristol Trust and University Hospitals Bristol) have carers strategies and carers support workers to support people in hospital including people with dementia and their carers.

Future plans

Commissioners should support carers organisations to develop strategies to increase the number of training sessions in relation to carers supporting people with dementia.

Training should be based on real life experience Avon and Wiltshire Mental Health Partnership, South Gloucestershire Council, Sirona and other partners are piloting 'Hints and Tips for Real Life with Dementia' training for carers of people with dementia in early 2016/17.

Investigate support for people who do not wish or are unable to attend groups.

6. Improve provision for people who can no

longer live at home, supporting care homes to meet the needs of people with dementia and developing alternatives

Context

By encouraging people to live well with dementia it is hoped to reduce the number of people who will need care homes services, but knowing there is good, affordable care available to people with dementia can reduce anxiety for both carers and the person with dementia. In South Gloucestershire there is a shortage of nursing home places for people with dementia, and little or no alternative provision. On occasion this results in people being placed away from their communities. A lack of availability of respite beds and people whose dementia is causing them to exhibit, behaviours that challenge means that they often spend longer than necessary in hospital.

Ongoing work

There is no nationally recognised training for care and support workers, providers often purchase training by a variety of providers. South Gloucestershire Council has worked with Skills for Care to develop work in this area as well as providing training for people working with people with dementia for home care, care home and other health and social care staff.

We plan to introduce person centred dynamic purchasing for care home placements.

During consultations with care home providers we heard that on occasion there was a reluctance to accept new placements into their home of people with behaviours that challenge. This was because of concerns about the safety of other residents, their staff lacked confidence in dealing with anti-social behaviours and they felt community support services did not support them if they experienced difficulties. We also heard from the care home providers who said that sometimes the only option for people exhibiting anti-social behaviour was to arrange admission to a hospital setting. Care Home Liaison at Avon and Wiltshire Partnership support care homes to manage the residents they find most challenging, most of whom have dementia. In 2015/16 the South Gloucestershire Clinical Commissioning Group made an additional investment to enable them to work with all 40 care homes. A further three year's funding has recently been agreed to enable them to continue to do so, and to develop and deliver training programmes in the care homes. We anticipate through their intervention the lives of people with dementia and living in care homes will be enriched and stable, creating a greater confidence that people with dementia can live well in care homes and reduce the fears and anxiety of people diagnosed with dementia. From a safeguarding perspective it is hoped that improved staff knowledge about meeting the individual needs of people with dementia will reduce the number of incidents between residents.

We have developed a day of specialist training for care home staff to support people with a learning difficulty and a dementia diagnosis.

Future plans

We need to raise awareness with carers about the end stages of dementia and the way that care is given. There should be opportunities for honest and open discussion between medical professionals and family, friends and carers about any decisions to withhold or withdraw treatment.

To investigate respite support for carers of people living with dementia to make it more creative, flexible, and accessible. This should include investigating the development of “pop in”, overnight care, or evening sitting service rather than the service user being placed in a specialist respite accommodation for a number of weeks throughout the year (Expanding Options report recommendation no 6). Potentially redistributing funding from acute hospitals into community provision.

It has been calculated that one new care home with nursing that provides services for people with dementia needs to open in South Gloucestershire annually. South Gloucestershire Council has marketed three development care home development sites. We also know that three new care homes with nursing which will provide services for people with dementia are either being built, or have recently been completed in the area. To support the market South Gloucestershire Council has made a commitment to block commission nursing dementia beds for a period of years with new care home sites.

We will continue to encourage further private investment to build care homes to provide choice for people considering living in a care home.

In addition to increasing the number of care homes we need to continue developing and retaining and increasing the number of people who work in care homes and consider building a career in care homes.

Investigate mapping information to give precise details of the number, location and additional capacity needed to address the shortfall in specialist care home provision. (Expanding Options report recommendation no 7).

Investigate the development of specialist Extracare housing for people with dementia (Expanding Options report recommendation no 8).

