Public Document Pack

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Friday, 18 November 2022

Notice of Reports Received following Publication of Agenda.

Public Services Scrutiny Committee

Monday, 28th November, 2022 at 10.00 am,
County Hall, Usk - Remote Attendance

Attached are reports that the committee will consider as part of the original agenda but were submitted to democratic services following publication of the agenda.

Item No	Item	Pages
4.	**Dementia Services** To discuss service provision in Monmouthshire with the Chair of the Dementia Board.	1 - 54

Paul Matthews
Chief Executive

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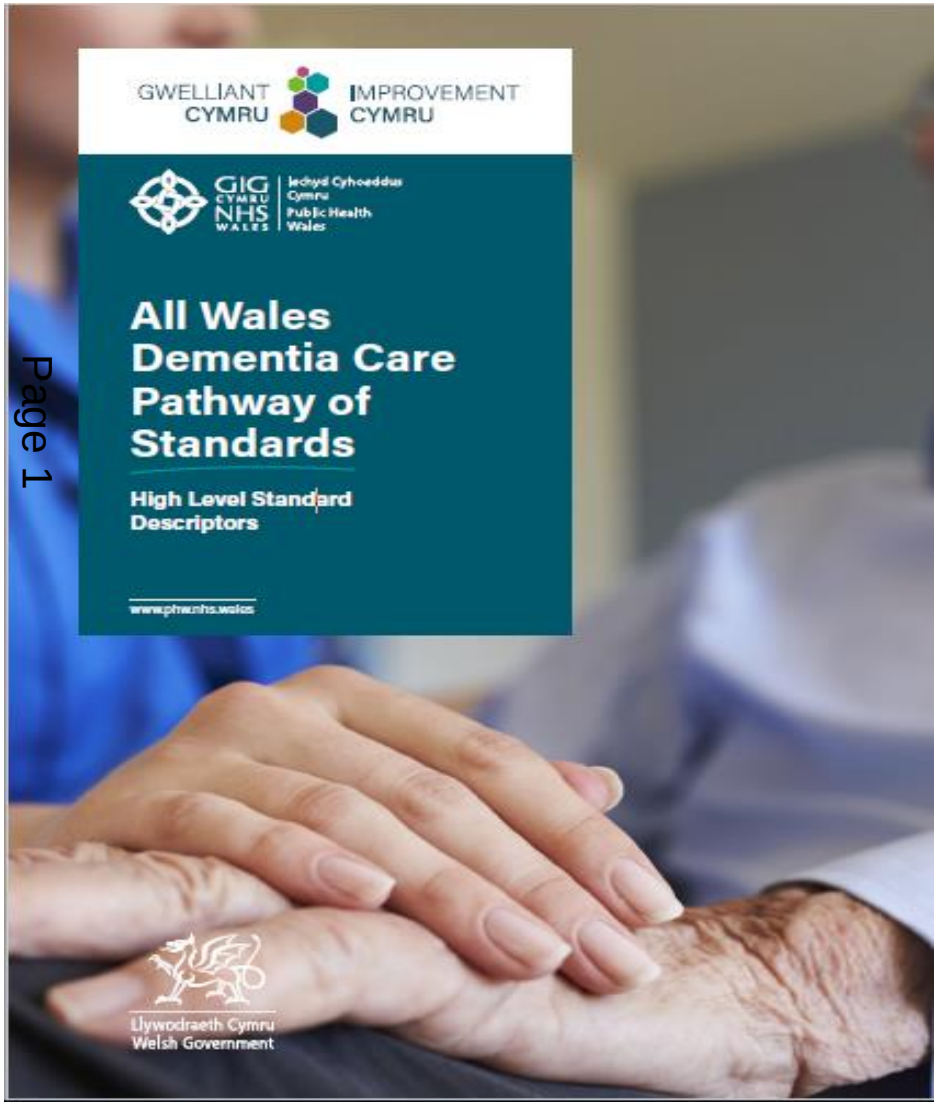
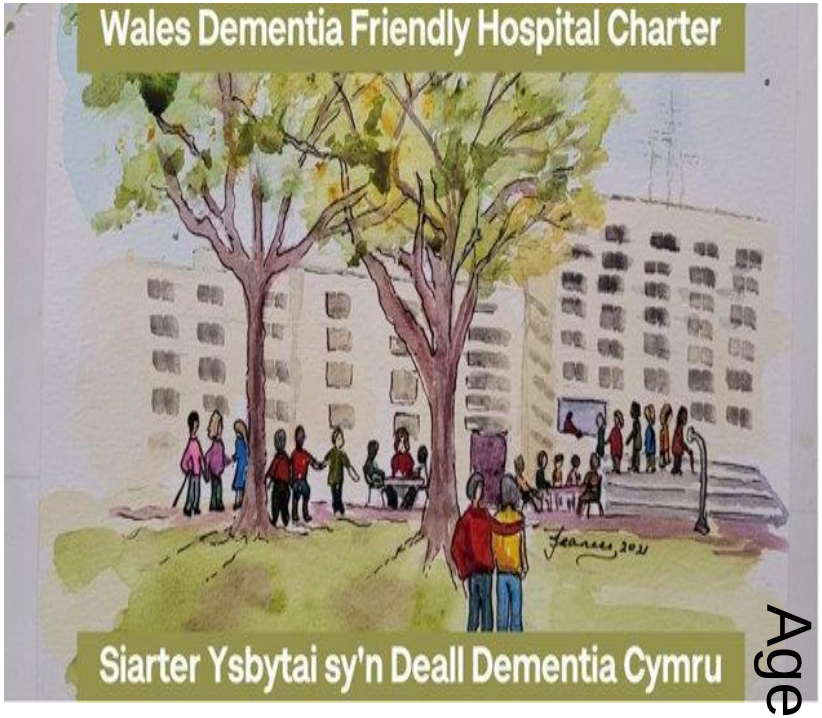
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board





Amanda Whent, Lead Nurse Dementia ABUHB

Natasha Harris, Service Manager, Partnerships and Development, Gwent Regional Partnership Team

Welsh Government Dementia Action Plan for Wales, 2018-2022.

Risk reduction and delaying onset.	Raising awareness and understanding.	Recognising and Identification.
Assessment and Diagnosis.	Living well as possible, for as long as possible with Dementia.	The need for increased support.

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

Dementia Friendly Communities

Consists of a range of partners including:

People living with dementia, carer's, elected members, local authority, ABUHB, Gwent Police, South Wales Fire and Rescue, Welsh Ambulance Service, third sector and community groups.

Meet bi-monthly

Supports the Gwent Dementia action plan.

Supports the work ready for implementation of the All Wales Dementia Care Standards

Standing item on the agenda, at Dementia Board

Annual conference to enable coproduction, joint working and sharing of good practice.

Dementia care Pathway Of Standards

Developed by Improvement Cymru Delivery Framework.-

- **Three priorities.**
- **2-year scoping/1800 people, carers and partners**
- **Focus on people living with dementia identified would make a difference**
- **100 standards/20 Standards**
- **2-year Delivery Framework 2021–2023**

4 Themes 20 standards wrapped around the person

- Accessible
- Responsive
- Journey
- Partnerships & Relationships

Kindness & Understanding

Standard Descriptors

Standards 1-5

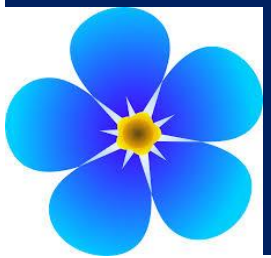
Phase One: **community engagement** using one locality within a region working in partnership, taking 6 months. 'what dementia care and intervention looks like around here' .

Services at the points of contact will provide **reasonable adjustments** to care. Includes community and inpatient settings

Memory Assessment Services (MAS) and Primary Care (GP) **adopt READ Codes** to capture diagnosis /MCI. Includes Inpatient

Learning Disability services will define a process to capture the total population of people living with Learning Disability and specifically **Downs Syndrome** to offer a **cognitive wellbeing check**.

Health and social care services should provide the **outcomes** of an agreed set of completed **assessment & interventions** (listed) when referring to Memory Assessment services (where presenting need is indicated)



Standard Descriptors

Standards 6-10

Memory Assessment Services within a **12 week** period from point of referral **provide a range of interventions** (listed) to support diagnosis. Digital platforms and other adaptions and approaches may need to be considered.

