GWELLIANT CYMRU IMPROVEMENT CYMRU

GIG CYMRU NHS WALES

All Wales Dementia Pathway of Standards

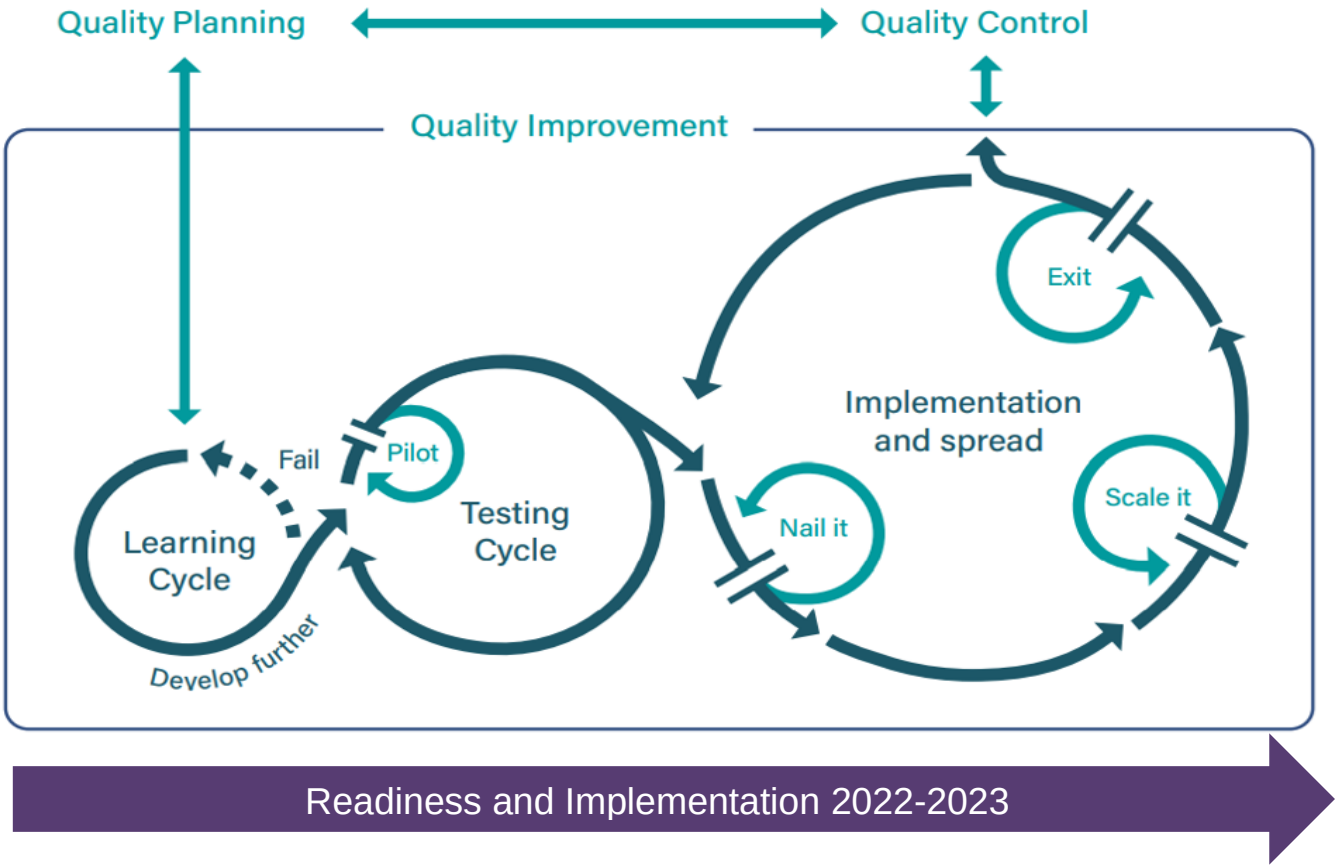
Workstream 3: Dementia Connector

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.

Introduction

This document outlines a range of self-assessment questions that supports the regional workstreams in preparing for the All Wales Dementia Pathway of Standards delivery framework, (readiness and implementation programme of work). The questions will help each workstream get ready, identify areas of focus, along with ensuring support is in place to meet key requirements and the regions commitment to achieving the dementia pathway of standards.

Take some time to answer the questions. Keep in mind that this piece of work supports the workstream leads and membership to develop implementation plans, review existing processes and determine that the correct stakeholders are represented.

The responses to the questions will help with a regular review of progress going forward and to look back and assess achievements.

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.