Explore whether specialist Shared Lives placements could be an alternative to care home placements and/or emergency respite (Expanding Options report recommendation no 9).

Investigate requiring specialist care homes to become accredited to the Dementia Quality Mark for Care Homes, or similar quality mark (Expanding Options report, recommendation no 10).

7. High quality hospital care and alternatives to

hospital care for people with dementia, including pathways to ensure appropriate and timely and discharge

Context

The length of stay of for people in North Bristol Trust has reduced in the past two years but the length of stay for people with dementia is twice that of people of the same age who do not have dementia.

Most people admitted to the South Gloucestershire Clinical Commissioning Group's beds in Laurel Ward, Callington Road Hospital stay for months not days. Their health often deteriorates before they can be discharged, and other people are denied access to assessment.

Ongoing work

North Bristol Trust has a dementia team of: clinical lead, dementia matron and a dementia trainer. The trust is working towards improving the admission for people with dementia, by providing meaningful activity programmes and a better environment, developing the care pathway for people with cognitive impairment or dementia.

Hospital is not the right place to make a diagnosis of dementia so GPs are informed when the inpatient team thinks there may be a problem with cognition. All members of staff (clinical and nonclinical) receive training in dementia. There is a cognitive care bundle which should allow personal care plans to be in place for each person.

North Bristol Trust and the Alzheimer's Society have established a Memory Café at Southmead Hospital that has been of great support to people living with dementia and carers.

We have specialist learning difficulties hospital liaison nurses at Southmead Hospital to support people with learning difficulties and dementia.

Work has started to define operational standards consistent with the Choice Directive for Laurel Ward at Callington Road Hospital. A priority for 2016.

Avon and Wiltshire Partnership improved the physical environment on Laurel Ward, Callington Road in 2015.

Future plans

Laurel Ward at Callington Road Hospital should be supported to undertake a further streamlining of existing processes in order to reduce delays and minimise risks associated with protracted lengths of stay (Expanding Options report recommendation no 14).

Consider any potential value in co-locating adult social work practitioners within inpatient units (Expanding Options report recommendation no 15).

Share the learning from initiatives in the acute sector and Avon and Wiltshire Partnership, where appropriate, and apply to relevant parts of each organisation (Expanding Options report, recommendation no 16).

Laurel Ward at Callington Road Hospital should clarify and widely publicise its admission criteria and explore how its staff team can be creatively deployed to support safer discharge (Expanding Options report, recommendation no 17).

Commissioners should explore the feasibility of a 'Discharge to Assess' model and possible associated step down facility for people with dementia (Expanding Options report recommendation no 18).

Commissioners should develop, with partner agencies, appropriate guidance for the implementation of the Choice Directive (Expanding Options report, recommendation no 20).

We are investigating the Discharge to Assess process to ensure that people with learning difficulties have the same access to this service. Considering whether there is a need to commission specialist beds in the future. recommendation no 10).

8. High quality end of life care

Context

Dementia is a progressive condition for which there is currently no cure. All people who develop dementia will have dementia at the end of their lives, either as the condition they die from or as a factor which may complicate the care of a different condition. People with dementia have the same right to a good death as people with other health conditions.

Diminishing capacity means that it is important for the person with dementia to plan for the end of their life at an early stage. Problems with capacity and communication can also contribute to undignified treatment and the treatment of pain in people with dementia at the end of their lives.

The Department of Health (2008) suggests that, for many, a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. However people with dementia may not be referred for specialist end of life care or receive appropriate treatment.

Ongoing work

We offer courses for managers and practitioners who work with people with dementia to consider approaches and practices that work well when connecting with people who live with dementia as

the disease progresses.

The End of Life Coordination Centre operates seven days per week and coordinates referrals for end of life care in the last few months of an individual's life to enable people to choose where they want to be cared for. We know that most people want to die at home instead of in hospital but it doesn't always happen. We want to make sure individuals and their carers feel supported and confident to cope at home at end of life where this is a person's preference and that the right care is provided at the right time by the right services and staff.