People access a **contact** that can provide **emotional support** throughout the assessment period and over the next **48 hours after receiving a diagnosis** and ensure, following this period it is offered as required

People living with **Mild Cognitive Impairment** (MCI) will be offered a choice of **holistic services** monitoring their physical, mental health and wellbeing

Within 12 weeks of receiving a diagnosis people living with dementia (after diagnosis) will be offered **education and information** on the importance of physical health activities to support and promote health

People living with dementia, carers and families will be offered **learning, education and skills training.**

Standard Descriptors

Standards 11-15

Wales will adopt the **Dementia Friendly Hospital Charter** with a regular review of implementation and outcomes
People living with dementia and their carers will have a **named contact (connector)** to offer support, advice and signposting, throughout their journey from diagnosis to end of life.
People living with dementia will have access when needed to relevant (and when accessing mental health services) **dedicated services post diagnosis** no matter their residence (listed) e.g. physiotherapy, dietetics
People living with dementia will have a current **face to face** appointment where a **physical health review** will be delivered in partnership by primary and secondary care.
Within 12 weeks of diagnosis will be offered support to commence **planning for the future**, including **end of life care**

Standard Descriptors

Standards 16-20

Organisations and care settings providing intensive dementia care, (this includes mental health and learning disabilities inpatient settings) provide **Dementia Care Mapping in routine practice**

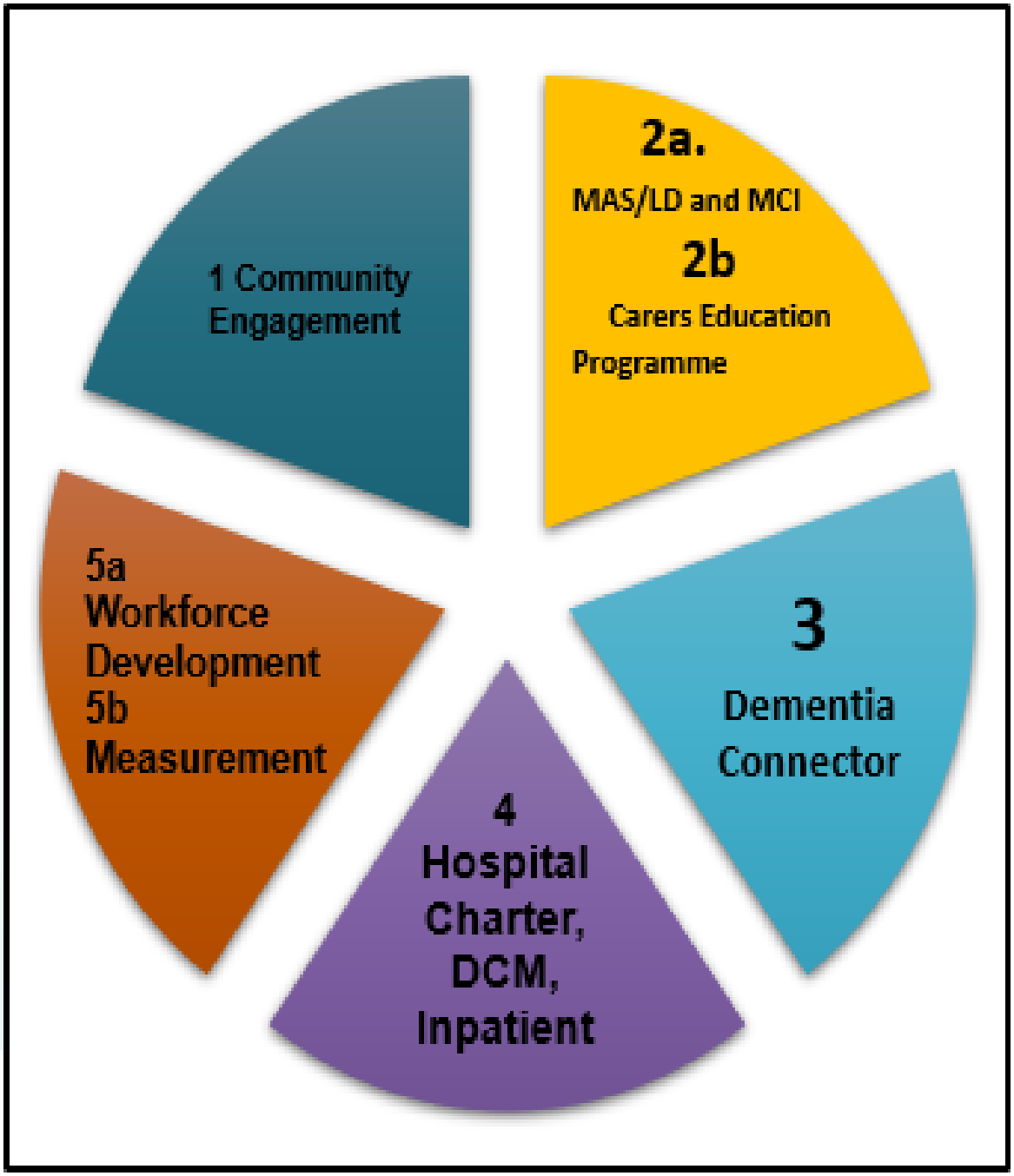
All staff delivering care at all levels within **all disciplines and settings**, will have the opportunity to participate in **person centred learning and development** with support to implement into daily practice

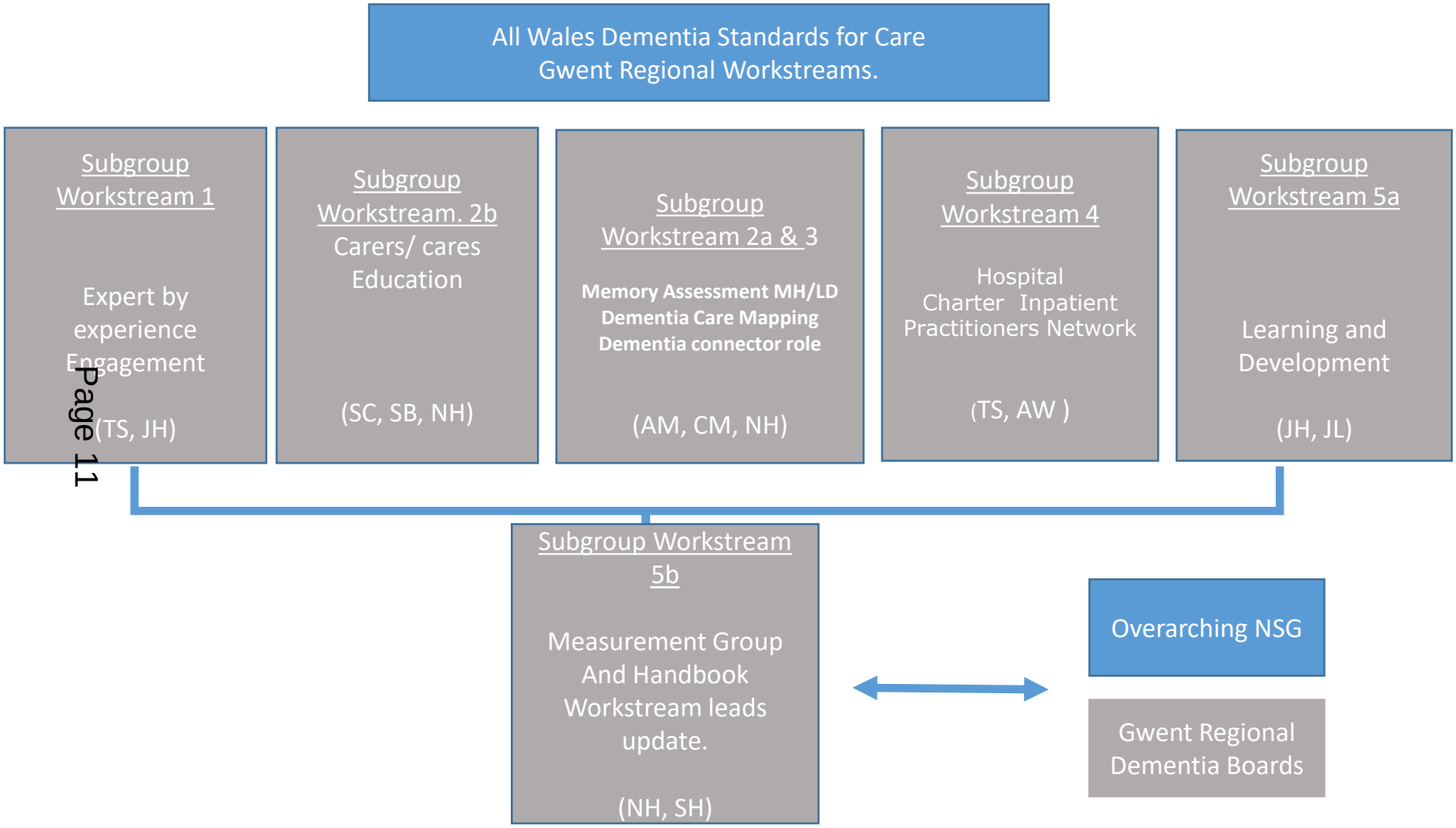
People living with dementia and their carers / families will have **support and assistance** to engage with appointments.