1. Workstream 3 Focus Areas

Standard 2	Services at the points of contact will provide reasonable adjustments to care. Includes community and inpatient settings
Standard 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.
Standard 15	Within 12 weeks of diagnosis will be offered support to commence planning for the future, including end of life care

2. Connected areas to consider related to workstream focus

Standard 1	Engage with a community to determine what dementia care looks like – what does that community need and want. There is a focus on developing engagement activities to inform future planning
Standard 3	Memory Assessment Services (MAS) and Primary Care (GP) adopt READ Codes to capture diagnosis /MCI. Includes Inpatient
Standard 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.
Standard 5	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 6	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
Standard 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

Standard 8	People living with Mild Cognitive Impairment will be offered a choice of holistic services monitoring their physical, mental health and wellbeing
Standard 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
Standard 10	People living with dementia, carers and families will be offered learning, education and skills training
Standard 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 e.g. physiotherapy, dietetics
Standard 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
Standard 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
Standard 18	People living with dementia and their carers / families will have support and assistance to engage with appointments
Standard 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
Standard 20	Working in partnership the region will deliver on the requirements of the agreed data items (measurement workbook (handbook)) for reporting and assurance

3. Questions for the workstreams to consider

This set of questions can help you to get ready, ensuring that you have all the necessary processes, membership and resources in place to support this workstream. The questions below are for consideration.

1. Do you have a lead(s) for dementia workstream 3 – who are they and if you have more than one, how can they work together?

2. Do you have identified, dedicated programme support? Admin support? That offers programme support to the workstream?

3. How will you ensure that people living with dementia and their carers are engaged, involved and coproducing in every stage of this work?

4. Have you engaged your Quality Improvement / transformation team or identified individuals to help with the standards related to your workstream. How are they going to support you?

    - Who and how can you get the Quality Improvement / transformation leads involved?
    - Is there anybody else within the teams, organisations and systems that might have skills and experience in Quality Improvement?

5. Who should be part of the workstream? Do you have the right membership to ensure delivery of the focus areas within the standards? Members can come from a wide range of representatives – see the Overarching Guide to National and Regional Workstreams document for further guidance.

6. Do you have a reporting template and mechanisms to support feedback to your regional dementia board (where responsibility for the dementia standards will sit)?

7. How will you link and connect with other workstream and areas to keep up-to-date with the other standards and pieces of work which may directly influence or be related to your workstream work?

8. How often will you meet as a workstream? When considering this be mindful that you may also need working groups to support the detail of the workstream. These will be identified as you work through the standards and start to drill down to the detail.

9. Does your workstream have a shared purpose, values and beliefs statement? Would you like support from Improvement Cymru to create a shared purpose, values and beliefs statement? This maybe a good starting point to support partnership working and informing the work.

10. What further support do you need as a workstream to support the standards programme?

4. Reporting and feedback

1. Who will the workstream lead/s be reporting to? Is there a clear structure and line of communication?
2. What networks will receive reports and updates? How are you going to feedback to other networks?
3. How frequently will you feedback on your progress to the dementia board, regional partnership board and other networks?
4. Is there a person responsible for this workstream sitting on the dementia board or regional partnership board?
5. Do you have representatives attending the national workstreams, meetings, networks and community of practice?
6. Consider what support you need.

5. Communication and publicising

1. Do you have a communications representative that links to the workstream? Do you have a communications plan?
2. How will you go about publicising the work of the workstream and the standards to:
   a) The public b) Organisations c) To the workforce?
3. What resources do you need to publicise the Dementia Pathway of Standards? What support will you need?
4. Will you be able to promote the standards on websites (health, LA, 3rd sector, other) and in any other forms of communications that you have?
5. How do you share good practice across your region and other regional partnership boards?
6. What support do you need?
7. Consider developing a regional taskforce approach to share, communicate and implement the workstream.

6. Activities for the workstream lead and others to consider to inform the work programme

1. Connect and find out more about the service areas / communities related with the standard e.g. community groups and services, hospital services and settings, mental health, learning disability, different disciplines and departments.

2. Understand the hospital and community infrastructure, services and systems that relate to the standards. To do this you might want to consider the following:

    - Meet with teams, partners and organisations to understand the process, culture and systems
    - Connect with people receiving and delivering the service to find out about their experience
    - Analyse information and data already available from the service areas, clusters, organisations that relate to the hospitals and community you are working with
    - Determine what you know and what you don't know
    - Undertake engagement activities with the hospital community – people and groups
    - Use a range of improvement tools such as process maps (map the areas which you know are problematic). Pareto Charts may help you identify where to focus improvement activity, driver diagrams to focus and generate ideas
    - Plan and coproduce with all partners to achieve the identified aims
    - Undertake a workstream values and beliefs exercise – this will determine the workstreams shared purpose and any differing views within the membership.

7. Other

1. Do you see any risks, have any concerns, or have any questions? Use the national leads and workstreams for support and advice.

2. Do you already implement any dementia-friendly initiatives? E.g. dementia care volunteers, IT technology, technology support etc.

3. Do people know about any dementia-friendly initiatives, do you know the impact of these initiatives – how can you build upon them, are they connected to this work stream?