Our practice ensures that there is a specific focus on good end of life care and planning for people with learning difficulties and dementia.

Future plans

Dementia advisors will encourage all people with dementia to record their wishes for person with dementia to plan for the end of their life at an early stage.

We should always focus on quality of life, rather than length of life, in the final stages of dementia. Withholding or withdrawing treatment is especially ethically complex and emotionally challenging for a person with dementia as they may lack the ability to communicate, the capacity to make decisions and may not have prepared instructions about their wishes. There should always be an honest and open discussion between medical professionals and family, friends and carers about any decisions to withhold or withdraw treatment.

The quality of life and comfort of the person with dementia is paramount. Palliative and comfort care should be available to the person at all times and appropriate emotional support should be available for families.

Declining ability to communicate characterises the later stages of dementia. All health and social care professionals should be trained to provide high quality, person centred care to improve dignity and quality of life even when communication has diminished. We need to ensure that people working with someone at the end of their life are able to communicate honestly and sensitively, both to the person with dementia and their families.

Action plan and governance

Action plan

The detailed commitments that will help us achieve this strategy are in our action plan.

The action plan also address the priorities, improvements and gaps identified in the Dementia JSNA. The action plan will be led by South Gloucestershire Council and South Gloucestershire Clinical Commissioning Group and will be delivered in partnership with the local organisations from whom we commission services.

This is not a fully costed action plan, as suggested in the recommendation from the Expanding the Options Report. Having reviewed the complexity and patchwork of funding that makes up dementia support and care in South Gloucestershire and it has not been possible to develop the detailed financial information required to do this.

Governance

The action plan will be overseen by the South Gloucestershire Dementia Planning Group.

This group is a multiagency group that is jointly chaired by South Gloucestershire Clinical Commissioning Group and South Gloucestershire Council and consists of representatives from health and social care organisations and the voluntary sector. It meets bi-monthly and is accountable to the Better Care Fund Delivery Group and the Health and Wellbeing Board via the Older People's Planning Group.

We will endeavour to adhere to these principles in the delivery of this strategy.

Bibliography

National Dementia Declaration, National Dementia Action Alliance
http://www.dementiaaction.org.uk/assets/0001/1915/National_Dementia_Declaration_for_England.pdf

National Dementia Strategy "Living well with Dementia" 2009
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051

.pdf

Quality Outcomes for People with Dementia: building on the work of the National Dementia Strategy, September 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213811/dh_119828

.pdf

The Prime Minister's Dementia Challenge, March 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215101/dh_133176

.pdf

Alzheimer's Society, 2009. Counting the cost. Caring for people with dementia on hospital wards, s.l.: s.n.

Alzheimer's Society, 2014. Dementia 2014: Opportunity for change., s.l.: s.n.

Alzheimer's Society, 2014. Dementia UK: Update, s.l.: s.n.

Alzheimer's Society, 2015. Policy statement - Financial cost of dementia.
https://www.alzheimers.org.uk/info/20091/what_we_think/146/financial_cost_of_dementia

The £20 Billion Question - an inquiry into improving lives through cost effective dementia services from the All-Party Parliamentary Group on Dementia, s.l.: Alzheimer's Society/All-Party Parliamentary Group on Dementia.

Department of Health, 2009. Living Well With Dementia: a national dementia strategy, s.l.: s.n.

Department of Health, 2013. Dementia: A state of the nation report on dementia care and support in England, s.l.: s.n.

Eardley, T, 2015. Expanding the options for older people living with dementia, s.l.:

Unpublished - Organi Associates.

HIT, 2015. Dementia Health Integration Team (HIT)
http://www.bristolhealthpartners.org.uk/health-integration-teams/dementiahit/

NICE, 2006. NICE guidelines [CG42] Dementia: supporting people with dementia and their carers in health and social care, s.l.: National Institute for Health and Care Excellence.