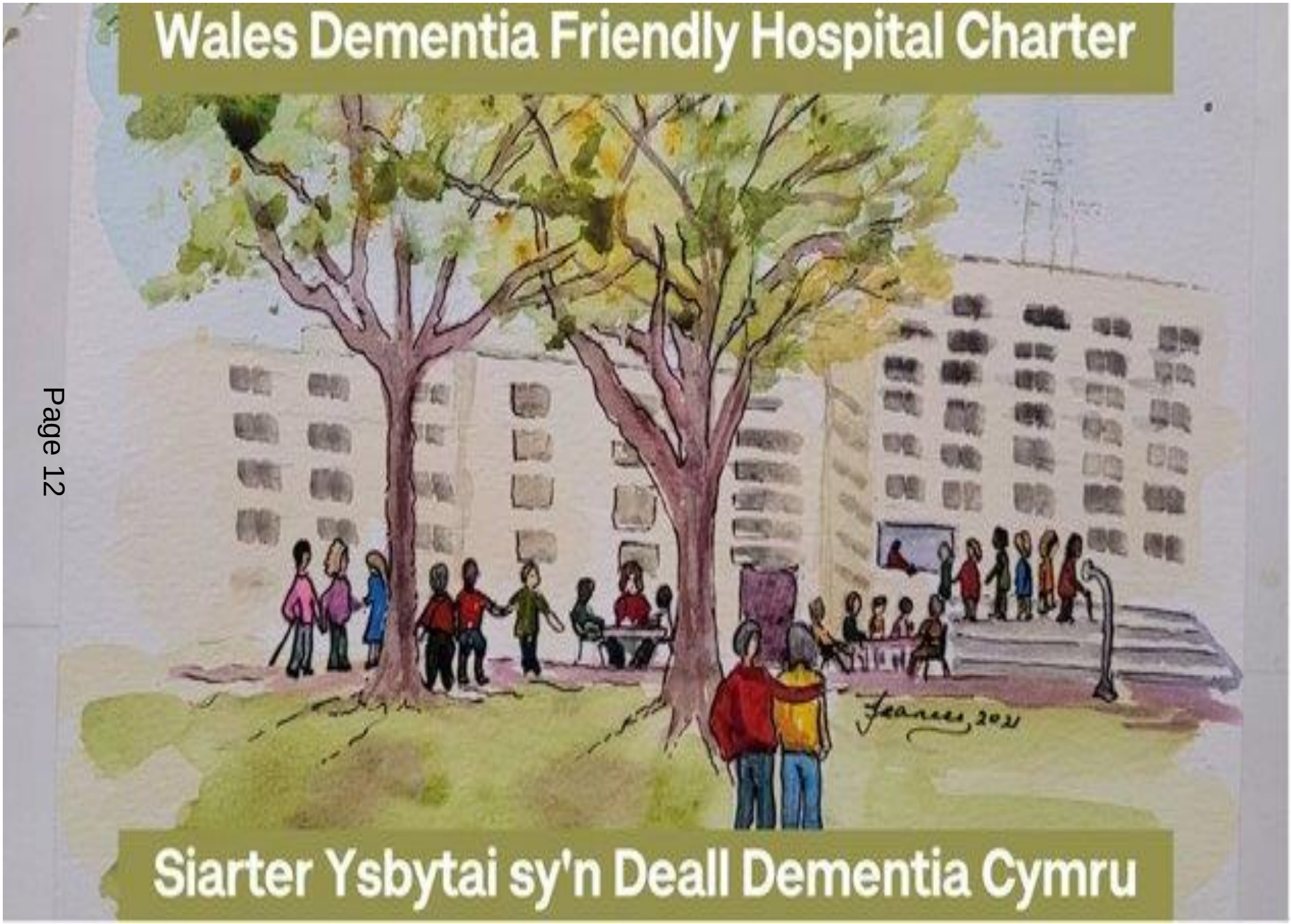
Services will ensure that when a person living with dementia has to **change / move between any settings or services,** care, will be appropriately coordinated to enable the person to consider and adapt to the changed environment.

Working in **partnership** the region will deliver on the requirements of the agreed **data items** (measurement workbook) for **reporting and assurance.**

National Workstreams




All Wales Dementia Standards for Care
Gwent Regional Workstreams.
Subgroup Workstream 1
Expert by experience Engagement
(TS, JH)
Subgroup Workstream. 2b
Carers/ cares Education
(SC, SB, NH)
Subgroup Workstream 2a & 3
Memory Assessment MH/LD
Dementia Care Mapping
Dementia connector role
(AM, CM, NH)
Subgroup Workstream 4
Hospital Charter Inpatient Practitioners Network
(TS, AW)
Subgroup Workstream 5a
Learning and Development
(JH, JL)
Subgroup Workstream 5b
Measurement Group And Handbook Workstream leads update.
(NH, SH)
Overarching NSG
Gwent Regional Dementia Boards


Wales Dementia Friendly Hospital Charter
Siarter Ysbytai sy'n Deall Dementia Cymru

Charter Aims

- **National 'Premier'- 6th April 2022**
- **Clear Statement of Key Principles that contribute to a Dementia Friendly Hospital**
- **Informs people, carers and staff what they should expect**
- **Fundamental Aims: to support wards to implement person centred dementia practice**

Feedback From Person Living with Dementia

*"The Charter will improve the **experience** of people affected in hospital care settings.*

*An experience that recognises their **personhood**, **diversity** and **preferences** shaped by recognising the importance of **dignity, respect** and **kindness**".*

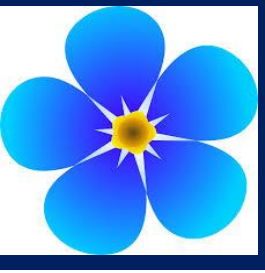
Mr AH.

Actions Taken and Actions Needed

- Revised **Regional Dementia Action Plan to reflect the standards**
- In the process of forming the **Regional Workstreams**
- Revised **In-Patient Hospital Group**

Actions Needed: **We need your help !**

- **Collaboration !**
- **'Expert by Experience'** Groups.
- Feedback from people living with dementia and their carers/families must be used to transform services and improve people's lives.
- Listening events and training.



Questions?

Thank you

For more info Contact:

Amanda Whent, Lead Nurse Dementia ABUHB

Natasha Harris, Service Manager, Partnerships and Development, Gwent Regional Partnership Team

Dementia Friendly Hospital Charter for Wales

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

GWELLIANT CYMRU
IMPROVEMENT CYMRU

Alzheimer's Society Cymru
Unedig Yn Erbyn Dementia
United Against Dementia

"When you have met one person with dementia, you have met one person with dementia"

Everyone is different.

This document explains the content of the Dementia Friendly Hospital Charter for Wales. It will break the Charter into sections to make becoming dementia friendly more manageable and easier to understand.

This document is for anyone interested in providing good person-centred dementia care including, but not limited to:

- Healthcare professionals
- People living with dementia
- Carers, family members and supporters
- Managers and leaders
- The general public.

As such, the document has been reviewed to make content as easy to understand as possible.

Key message:

Hospital staff speak to the person with dementia, care partners and families about what they can expect when receiving care

Providing care centred around the person, building relationships and partnerships runs throughout this document and should be considered within each principle.

Foreword

Hospital admissions can trigger, confusion, distress and sometimes delirium for someone with dementia and their carers and supporters.

The purpose and outcomes of the Hospital Charter is to make space for an improvement in the experience of people affected by Dementia in hospital care settings.

An experience that recognises their personhood, diversity and preferences that are shaped by recognising the importance of dignity respect and kindness.

The Hospital Charter from the beginning followed an emphasis of co-production Lleisiau Dementia as an independent voice were involved from the very beginning. Providing strong voices through the Charter development with an emphasis on safe care which is person centred underpinned by kindness and dignity which are considered within the principles throughout the charter.

At present Dementia has no cure but with adjustments positive changes can be made to the world people affected with Dementia live in.

Lleisiau dementia - voices from Wales

Introduction

The Dementia Friendly Hospital Charter for Wales (the Charter) outlines the principles that a dementia friendly hospital should provide. This should fully support the Dementia Action Plan for Wales 2018-22, where the vision is to:

'Create a society without stigma... Where people living with dementia continue to go about their lives and are understood by the wider public who know how to provide support.'

The Charter provides a focus for people living with dementia and their carers whilst they are in hospital. It outlines the care, treatment and understanding required to achieve the vision of the Dementia Action Plan and All Wales Dementia Pathway of Standards. In 2019 Improvement Cymru, part of Public Health Wales, supported by Welsh Government, began the process of developing a Dementia Friendly Hospital Charter for Wales.

The background to the Charter started in England in 2012, when the National Dementia Action Alliance (NDAA) launched the 'Right Care: a call-to-action' to create dementia friendly hospitals and published a Charter for English Hospitals in 2015.

Purpose of the Dementia Friendly Hospital Charter for Wales

The purpose of the Charter is to enable hospitals to create a dementia friendly care experience and environments that meet the needs of people with dementia, their families, carers and supporters in Wales.

The Charter will...

