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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.





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

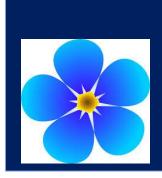
Standing item on the agenda, at Dementia Board

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



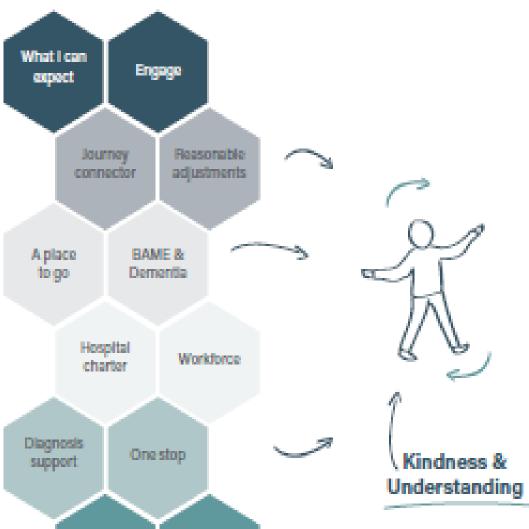
4 Themes 20 standards wrapped around the person

Accessible

Responsive

Journey

Partnerships & Relationships



Learning

disability &

dementia

Carer

learning



Standard Descriptors 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

Standards 1-5 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

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

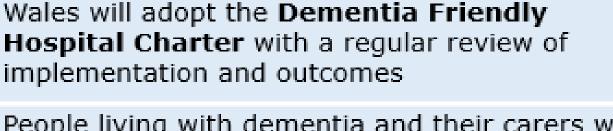
Standards 6-10

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



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 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

Standards 16-20 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

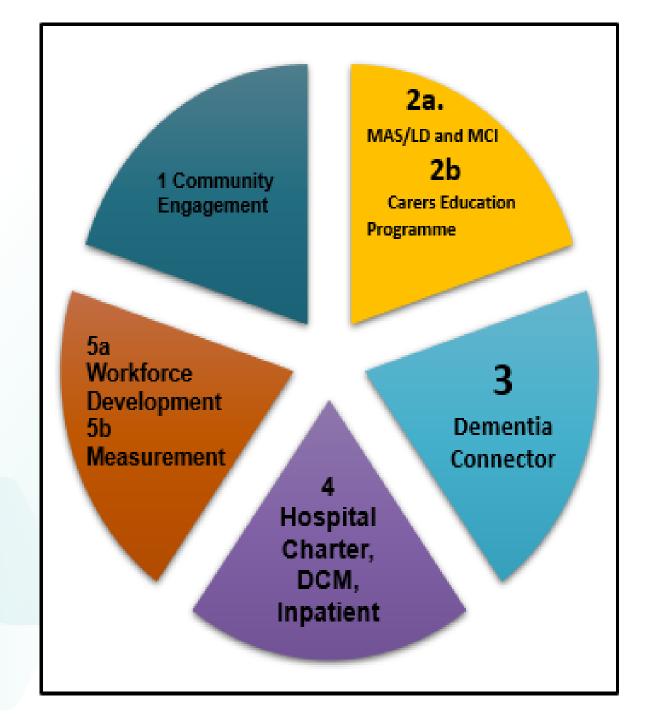
learning and development with support to

implement into daily practice

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)

<u>Subgroup</u> Workstream 5a

Learning and Development

(JH, JL)

Subgroup Workstream
5h

Measurement Group And Handbook Workstream leads update.

(NH, SH)

Overarching NSG

Gwent Regional Dementia Boards



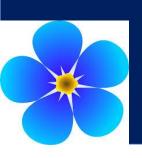
Charter Aims

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

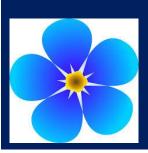


Feedback From Person Living with Dementia

"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

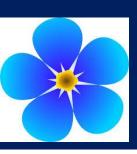
 Revised Regional Dementia Action Plan to reflect the standards

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?





For more info Contact:

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