NICE, 2015. Dementia
https://pathways.nice.org.uk/pathways/dementia

NICE, 2015. Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, s.l.: National Institute of Health and Care Excellence.

POPPI, 2015. Projecting Older People Population Information System
http://www.poppi.org.uk/

Prime Minister's Office, 2012
https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Learning difficulties and dementia
https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=10

Appendix one -draft dementia strategy action plan

Version 5 - last updated 9 December 2016

This action plan is owned by South Gloucestershire Council (SGC) and South Gloucestershire Clinical Commissioning Group (CCG). Reports on progress are made to the Dementia Planning

Group.

1. Increase awareness and understanding of dementia amongst professionals and the public

	OBJECTIVE	WHAT WILL WE DO	WHO WILL DO IT	BY WHEN
1.1	Increase awareness of dementia and reduce stigma	**1.1.1** Grow SGDAA work to increase awareness, reduce stigma & build community support.	Winsome Barret-Muir – Southern Brooks	Until August 17
		1.1.2 Increase the number of Dementia Friends in South Glos.	Winsome Barret-Muir – Southern Brooks	Ongoing
		1.1.3 Roll out Dementia Friends for people with learning difficulties	Winsome Barret-Muir – Southern Brooks	December 2017
		1.1.4 Continue working with BME communities to raise awareness	Winsome Barret-Muir – Southern Brooks	Until August 17
		1.1.5 Continue Roadshows and Dementia Guide to Services.	Paul Frisby – CCG Sue Jaques – SGC	Ongoing
		1.1.6 Work towards accrediting GP practices as carer and dementia friendly.	Paul Frisby - CCG Fiona O'Driscoll – SGC	June 2018
		1.1.7 Develop message about the positive aspects of getting a dementia diagnosis.	All	Ongoing
		1.1.8 Raise awareness of dementia amongst businesses to support customers with dementia and large employers to support employees with dementia to continue working	Winsome Barret-Muir – Southern Brooks	Until August 17
1.2	Encourage and promote the value of healthy lifestyles	**1.2.1** Continue SGC initiatives to encourage everyone to be active and healthy.	Sarah Weld – SGC	Ongoing
		1.2.2 Build on national One You Public Health initiative	Sarah Weld – SGC Paul Frisby - CCG	Ongoing
		1.2.3 Health and care staff promote healthy lifestyles.	Sarah Weld – SGC Paul Frisby - CCG	Ongoing
1.3	Connect people with dementia with their friends and communities.	**1.3.1** Community Connectors improving opportunities for all vulnerable adults.	Robin Woodward - Curo	Until March 18

2. Improve diagnosis rates and ensure a timely diagnosis for those with dementia.

	OBJECTIVE	WHAT WILL WE DO	WHO WILL DO IT	BY WHEN

2.1	Continue to improve dementia diagnosis and assessment	**2.1.1** Build on GP knowledge base and support them to provide timely assessment and diagnosis.	Peter Bagshaw & Paul Frisby - CCG	Ongoing
		2.1.2 Demonstrate referral to treatment times for people with cognition concerns are within 18 weeks.	Peter Bagshaw & Paul Frisby - CCG	Ongoing
		2.1.3 Create self-referral pathway for people with young on set dementia and those with memory concerns.	Peter Bagshaw & Paul Frisby – CCG Grace Mawson - AWP	December 2018
		2.1.4 Investigate screening people of dementia as part of regular health checks.	Paul Frisby – CCG Sarah Weld - SGC	June 2017
		2.1.5 Develop and publish a dementia pathway (BNSSG) for people and professionals to use	Dementia Planning Group	December 2017
		2.1.6 Support GP's with clear guidance on how to recognise less common forms of dementia to refer to specialists	Paul Frisby – CCG Grace Mawson – AWP Judy Haworth - NBT	June 2018
		2.1.7 Review the diagnostic assessments used in primary and secondary care and whether they are culturally appropriate for BAME groups.	Peter Bagshaw & Paul Frisby – CCG Grace Mawson - AWP	December 2018
		2.1.8 Regular screening and health checks for people with learning difficulties	Emily Denham - Sirona	Ongoing
		2.1.9 Investigate a self-referral pathway for people worried about memory loss	Peter Bagshaw & Paul Frisby – CCG Grace Mawson - AWP	December 2018
		2.1.10 Continue to ensure undiagnosed cognitive impairment in secondary care is investigated.	Judy Haworth – NBT Paul Frisby - CCG	Ongoing
		2.1.11 All partners to ensure people with cognition concerns are offered screening by GP	All	Ongoing
2.2	Improve support for people at risk of developing dementia	**2.2.1** Investigate support and monitoring of people diagnosed with mild cognitive impairment.	Peter Bagshaw & Paul Frisby - CCG	March 2019