- Act as a short, clear statement of the key principles that contribute to a dementia friendly hospital.
- Provide a set of principles and indicators that focus on the needs of people with dementia and their families, carers and supporters.
- Inform people of what to expect when they receive care and visit a dementia friendly hospital.
- Build on the foundation offered by the Royal College of Nursing's Staffing, Partnership, Assessment, Care and Environment (SPACE) principles. This includes the latest developments and resources that hospitals can use to provide dementia care and support.
- Offer an improvement guide to assist hospitals in their self-assessment against the dementia friendly principles.

These points will be discussed in more depth later in this document.

The Dementia Statements

The Dementia Statements, published in 2017, reflect what people with dementia and carers say are essential to their quality of life. These statements were developed by people living with dementia and their carers and these rights are enshrined in the Equality Act, Mental Capacity legislation, health and care legislation and international human rights law. The statements are fully supported by the Wales Dementia Action Plan 2018-22 and include:

- We have the right to be recognised as who we are, to make choices about our lives including taking risks and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.
- We have the right to continue with day-to-day and family life, without discrimination or unfair cost. We also have the right to be accepted and included in our communities and not live in isolation or loneliness.
- We have the right to an early and accurate diagnosis.
- We have the right to receive evidence-based, appropriate compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.
- We have the right to be respected and recognised as partners in care, provided with education, support, services and training which enable us to plan and make decisions about the future.

- We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.
- We have a right to be treated in a non-discriminatory way and to be shown respect and recognition of us as individuals and our cultures.

And in Wales:

- We have the right to receive assessment, care and support in Welsh without having to ask for it (in accordance with the principle of the active offer) if that is what we need and prefer.

The Charter supports key documents and legislation within Wales:

Wales Dementia Action Plan

The Action Plan sets out a clear strategy for Wales to become a dementia friendly nation that values the rights of people with dementia to live as independently as possible in their communities. It pledges to consider the rights, wishes and preferences of people with dementia in the implementation of the plan.

All-Wales Dementia Pathway of Standards

The All-Wales Dementia Pathway of Standards are statements that reflect what people believe will make a positive difference to dementia care in Wales. They were developed over two years and involved over 1800 people ranging from people living with dementia to voluntary sector organisations to practitioners across Wales and the UK. After a list of over one hundred potential standards were identified they have been narrowed down to 20 which are seen as being key to the promotion of dementia-friendly care across Wales.

Health and Care Standards Framework

The Health and Care Standards Framework supports the NHS and partner organisations in providing effective, timely, accessible and quality services across all healthcare settings. Seven themes were developed through engagement with patients, clinicians, stakeholders and identified as the priority areas for the NHS to be measured against. The framework standards underline the importance of providing services in Welsh.

The Charter aligns with other key documents:

- Well-being of Future Generations (Wales) Act 2015
- Older People's Commissioner for Wales' overarching priorities
- Impact of the COVID-19 pandemic on hospital care for people with dementia. Royal College of Psychiatry 2020
- The Good Work Dementia Learning and Development Framework 2016
- Home First: The Discharge to Recover then Assess model (Wales) 2021
- Creating healthier places and spaces for our present and future generations

- A healthier Wales: our plan for Health and Social Care 2018
- Social Services and Well-being (Wales) Act 2014
- Mental Health (Wales) Measure 2010
- Mwy na geiriau/More than just words 2016
- Dementia Action Plan: Strengthening provision in response to COVID-19 2021.

SPACE principles

SPACE is a set of five principles that form a shared commitment to improving care for people with dementia and their families. Based on evidence from people living with dementia, carers and practitioners, each principle is considered essential to the delivery of care. Developed by the Royal College of Nursing and updated in 2019, the principles are designed for use in a wide range of health and social care settings and are used to inform the Charter. During the Wales Charter consultation, stakeholders felt that two extra principles were required, therefore Volunteering and Governance are included (SPACE-VG).

The SPACE-VG principles include:

Why are Improvement Cymru, NDAA and its partners leading this work?

Because of its core role and strategic position, Improvement Cymru can:

- Facilitate and support the readiness and implementation of the dementia friendly principles in hospitals (supported by Welsh Government).
- Build relationships and partnerships, liaising with relevant people and agencies including those who plan, deliver and care within hospitals.
- Share good practice across settings, organisations and regions promoting improvement.

Vision Statement

'Dementia is a priority in all our Welsh hospitals and the Charter outlines the national and regional shared values and principles to achieve this. The values and principles are for all staff in hospital, community and other care settings and shows people with dementia and their carers coming into hospital from their own home what to expect.'

All Wales Shared Values

- Organisations and hospital staff are committed to listening, learning, enabling, being kind and caring. Staff at all levels alongside people living with dementia and carers can make a positive difference together in achieving good care.
- There is strong partnership working between the person, hospital staff, the person's carers, family and supporters. This also should include community settings such as care homes and other organisations involved in the person's care.
- People living with dementia, their carers, family and supporters are given appropriate and timely information for them to make choices about care, to further increase their independence and decision making.
- Hospitals and healthcare settings take active steps to provide what each person living with dementia needs during their hospital stay. People are made to feel welcome and heard, with the diverse cultures, experiences and needs of people from groups such as BAME, LGBTQIA+, Welsh speakers and people with learning disabilities being recognised and valued.

We will...

- Understand you may prefer to speak to us and be cared for in Welsh. We will make sure that you can do so.
- Ensure people with communication and language needs have access to appropriate services including translation services to support their care needs.
- Ensure people with sensory impairment such as poor sight or hearing have access to their glasses and hearing aids. When they are not in a good state of repair, steps should be taken to fix them as soon as possible. In the case of full sensory loss such as blindness or deafness, information should be provided in a way that it can be understood by the person. This may involve getting written resources translated into braille or the use of an interpreter for sign language.
- Offer people from different ethnic communities' culturally appropriate and understandable information about dementia. This should include information on existing services and support and make sure that people understand dementia is a medical condition.
- Not judge people from different communities for having a different understanding of dementia to our own. We must ensure that different opinions or beliefs do not result in people with dementia not getting the care and support they might need or benefit from.
- Always maintain people's dignity. Assist people with hygiene and personal care as they require to promote as much independence as possible.
- Never talk about someone in front of them without them being part of the conversation. It is important that we see the person not the dementia. Make sure that when you are talking about a person that the language used is respectful, avoids labels and negative remarks.
- Be careful about when and where we talk about people's private information.
- Communicate with people as they wish to be communicated with, without the use of language that treats the person as a child.
- Not start disagreements with people living with dementia. If there are disagreements or difficulties, we deal with them in a kind way, professionally and away from others.
- Never dismiss or ignore people and ensure their fears and anxieties are always taken seriously. We should take time to understand people's needs and address them.
- Support people when they are distressed, try to understand why they are feeling this way and respond to their needs, supporting them in a safe way.
- Promote and support people's emotional care. This is equally as important as completing practical tasks.
- Work in collaboration with those who know the person best.
- Understand when people are distressed they can behave differently. This can be upsetting for the person, their carer, supporters, family and staff. We should reassure everyone that we are aware that this can happen and talk about it together.

Welsh hospitals are committed to achieving the Dementia Friendly Hospital Charter. The following SPACE-VG Principles outline Welsh hospitals commitment to dementia care.

S - STAFFING

See it, sort it!

Staff at all levels are given permission and encouragement to make a difference to shape good care. The learning and development of staff in dementia care is important and opportunities to undertake training are valued, supported and invested in. Staff are recruited who share the values and beliefs of the Charter.

Charter Principles:

- Staff are valued, are in the habit of sharing good practice and the good work they deliver is celebrated.
- At all levels, there are specific leadership roles identified that have responsibility for putting the Charter into practice and for the safe delivery of dementia care. These roles are visible, easy to access, and staff understand the organisation's structure and who is responsible.
- Specialist dementia care staff are available, routinely offering support and advice where required within inpatient and community settings.
- All aspects of care and care planning involve the person and carers, family members, supporters and care home staff where appropriate.
- All staff are responsive to the needs of the person with a curious and helpful attitude, recognising and responding to the needs of people.
- Staff provide personalised care in a timely way and adjustments are made to enable and support the individual.
- Dementia care learning and development is mandatory for all staff and volunteers working in clinical areas with people living with dementia. The training should be at the appropriate level which is described in the Good Work Framework. This should involve how to assess needs and plan care. Once the care has taken place, we should see whether this has made a difference to the person.
- Observations of the person's experience is examined using tools such as Dementia Care Mapping (Insert link and graphics). This information is then used to develop ways of moving forward and support learning.
- Staff enable people to participate in activities in addition to care. This may be as simple as engaging in a conversation or providing stimulation in the form of things that they enjoy such as leisure activities.
- Staff are aware that people's behaviour is a form of communication, therefore they may need to adjust in order to meet that individual's needs in that moment.
- Staff always properly introduce themselves to patients, carers and families. The 'Hello my name is' campaign is one way of doing this #hellomynameis.
- Staff are aware of the importance of ensuring Welsh speakers are offered services in Welsh and other languages. Staff recruitment and training will support this.
- Staff have a working knowledge and apply the principles of all laws that relate to dementia for example the Mental Capacity Act (2005) and Mental Health Measure (2009).
- Staff are encouraged and assisted to look after their own health. A healthy workforce is connected to achieving better outcomes for people with dementia.

