GWELLIANT CYMRU IMPROVEMENT CYMRU

GIG CYMRU NHS WALES

# All Wales Dementia Pathway of Standards

## Overarching Guide to National and Regional Workstreams

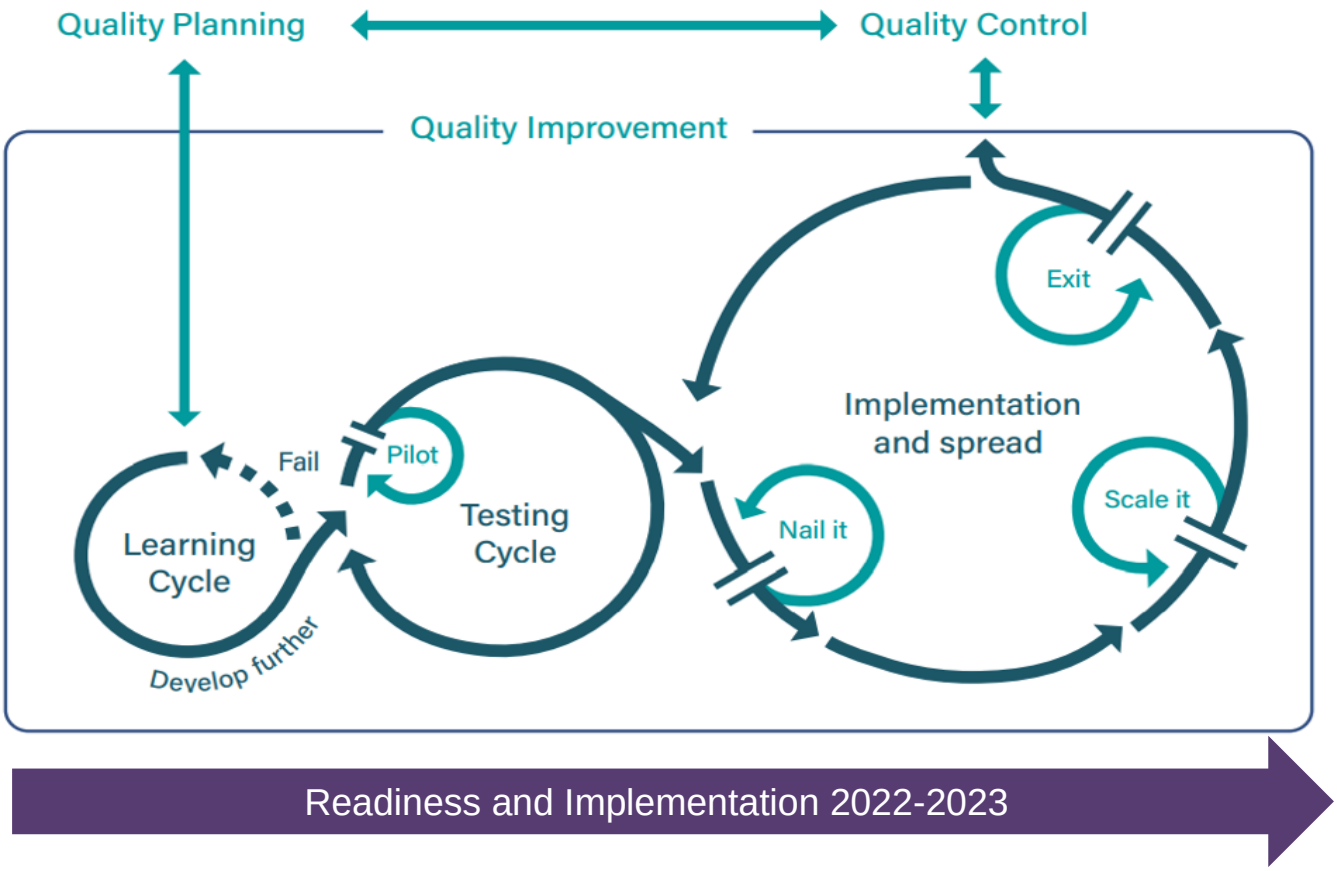
January 2022

# 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.**

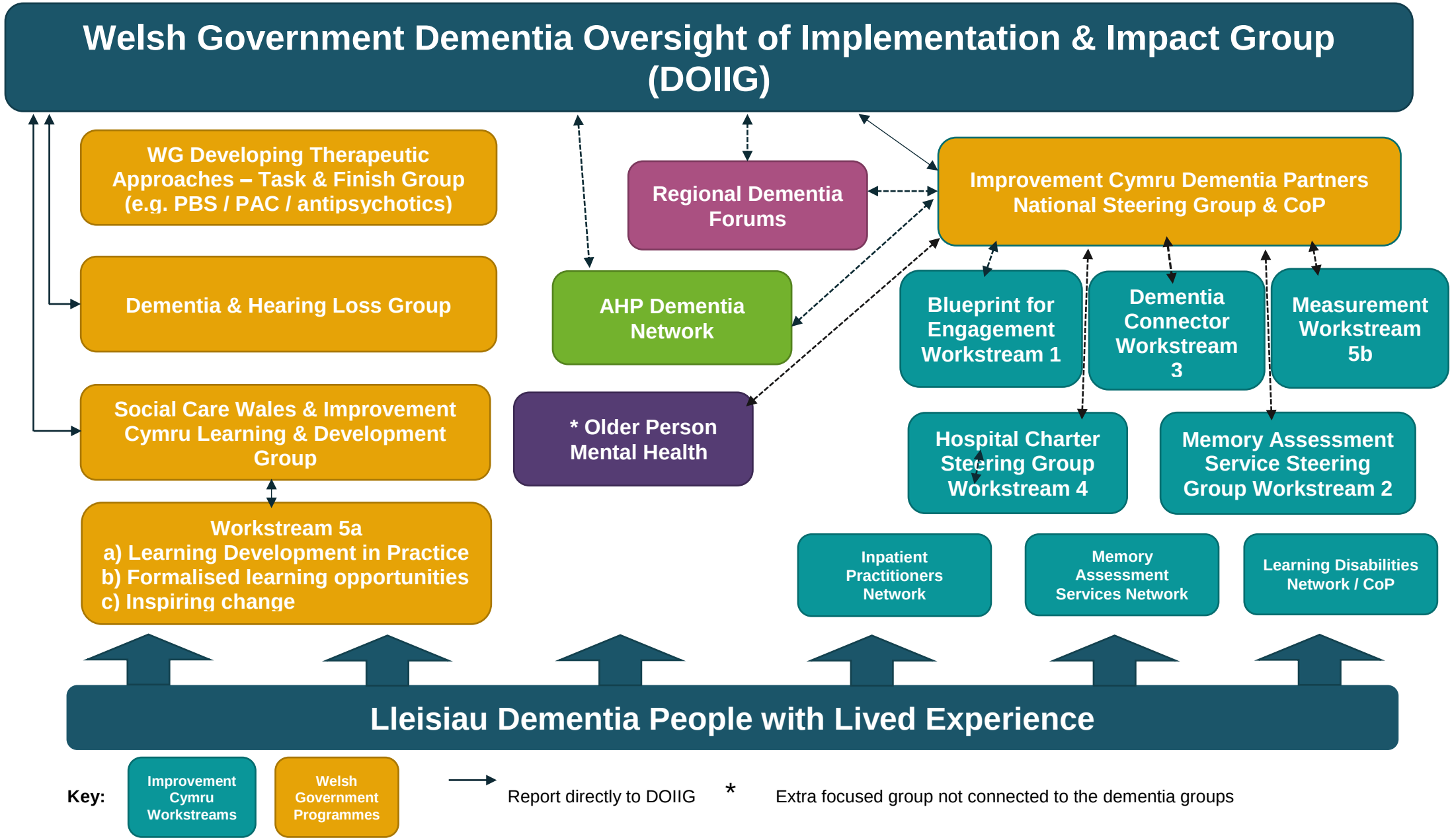
# Delivery Framework



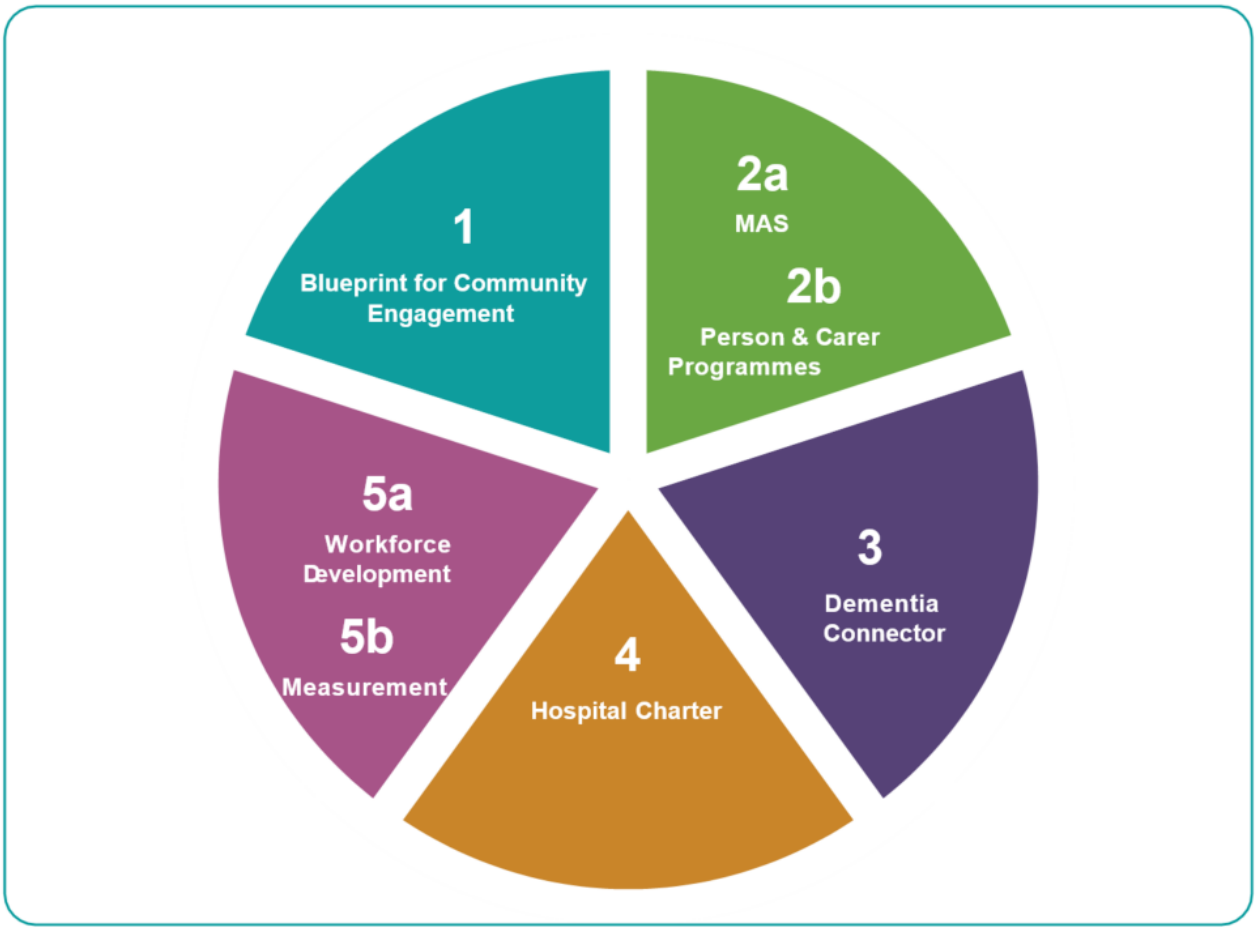

The Improvement Cymru Delivery Framework offers a systematic, repeatable process that adapts to the specific needs of each regional context and provides opportunities for learning, testing and sharing ideas. It seeks to support organisations and health and care professionals to navigate the stages of 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 |
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| 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)* | |

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| 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**<br>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

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

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| 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. |

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| 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 |