3. Ensure high quality information about dementia, local services and support is available to all those with a dementia diagnosis and their carers

	OBJECTIVE	WHAT WILL WE DO	WHO WILL DO IT	BY WHEN
3.1	Ensure the staff are trained to recognise and support people with dementia.	**3.1.1** Continue specialist dementia training for staff working with people with learning difficulties.	Sue Parris/Emily Denham – Sirona	Ongoing
		3.1.2 Increase dementia awareness for care home staff.	Care Home Liaison – AWP	December 2017
		3.1.3 Promote participation in research for individuals and professionals	Paul Frisby – CCG Sue Jaques - SGC	Ongoing
		3.1.4 Understand the links between sight loss and dementia and ensure appropriate information and support is available.	Paul Frisby – CCG Sue Jaques - SGC	December 2018
3.2	Generic transferable dementia training across the sector	**3.2.1** Develop generic dementia training	Dementia HIT Partnership Judy Haworth - NBT	December 2020
3.3	Ensure people with learning difficulties are assessed and supported appropriately.	**3.3.1** Continue to work in partnership to assess and support people with a learning difficulty and dementia diagnosis.	Sue Parris/Emily Denham - Sirona	Ongoing
		3.3.2 Maintain a comprehensive library of information about joint diagnosis of dementia and learning difficulties.	Sue Parris/Emily Denham - Sirona	Ongoing
		3.3.3 Continue to develop specialist training to support people with dementia and a learning difficulty living in a care home or support living.	Sue Parris/Emily Denham - Sirona	Ongoing

3.4.	Support people with dementia throughout the progression of the disease.	**3.4.1** Submit Dementia Advisors proposal to build on this year's pilot to provide a named contact, support and signposting to other services and support people nearing crisis.	Paul Frisby – CCG Sue Parris – Sirona Lorna Robertson - Alz Soc	Current service until June 2017
		3.4.2 Encourage partnerships between carers, health, social care and voluntary sector to support people with dementia.	Sue Jaques- SGC Paul Frisby - CCG	Ongoing
		3.4.3 Continue to offer the 'Real Life with Dementia' course.	Beth Tovey – SGC Paul Frisby - CCG	Ongoing
		3.4.4 Ensure post diagnostic courses are offered to everyone with a diagnosis.	Paul Frisby- CCG Grace Mawson - AWP	Ongoing
		3.4.5 Encourage individuals to access psychological support.	Paul Frisby – CCG Rowena Hastings - CCG	Ongoing
		3.4.6 Maintain a range of community activities for people with dementia and their carers	Paul Frisby- CCG Sue Jaques – SGC Lorna Roberston - Alz Soc	Ongoing
		3.4.7 Investigate advocacy and develop provision for people with dementia.	Paul Frisby – CCG Sue Jaques - SGC	Ongoing
		3.4.8 Investigate developing dementia specialists in each team, health and care setting.	Paul Frisby – CCG Sue Jaques - SGC	December 2019
		3.4.9 Ensure that services and support are sensitive to sexual orientation and trans people, both the person with dementia and their carer.	Paul Frisby – CCG Sue Jaques - SGC	December 2019
		3.4.10 Services to collaborate to ensure a dementia diagnosis is shared (the people may not)	All	Ongoing
		3.4.11 Understand the issues for people that live alone with dementia and communities that support them.	Paul Frisby – CCG Sue Jaques - SGC	December 2017
3.5	Support people with young onset dementia	**3.5.1** Investigate different support for younger people with dementia.	Paul Frisby – CCG Sue Jaques - SGC	December 2019

4. Develop care and support to meet the needs of individuals with dementia and their families and other carers, to maintain independence and avoid crisis.