P - PARTNERSHIP

Working together

It is important that people with dementia, families, care agencies, care home facilities and professionals work together for the best outcome. All people should be equally recognised as partners in providing care and supporting transitions between care settings and home. Partnership includes choice and control in decisions reflecting everyone's needs and opinions about the support required.

Charter Principles:

- The organisation uses the 'Triangle of Care' principles between the person with dementia, health professionals and their family/carers. The implementation of John's Campaign or other carer focussed projects give the family, carers and supporters a voice and allows their needs to be considered.
- Seamless transition between care settings and home is seen as vital. Discharge planning starts on the day of arrival into hospital. Either the person with dementia or someone who can represent their needs should be involved in co-ordinating their care.
- People's language preference and cultural needs should be recorded and acted upon to form part of their plan of care. This should always be communicated between the staff involved.
- When people who live alone and have dementia are discharged from hospital, they are followed up with a wellbeing check within 24 hours. This may be provided by a staff member from health, social care services or a charitable organisation.
- The person has a document that tells you useful information about them and their life such as a 'This Is Me' document. This document is always kept with them and updated by care partners and health professionals. This ensures that everyone can engage on a personal level and are aware of the needs and preferences of the person.
- People living with dementia and their carers or families are offered opportunities to say how they have been cared for and what their experience has felt like.
- Good communication and access to clear information is essential in discharge planning. This will help the discharge be understandable to people involved, give opportunities to raise any questions or concerns and lead to safe discharges either home or to other care settings.
- Staff should help people with dementia and their families, carers and supporters to develop plans to support them at home after discharge. This may involve finding and contacting services and activities in the local area.
- Topics such as Lasting Power of Attorney, Advanced Care Planning (making decisions about treatment prior to being unwell) and end of life discussions should be explored and revisited. This should be done sensitively and take into consideration the needs and situation of all people involved.
- Bereavement support may be helpful for families and carers and this support is offered in advance of a person dying.

A - ASSESSMENT

Knowing the person

Assessments are always centered around the person and seek to identify strengths to enable care and support to be built around their needs. Assessment includes identification and treatment of a range of conditions and symptoms, such as delirium, depression, continence care and pain. 'This Is Me' or an equivalent document is used to get to know the person and information is accessible for all staff.

Charter Principles:

- Assessments should include:
  - the person living with dementia
  - the carer / family
  - care home staff
  - person's representative or advocate
  - other care agency if appropriate
- Assessment encompasses people's social, emotional and spiritual needs, including their ambitions and individual goals, as well as their physical and mental health needs.
- Assessment includes what language and communication people with dementia and their families say they prefer and need. This is regularly reviewed as the person's circumstances change. This will include Welsh and/or other languages.
- Assessment of spiritual or religious beliefs. This should include whether they would like any support to continue worshipping or be part of a spiritual or religious community whilst in hospital.
- Hospitals work with organisations such as Diverse Cymru to ensure reasonable adjustments are made in supporting cultural and ethnic diversity.
- Pain is assessed regularly whilst in hospital. When medication is prescribed, staff should assess whether the painkillers have any effect so that adjustments can be made. Similar assessment should take place when considering other methods of pain reduction.
- People are not 'labelled', and staff understand and explore the person's regular routines, preferences and responses. Changes in a person's behaviour should not be ignored.
- An assessment of a person's everyday functioning takes place in their own home (where possible) as it is a familiar environment. This will enable a better understanding of the person's abilities and routines.
- Discussion around loneliness takes place during a hospital stay. Where needed, a support plan is agreed with the person to reduce loneliness when they are discharged from hospital.

- There are clear discharge plans around medication, to ensure safety. This should involve assessments of the person prior to being discharged from hospital (where possible) and may involve further monitoring in the community.
- Whilst a diagnosis of dementia is generally made outside of a hospital setting, however when it is made in hospital, the Welsh Government READ code circular and guidance is followed. This will enable the person to be referred and connected to their local memory assessment service and GP, which will ensure access to post-diagnostic treatment, information and support.
- A person with dementia will be supported in making decisions about their care for as long as possible. Where the person lacks capacity for a particular decision, any appropriate Lasting Power of Attorney should be used. Where there is no Lasting Power of Attorney, a family member or carer can communicate the person's views, or an Independent Mental Capacity Advocate will help make decisions on their behalf. The person with dementia should be helped to be part of these decisions throughout the process.
- Discussions around future care and the use of 'Advance Care Planning' should be encouraged as early as possible to establish end of life wishes and care preferences.
- When a person is approaching the end of their life, timely communications take place with the person, their carer and family or advocate.
- For people that speak Welsh, care is delivered by Welsh speaking practitioners avoiding the use of translation services and where there is a language barrier, interpreters will be used.
- To identify physical deterioration at an early stage, staff should make every effort to understand what the person is like normally (when not unwell) and pay particular attention to new or worsening confusion. If the person's function and behaviours are unknown, then the confusion should be treated as new.

C - CARE

With and around the person

Care is kind, enabling, responsive and where possible, promotes self-care and individual strengths, skills and abilities. Care supports and enables the person to maintain their sense of self and relationships with loved ones.

Charter Principles:

- Human rights and equality legislation is essential when developing care for people with dementia in hospital settings.
- The views, opinions and preferences of the person with dementia, their carer, family or advocate are actively sought out. These views should help form their plan and delivery of care.
- The use of documents such as 'This is Me' are used to make connections with people living with dementia. They should be read, reviewed and updated regularly.
- Information is provided in a way that is accessible and suitable to the person. This may include adaptations for hearing and sight loss and changes in language skills.
- Care, information and support will be provided in the language of preference if that is the person's need or requirement.
- Staff ensure that people with dementia can maintain physical contact and relationships with their loved ones and significant people in their lives.
- Care is delivered by a team of staff providing advice and intervention to address needs.
- Where possible, adjustments are made to ensure that care is sensitive to cultural needs. If this cannot always be accommodated, then discussions between the person, family and carers or advocate should take place to see if there are other ways that care can be delivered.
- Care enables people to be physically and cognitively active. This can include engaging in activities important to them or maintaining existing skills such as personal care for example, washing and dressing, brushing their hair and encouraging independence.
- Care includes conversations and information to support physical and mental health and healthy lifestyle choices for people when they return home. This is an important message to help people stay healthier for longer.
- People with dementia have the right to equal access to palliative care when approaching the end of their life. This should include medication for pain and symptom control and plans to keep them comfortable.
- Staff are aware of the person's preferred place of care at the end of life such as going home or into a hospice. Staff should know how to access this for the person and their families.
- Clothing and equipment required for therapeutic activities are available to all people free of charge.

- Care can include technology. There should be access to free Wi-Fi and technological devices
- People with dementia are supported to take positive risks that will continue to promote their independence and happiness, such as engaging in leisure activities if it is safe to do so.
- People will have access to an independent advocate where needed.
- The person or family and carers can opt in or out of hospital dementia care schemes.

E - ENVIRONMENT

Enabling the person

The environment is comfortable, empowering and promotes independence. The environment encourages usual mobility, activity and social interaction. Hospital planning and maintenance incorporates dementia friendly areas and there is support from all departments to design, achieve and upkeep them.

Charter Principles:

- People living with dementia and staff work together to ensure that the environment is appropriate, aided by The King's Fund Dementia Friendly Environmental Assessment tool. Areas of interest include wards, outpatient clinics, dementia friendly parking places, toilet facilities, including those for carers, family members and supporters within wards and treatment areas with A&E (Emergency departments) and minor injuries departments.
- Signage, symbols and markers support navigation throughout buildings and are consistent throughout the region's hospitals.
- Adaptations are made to support the person in moving around the environment safely rather than restricting movement.
- A document or 'welcome pack' should be provided and can be translated in the person's preferred language. This explains what resources, equipment and facilities are available in the hospital. This should include a carer and family room, key contact information and how carers and family can assist the person's care (if they would like to) whilst in hospital.
- People have opportunities to explore the layout of the ward as part of the admission process. Staff should take time to show people where things are and assist people whenever they appear unsure. This could include the use of fixtures and fittings that may be different to home such as taps and handles.
- Where possible, there is a supported dementia friendly outside space or garden that people with dementia, carers and family can access and enjoy.
- The area offers quiet spaces designed for people to ensure that noise and distractions are minimised.
- The environment helps people to see, hear and communicate better and promote independence.
- The use of technology, for example, call bells and radios available within the environment will be discussed as will fixtures, fittings and the use of appropriate furniture and equipment.
- Staff are vigilant about changes in temperature and lighting, and they manage this for the comfort of the person.
- Moving beds and changing wards within the hospital are minimised where possible. Sometimes a move to another setting is unavoidable so every effort must be made to

support the person and that the carer and family are informed. This includes where the person has moved to, the reasons for the move and steps to support them to adapt to the new environment.

- People receive the support and care to die with dignity. Considerations are made such as single room access or adaptations to the environment for the dying person and their families and carers to support privacy.
- The person will have an accessible space to keep their personal and comforting belongings. Staff will help the person to use and enjoy them.
- People have access to fundamental items such as dentures, glasses, hearing aids and other aids and adaptations that make them feel reassured and safe. Staff ensure these are clean and in working order.

V - VOLUNTEERING

Opportunities

Volunteers have learning and development opportunities to support people with dementia and their families. This should include providing person-centred support for meaningful activities and pastoral care with safety and dignity. Volunteers complement paid staff and are not a substitute for them.

Volunteers Charter Principles:

- Undertake an Alzheimer's Society Dementia Friend awareness session.
- To be aware of the language needs of people with dementia, their carers, supporters and family. Where there is a language need, support should be available in Welsh or other languages, including sign language.
- Volunteers are regularly supervised and supported in their role. They are encouraged to take part in learning and development opportunities provided by Welsh health boards.
- Ensure that the person is comfortable and willing to engage in activities. Essential communication items such as teeth, glasses and hearing aids should be used. In cases of sensory loss, volunteers should be supported to expand their knowledge and skills
- Volunteer roles are clearly defined in the health board's policies. This is communicated to and understood by the volunteers and staff members working with them.
- There are a range of volunteering experiences available throughout the hospital. These involve intergenerational work, people with dementia being experts by experience and staff members volunteering. Regions actively recruit and welcome applications from volunteers with diverse backgrounds and abilities.

G - GOVERNANCE

Right time, right place, right person

Governance means that we make sure that we are doing what we say we are going to do. This involves audits, surveys and speaking to people to establish how we are doing. Where things are not as they should be, steps are taken to improve. Systems are in place to support continuous improvement in the quality of care for people with dementia and their carers whilst in hospital. This should include information given to people in a dementia friendly way and that the hospital adopts ways of working that support staff to deliver care that is dementia friendly.

Charter Principles:

a. Governance structures:

- The health board is signed up to the Dementia Friendly Hospital Charter for Wales and the Dementia Statements are used to inform approaches to care.
- There is a senior member of staff within each region who guides and monitors delivery of the regional dementia strategy.
- The health board has an Executive Board member designated with responsibility for dementia care.
- Clinical dementia specialist leads have access to dementia champions / link workers and volunteers that can work with each area to support the delivery of dementia care.
- There is a Dementia Friendly Hospital Charter Workstream Group that connects to the regional dementia board. It is inclusive of all staff groups, third sector and members of the public that monitor the delivery of care and includes perspectives of people with dementia, their carers and family members.
- The quality of care is monitored both internally and externally via the Charter Regional Partners Review Task Group.
- The Dementia Friendly Hospital Charter Steering Group provides regular dementia care updates to the regional dementia board and the regional partnership board.
- The contracts with agency staff and contractors specify how they will uphold the principles of the Charter and are involved in the implementation.
- The organisation is supportive of the Alzheimer's Society's Dementia Friends initiative.
- The organisations have good quality, robust and accessible practices to ensure safeguarding and whistleblowing.
- The organisation upholds a “see it, sort it” principle to address themes relating to the care and needs of people living with a dementia.

b. Human Resources:

- Support is provided for staff to work flexibly when they care for a person with dementia.
- Policies and procedures help combat stigma towards employees affected by dementia and reasonable adjustments are made to enable them to continue working.

c. Feedback:

- There is a robust system for routinely gathering timely meaningful feedback, capturing the experiences from people with dementia, their carers and staff. Where feedback highlights areas for improvement, time should be taken to explore the issue and respond if requested. The responses should address the issue and highlight any steps to be taken to change and improve the experience of people living with dementia.
- This system for feedback is clearly visible and readily available when required.

Communication Principles:

- There is a communication strategy for the Dementia Friendly Hospital Charter.
- A compliments and complaints policy are accessible in an appropriate format for people with dementia and their family.
- Regular focus groups and other engagement mechanisms are organised with people with dementia and their carers, plus outside partners, where appropriate.
- The hospital participates in the National Audit for Dementia Care using a multi-disciplinary approach.
- Patient Advice and Liaison Service (PALS) is available, clearly signposted and provides dementia-specific information, care and support. They are trained to understand the needs of people with dementia and their carers, supporters and family members.
- Advocacy services for people living with dementia and carers are readily accessible.
- Religious and spiritual advice is readily accessible on a 24-hour basis for people living with a dementia.
- Services provide an active offer in Welsh where it is the person's primary language. Staff are supported to deliver care in Welsh. Services and care will be provided in Welsh and other languages where needed. Staff are encouraged to improve their Welsh language skills.
- Services provide translation in the person's primary language to support communication and care. This would also include the use of British Sign Language (BSL) interpreters.
- People living with dementia and their carers are informed about the opportunities and right to decide if they wish to be involved in research.

In addition to this Charter, there is:

- A readiness pre-assessment form to complete based on how ready a health board is in working towards adopting the Charter.
- A self-assessment online tool – Care Fit For VIPS that will be helpful for all partners to determine the health boards position in meeting the principles and to review progress in implementing the Charter.
- A growth (implementation) plan to assist all partners in meeting the Charter principles.


Providing care centred around the person, building relationships and partnerships runs throughout this document and should be considered within each principle.

WITH THANKS TO

The partners that have worked with Improvement Cymru and the Alzheimer's Society Cymru in coproducing the Dementia Friendly Hospital Charter for Wales:

- Age Cymru
- Bangor University
- British Deaf Association
- Cardiff University
- Care and Repair
- Care Inspectorate Wales
- Carers
- Cardiff University
- Crystal Creative Digital Agency
- Dementia Matters Powys
- Diverse Cymru
- Health Inspectorate Wales
- Improvement Cymru
- NHS Wales Delivery Unit
- NHS Wales Health Collaborative
- NHS Wales Hospitals
- National Institute for Health Research[1]
- People living with dementia
- Royal College of Psychiatrists
- Social Care Wales
- Swansea University
- TIDE
- University of South Wales
- University of Worcester
- WCVA (Wales Council for Voluntary Action)
- Welsh Ambulance Service
- Welsh Government
- Welsh Language Commissioner
- Welsh Regional Partnership Boards

With a special mention to:

- 3 Nations Dementia Working Group
- Alzheimer's Society Cymru
- Improvement Cymru
- Lleisiau DEMENTIA
- National Dementia Action Alliance
- Practitioners, volunteers and staff from across all settings

[1]https://fundingawards.nihr.ac.uk/award/13/10/80

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GWELLIANT CYMRU IMPROVEMENT CYMRU