	OBJECTIVE	**WHAT WILL WE DO**	**WHO WILL DO IT**	**BY WHEN**
4.1	Support to manage behaviours that challenge.	**4.1.1** Support before or at crisis to enable people with dementia to stay at home, or as close to that as possible.	Paul Frisby – CCG Sue Jaques - SGC Rowena Hastings – AWP Lorna Robertson – Alz Soc Sue Parris - Sirona	December 2017
4.2	Holistic long term care for people with dementia.	**4.2.1** Integrated community services to offer people with dementia and other LTCs more holistic care.	Paul Frisby - CCG Sue Jacques - SGC Parris - Sirona	June 2018
		4.2.2 Access for all people with dementia to a wide range of therapies and other meaningful activities.	Paul Frisby – CCG Rowena Hastings - AWP Sue Jaques- SGC Lorna Robertson – Alz Soc Sue Parris - Sirona	June 2018
		4.2.3 Constructive and pragmatic care plans that are used by professionals and individual that take account of all of the equalities groups.	Paul Frisby – CCG Sue Jaques – SGC Sue Parris - Sirona	Ongoing
		4.2.4 Ensure that people with dementia are able to maintain good dental health.	Sarah Weld – SGC Paul Frisby - CCG	June 2018
		4.2.5 Review the need for a crisis response team that operates outside of normal working hours.	Paul Frisby – CCG Sue Jaques - SGC	June 2018

5. Recognise the contribution of carers, and encourage and enable them to look after their own health and wellbeing as well as those they care for.

	OBJECTIVE	WHAT WILL WE DO	WHO WILL DO IT	BY WHEN
5.1	Support carers of people with dementia well.	**5.1.1** All people with diagnosis and their main carer are offered place on post diagnosis course.	Grace Mawson – AWP Paul Frisby – CCG Sue Parris - Sirona	December 2017
		5.1.2 All people with dementia and their carers have a support plan including advance care planning.	Paul Frisby – CCG Grace Mawson – AWP Sue Parris - Sirona	December 2017
		5.1.3 Work to ensure carers training continues and is supported by (Council/ CMHT, Alzheimer's Society, Carers Support Centre)	Paul Frisby – CCG Sue Jaques – SGC Lorna Robinson – Alz Soc Keith Sinclair - CSC	Ongoing
		5.1.4 Investigate annual checks & medication reviews for people with dementia	Paul Frisby - CCG	December 2017
		5.1.5 Use technology early in diagnosis whilst person has capacity and improve quality of life & use technology to support people with dementia	Sue Jaques - SGC	June 2017
		5.1.6 Work with people with dementia and carers encouraged them to remain in control.	Paul Frisby - CCG	Ongoing
		5.1.7 Investigate buddying and other types of support for people that cannot or do not want to join groups.	Paul Frisby – CCG Sue Jaques - SGC	Ongoing
		5.1.8 Supported families to understand the difference between neglect and disease management in end of life complex cases.	Sue Parris – Sirona Paul Frisby – CCG Sue Jaques - SGC	December 2019

6. Improve provision for people who can no longer live at home, supporting care homes to meet the needs of people with dementia and developing alternatives.