GIG CYMRU NHS WALES

All Wales Dementia Pathway of Standards

Overarching Guide to National and Regional Workstreams

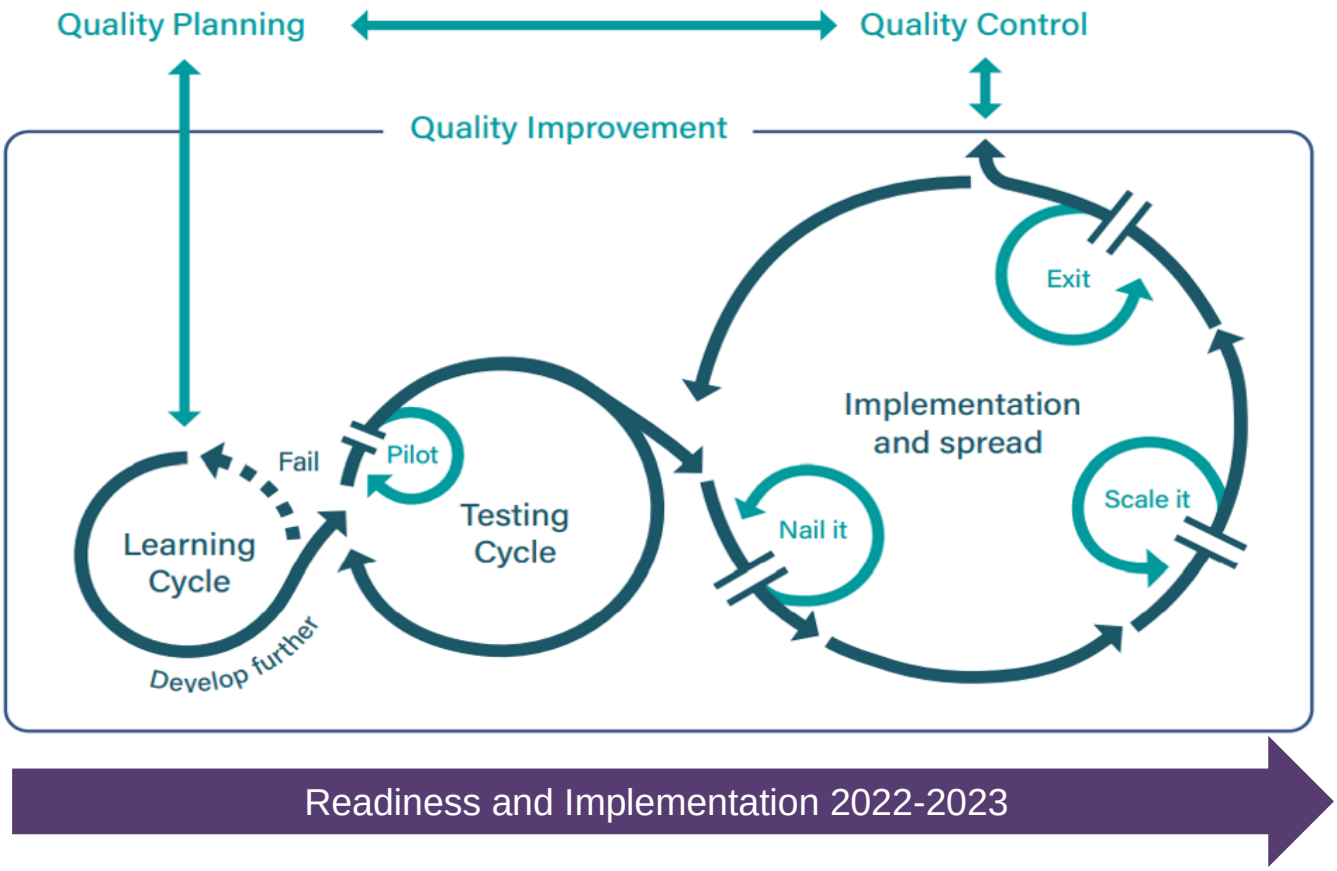
January 2022

Improvement Cymru Aims

To achieve our aim, we have three strategic priorities:

- **Support health and care organisations to redesign and continuously improve the service they provide.**
- **Support a focus on reduction in avoidable harm and safety within systems of care.**
- **Sustainably build improvement capability within the health and care system.**

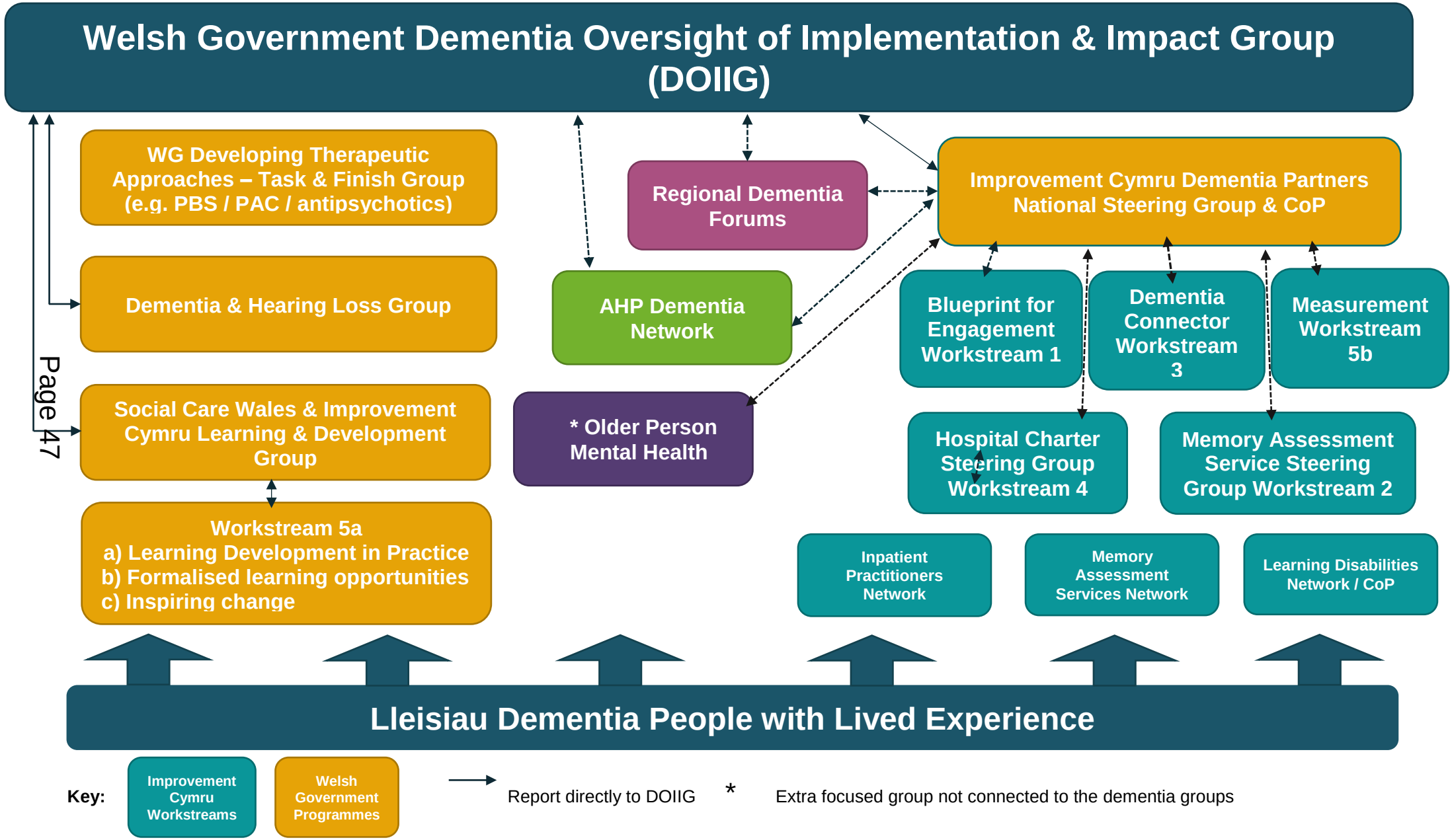
Delivery Framework



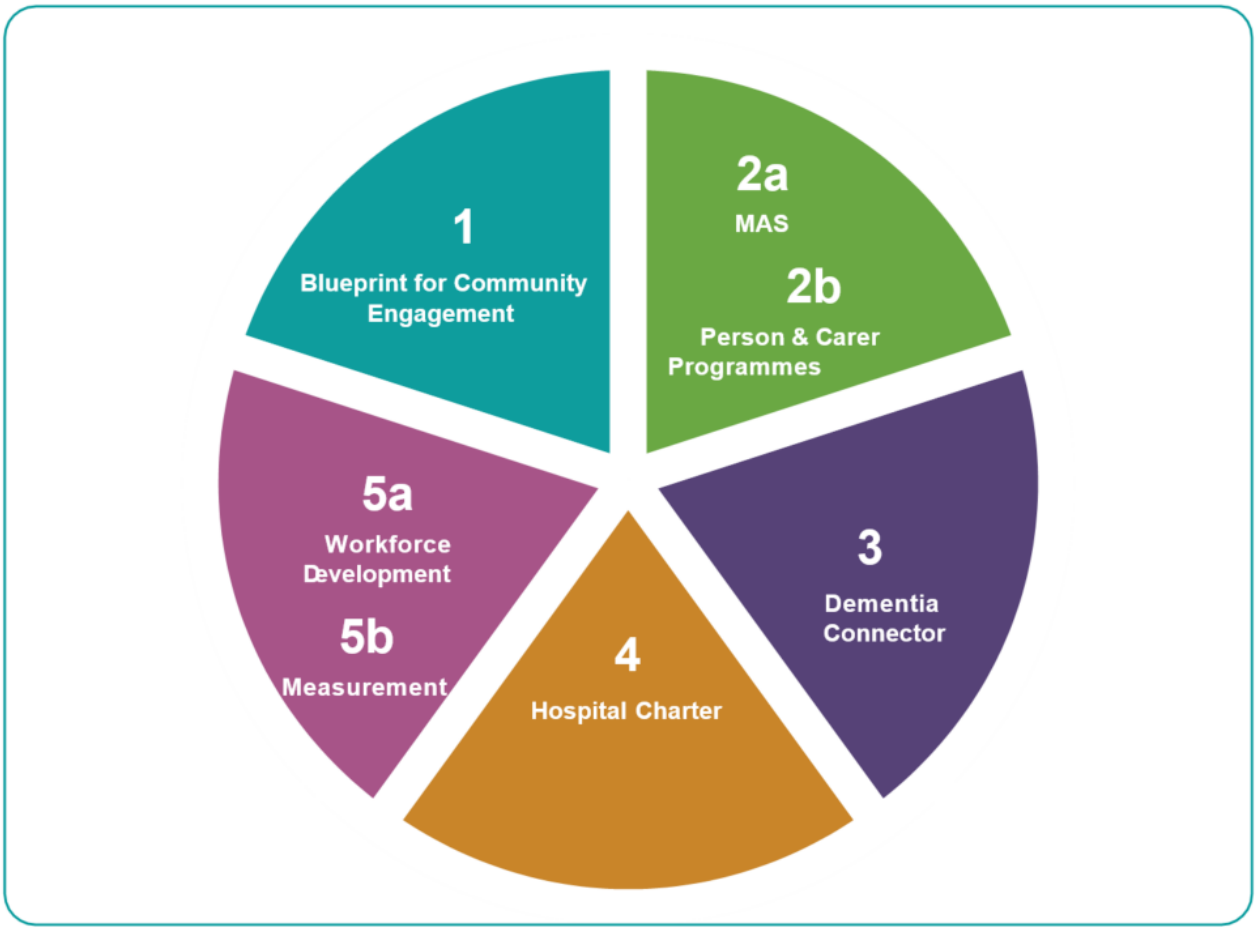
The Improvement Cymru Delivery Framework offers a systematic, repeatable process that adapts to the specific needs of each regional context and provides opportunities for learning, testing and sharing ideas. It seeks to support organisations and health and care professionals to navigate the stages of adoption in the critical early stages by enabling the testing and co-producing of improvements. The framework supports the readiness and implementation phases of the dementia pathway of standards.

Regions can use the framework to enable a focus on planning, engagement, testing and spread and scale of improvements, looking to build more effective, system wide improvement capability that integrates with local and national priorities. The framework also ensures citizen involvement at a local level so that improvements are co-produced and achieve outcomes that matter to citizens.

National Dementia Programme Structure



Workstream Wheel



The diagram above illustrates the national and local workstreams that support the regional dementia board with readiness and implementation of the all Wales Dementia Pathway of Standards. Each workstream has a focus on a relevant selection of standards. The national workstreams are in place for regional leads and workstream members to engage with, ensuring there is a focus on shared learning, coproduction and development of resources to enhance dementia care across Wales.

Dementia Workstream Descriptors

Workstream 1 Community Engagement	Workstream 2 MAS	Workstream 3 Dementia Connector	Workstream 4 Hospital Charter	Workstream 5 Workforce & Measurement
Standard one - Community engagement steering group *(1)*	**2A MAS** Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings *(2)*	Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings *(2)*	Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings *(2)*	**5A Workforce development** All staff delivering care at all levels within all disciplines and settings, will have opportunities to participate in person centred learning and development with support to implement into daily practice *(17)*
Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings *(2)*	Memory Assessment Services (MAS) and Primary Care (GP) adopt READ Codes to capture diagnosis /MCI. **Includes Inpatient – connection with Hospital Charter *(3)*	People living with dementia and their carers will have a named contact (connector) to offer support, advice and signposting, throughout their journey from diagnosis to end of life *(12)*	Wales will adopt the Dementia Friendly Hospital Charter with a regular review of implementation and outcomes *(11)*	**5B Measurement** Working in partnership the region will deliver on the requirements of the agreed data items (measurement workbook (handbook)) for reporting and assurance *(20)*
People living with dementia will have access when needed to relevant (and when accessing mental health services) dedicated services post diagnosis no matter their residence (listed) e.g. physiotherapy, dietetics *(13)*	Health and social care services should provide the outcomes of an agreed set of completed assessment & interventions when referring to Memory Assessment services (presenting need is indicated) *(5)*	Within 12 weeks of diagnosis will be offered support to commence planning for the future, including end of life care *(15)*	Organisations and care settings providing intensive dementia care, (this includes mental health and learning disabilities inpatient settings) provide Dementia Care Mapping (DCM) in routine practice *(16)*	
People living with dementia will have a current face to face appointment where a physical health review will be delivered in partnership by primary and secondary care *(14)*	Memory Assessment Services within a 12 week period from point of referral provide a range of interventions (listed) to support diagnosis. Digital platforms and other adaptions and approaches may need to be considered *(6)*		Transitions within hospital settings and flow in and out of hospital *(19)*	

People living with dementia and their carers / families will have support and assistance to engage with appointments. (18)	People access a contact that can provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis and ensure, following this period it is offered as required *(7)*			
	People living with Mild Cognitive Impairment will be offered a choice of holistic services monitoring their physical, mental health and wellbeing *(8)*			
	2B Person & Carer Programmes Learning Disability services will define a process to capture the total population of people living with Learning Disability and specifically Downs Syndrome to offer a cognitive wellbeing check. *(4)*			
	Within 12 weeks of receiving a diagnosis people living with dementia (after diagnosis) will be offered education and information on the importance of physical health activities to support and promote health *(9*			
	People with dementia / Carers education and skills programme *(10)*			

Commitment from Workstream Leads

Attend national Blue Print for Engagement (1.5hrs every 2/12) Develop and convene regional workstream e.g. membership and governance Support working groups as and when generated locally and ensure representation at national groups Take the learning and actions from all opportunities provided nationally and locally to support implementation in the region Coordinate and facilitate local planning and implementation with partners	Attend national Memory Assessment Services Sub Group (1.5hrs every 2/12) Develop and convene regional workstream e.g. membership and governance Obtain and use feedback from practitioners attending the LD Community of Practice in your region Support working groups as and when generated locally and ensure representation at national groups Take the learning and actions from all opportunities provided nationally and locally to support implementation in the region Coordinate and facilitate local planning and implementation with partners	Attend national Dementia Connectors Meeting (1.5hrs every 1/12 -due to convene March 2022) Develop and convene regional workstream e.g. membership and governance Attend or identify representative for the Memory Assessment Services Sub Group (1.5hrs every 2/12) Support working groups as and when generated locally and ensure representation at national groups Take the learning and actions from all opportunities provided nationally and locally to support implementation in the region Coordinate and facilitate local planning and implementation with partners	Attend national Hospital Charter Steering Group (1.5hrs every 2/12) Develop and convene regional workstream e.g. membership and governance Obtain and use feedback from practitioners attending the Inpatient Practitioners Network meeting Support working groups as and when generated locally and ensure representation at national groups Take the learning and actions from all opportunities provided nationally and locally to support implementation in the region Coordinate and facilitate local planning and implementation with partners	5a lead) Attend national Dementia Learning and Development for the workforce group (2hrs 1/12) 5b lead) Attend national Data measurement group (1.5hrs every 2/12) Develop and convene regional workstream e.g. membership and governance Support working groups as and when generated locally and ensure representation at national groups Ensure connection and purpose for measurement is clearly identified within local workstreams Take the learning and actions from all opportunities provided nationally and locally to support implementation in the region Coordinate and facilitate local planning and implementation with partners

** There will need to be alignment and liaison between workstreams to cross reference some areas of practice and need e.g. workstream one: community approaches to dementia care will link with programmes and interventions designed to support the person and carers pre and post diagnosis; flow into and out of hospital will align to approaches across a community; workforce development aligns with all workstreams as does measurement. This is where the overarching dementia board plays a role in connecting the functions, actions and learning.

Standards Descriptors

1	Phase One: community engagement using one locality within a region working in partnership, taking 6 months. 'what dementia care and intervention looks like around here'
2	Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings
3	Memory Assessment Services (MAS) and Primary Care (GP) adopt READ Codes to capture diagnosis /MCI. Includes Inpatient
4	Learning Disability services will define a process to capture the total population of people living with Learning Disability and specifically Downs Syndrome to offer a cognitive wellbeing check.
5	Health and social care services should provide the outcomes of an agreed set of completed assessment & interventions when referring to Memory Assessment services (where presenting need is indicated)
6	Memory Assessment Services within a 12 week period from point of referral provide a range of interventions to support diagnosis. Digital platforms and other adaptions and approaches may need to be considered
7	People access a contact that can provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis and ensure, following this period it is offered as required
8	People living with Mild Cognitive Impairment will be offered a choice of holistic services monitoring their physical, mental health and wellbeing
9	Within 12 weeks of receiving a diagnosis people living with dementia (after diagnosis) will be offered education and information on the importance of physical health activities to support and promote health
10	People living with dementia, carers and families will be offered learning, education and skills training.

11	Wales will adopt the Dementia Friendly Hospital Charter with a regular review of implementation and outcomes
12	People living with dementia and their carers will have a named contact (connector) to offer support, advice and signposting, throughout their journey from diagnosis to end of life.
13	People living with dementia will have access when needed to relevant (and when accessing mental health services) dedicated services post diagnosis no matter their residence (listed) e.g. physiotherapy, dietetics
14	People living with dementia will have a current face to face appointment where a physical health review will be delivered in partnership by primary and secondary care
15	Within 12 weeks of diagnosis will be offered support to commence planning for the future, including end of life care
16	Organisations and care settings providing intensive dementia care, (this includes mental health and learning disabilities inpatient settings) provide Dementia Care Mapping in routine practice
17	All staff delivering care at all levels within all disciplines and settings, will have the opportunity to participate in person centred learning and development with support to implement into daily practice
18	People living with dementia and their carers / families will have support and assistance to engage with appointments
19	Services will ensure that when a person living with dementia has to change / move between any settings or services, care, will be appropriately coordinated to enable the person to consider and adapt to the changed environment
20	Working in partnership the region will deliver on the requirements of the agreed data items (measurement workbook (handbook)) for reporting and assurance