	OBJECTIVE	WHAT WILL WE DO	WHO WILL DO IT	BY WHEN
6.1	Support to manage behaviours that challenge	**6.1.1** Care Home Liaison support homes to manage individuals they find challenging and deliver tailored training.	Paul Frisby – CCG Sue Jaques - SGC Rowena Hastings - AWP	December 2017
		6.1.2 Care homes offered time limited support to enable them to continue caring for people with behaviour they find challenging.	Paul Frisby – CCG Sue Jaques - SGC Rowena Hasting –AWP	December 2017
6.2	Increase and diversify the types of care available for people with dementia.	**6.2.1** Develop alternatives to care home placements eg Shared Lives.	Paul Frisby – CCG Sue Jaques - SGC	December 2019
		6.2.2 Increase nursing home placements for people with dementia.	Sue Jaques - SGC	December 2019
		6.2.3 Specialist extra care for people with dementia.	Sue Jaques - SGC	December 2019
		6.2.4 Ensure reablement services are accessible to people with dementia.	Sue Jaques - SGC	December 2017
		6.2.5 Continue to develop capacity for dementia nursing beds in care homes	Paul Frisby – CCG Sue Jaques - SGC	Ongoing

6.3	Investigate establishing a dementia care hub in South Gloucestershire	**6.3.1** Ensure co-ordinated care through establishing a dementia 'hub'.	Paul Frisby – CCG Sue Jaques - SGC	December 2019
6.4	Work with care homes to continue improve quality	**6.4.1** Continue to improve training in care homes	Paul Frisby – CCG Sue Jaques – SGC	Ongoing
		6.4.2 Explore introducing a Care Home Quality Mark	Paul Frisby – CCG Angela Marsh – SGC Care Home Partnership	June 2019

7. High quality hospital care for people with dementia, including pathways to ensure appropriate and timely discharge.

	OBJECTIVE	**WHAT WILL WE DO**	**WHO WILL DO IT**	**BY WHEN**
7.1	Continually improve quality of dementia care in local hospitals	**7.1** Work with hospitals to continue improving quality	Judy Haworth - NBT	Ongoing
7.2	Reduce length of stay in hospital for people with dementia.	**7.2** Investigate the feasibility of discharge to assess for people with dementia.	Paul Frisby – CCG Sue Jaques - SGC	
7.3	A memory Café at Southmead Hospital	**7.3** Develop Southmead Hospital Memory Café.	Judy Haworth – NBT Jet O'Neill - AWP Lorna Robertson – Alz Soc	June 2017
7.4	Improve access to and discharge from Callington Road Hospital.	**7.4.1** Introduce protocol and operational standards for Callington Road later life wards.	Jane Salmon – AWP Paul Frisby – CCG Kenny Braidwood - SGC	September 2017
		7.4.2 Consider provision of desks and IT links to enable social workers to spend more time at Callington Rd.	Paul Frisby – CCG Sue Jaques – SGC Jane Salmon- AWP	September 2017
		7.4.3 Publicise Laurel ward –criteria for admission.	Jane Salmon – AWP Paul Frisby – CCG Kenny Braidwood - SGC	September 2017
		7.4.4 Introduce discharge to assess for Laurel Ward	Paul Frisby- CCG Sue Jaques - SGC	September 2017

8. High quality end of life care

	OBJECTIVE	**WHAT WILL WE DO**	**WHO WILL DO IT**	**BY WHEN**
8.1	People with dementia have advance care and support plans for end of life	**8.1.1** Advance support and care planning offered to all people with dementia and their carers.	All Dementia planning group	Ongoing
		8.1.2 Ensure that people with learning disabilities and dementia are enabled to develop advance support and care planning.	Emily Denham - Sirona	Ongoing
8.2	People with learning difficulties and dementia have advance care and support plans.	**8.2.1** Ensure Sirona End of Life Co-ordination Centre meet the needs of people with dementia.	Sue Parris - Sirona	Ongoing
8.3	Bereavement support for carers of people with dementia after they die.	**8.3.1** Investigate Bereavement support for carers of people with dementia after they die, as with CLDT.	Paul Frisby - CCG	June 2018
8.4	Focus should be quality of life not length of life	**8.4.1** All partners to have honest and open conversation with people with dementia and their carers	All	Ongoing