Aberdeenshire Health & Social Care Partnership

‘Making Connections’, Aberdeenshire Dementia Strategy DELIVERY PLAN 2021 – 2022

Strategic Priority **A. BEING WELL INFORMED**				
Key outcome – **1.** People feel knowledgeable about dementia and are not afraid to talk to someone if they are concerned that they, or someone they care about, are experiencing the symptoms of dementia. (Locally identified).				
Outcome	**Link to AHSCP Priorities**	**Action**	**Milestones**	**Performance monitoring**
A1.	Prevention and Early intervention	Raise awareness within Aberdeenshire around the importance and benefits of seeking a diagnosis of dementia. This will include; • Formal launch of strategy with associated promotion in January 2021. • Programme of awareness raising / dementia positive events for Dementia Awareness week June 2021.	Feedback from those who use services indicates that the wider community within Aberdeenshire has a better understanding of the benefits of dementia diagnosis and the support available.	Majority of diagnosis made when person presenting with Early (Mild) Stage dementia as determined in the Scottish Government’s Dementia Post-Diagnostic Support (PDS) Dataset.

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B. GETTING A DIAGNOSIS OF DEMENTIA

Key outcomes -

- More people have increased say and control over their dementia diagnosis and are diagnosed early enough that they can take as full a part as possible in their own care planning. (Nationally identified)
- More people get earlier access to good quality, person-centred post-diagnostic support in a way that meets their needs and circumstances. (Nationally identified)
- People living with dementia receive a timely diagnosis and can access post-diagnostic support. (Locally identified)

Outcome	Link to AHSCP Priorities	Action	Milestones	Performance monitoring
B1 & B3 – Diagnosis	Prevention and early intervention	Manage the backlog in Dementia assessment referrals following paused services during the COVID-19 pandemic. Primary and Secondary Care working together to support timely diagnosis for those referred during the COVID-19 pandemic.	Backlog is reduced and diagnosis is carried out in a timely manner in line with expected national standards.	Comparative diagnosis data pre and post-pandemic indicates that the backlog has been reduced.
B2 & B3 – Post-diagnostic Support	Prevention and early intervention	Establish an Aberdeenshire Post-diagnostic support Monitoring Group to monitor overall delivery of PDS in Aberdeenshire. Remit of the group will be to; • Monitor the Alzheimer Scotland PDS link worker contract	PDS is delivered consistently across Aberdeenshire to everyone with a new Dementia diagnosis.	Scottish Government's Dementia Post-Diagnostic Support (PDS) Dataset indicate that Aberdeenshire HSCP are meeting national requirements. Contract Monitoring data from Alzheimer Scotland indicates targets are being met.

		including the development of PDS Groupwork Model. • Monitor consistency of PDS delivery across Aberdeenshire. • Ensure accurate and consistent recording and reporting of all people who receive post diagnostic support		Qualitative performance information gathered indicates those receiving PDS are satisfied with the support they receive.
B1. Care Panning	Prevention and early intervention	Promote ongoing development of anticipatory care planning for all PLWD in Aberdeenshire	PLWD less likely to have unsatisfactory outcomes as a result of crises and unplanned requirement for support as a result of planning ahead for future care needs.	Increase in ACPs completed for PLWD in Aberdeenshire.

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C. KNOWING WHO TO TURN TO

Key outcomes

1. People living with dementia understand what support may be available to them and are able to link into support as and when it is required. (Locally identified)

Outcome	Link to AHSCP Priorities	Action	Milestones	Performance monitoring
C1.	Prevention & early Intervention, Reshaping care	Aberdeenshire Dementia Pathway; Scope full Implementation of the Aberdeenshire Dementia Pathway, including Lead Worker Role (p. 28 & 29, Dementia Strategy).	PLWD report that they know who to turn to for support at any stage of the dementia pathway.	TBC – to establish a means of consistently recording 'lead worker' will require consideration of different Health and Social Care systems. Qualitative feedback from PLWD and carers indicates improvement.
C1.	Prevention & early intervention	Ensure the Aberdeenshire Dementia website is kept up to date with relevant information. • Initial review / refresh January 2021.	Information on advice and support is publicly available. Those who require information have a means of accessing information as and when they require it.	Increased use of Dementia Aberdeenshire Website.

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D. LIVING WELL WITH DEMENTIA

Key outcomes –

1. There are more dementia-friendly and dementia enabled communities, organisations, institutions and initiatives (Nationally identified)
2. The use of technology is promoted with people living with dementia. (Locally identified)
3. People living with dementia do not experience barriers to accessing their chosen communities and living a happy healthy life. (Locally identified)

Restrictions on groups and face to face contact currently in place to manage the COVID-19 pandemic have significantly impacted, and will continue to impact, on our ability to progress these outcomes. It is likely there will be additional actions to be taken forward in 2022 onwards to progress these.

Outcome	Link to AHSCP Priorities	Action	Milestones	Performance monitoring
D2.	Prevention and Early Intervention	Provide support to PLWD and Carers to increase the use of appropriate digital technology to improve access to support for people living with dementia.	PLWD can access support from professionals via digital means.	Increased use of 'Near Me' appointments for PLWD. Increased use of digital for visiting during hospital admissions.
D2.	Prevention and Early Intervention	Increase use of digital technology to maintain independence of PLWD at home. • Enhancing lives through technology programme - This project specifically focuses on the use voice controlled assistance devices to aid PLWD in their instrumental activities of daily living.	PLWD can live independently for longer and if care at home support is required it is needed at a later stage.	A range of performance measures are outlined within the project.
D1.	Prevention & Early Intervention, Reshaping Care	Working in partnership – Council, Independent & Third sector	PLWD have a range of community support options available including	To be determined following initial scoping work.

		Scope community support services available to people living with dementia in Aberdeenshire during the pandemic and beyond.	options for social support to reduce loneliness and isolation as a result of the pandemic.	
D1.	Prevention & Early Intervention, Reshaping Care	Holistic Services Review the holistic services contract currently in place with Alzheimer Scotland and consider requirements for the future.	A range of options of support are available for PLWD which reflect the needs of PLWD in Aberdeenshire.	Performance information from existing contract to be considered.
D3.	Prevention & Early Intervention, Reshaping Care	Work in partnership with those who have a young onset dementia diagnosis to develop appropriate support services. • Work with partners across Grampian (including Aberdeen City & Moray HSCPs) to consider the support needs of people with a young onset dementia diagnosis and the development of support options for this group.	The AHSCP can demonstrate a better understanding of the support needs of people with a young onset diagnosis and support is tailored to these needs.	People with a young-onset diagnosis report more positive outcomes. An understanding of the needs of People with a young onset diagnosis in Aberdeenshire informs the 2022-2025 Delivery plan.

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E. DEVELOPING HEALTH AND SOCIAL CARE SUPPORT FOR PEOPLE LIVING WITH DEMENTIA

Key Outcome –

1. People living with dementia are supported to maintain independence and where support or services are required this is appropriate, proportionate and person-centred. (Locally identified)

Outcome	Link to AHSCP Priorities	Action	Milestones	Performance monitoring
E1.	Reshaping Care	Social Support options. Support the H&SC workforce to develop appropriate social support options for those with eligible needs, in partnership with PLWD, in line with current COVID-19 pandemic limitations.	Social isolation is reduced for PLWD who are unable to access their usual social supports as a result of the pandemic.	Unmet need is reduced. Increase in alternative social support packages for PLWD.
E1.	Prevention & Early intervention	PLWD have independent advice and support so their past and present views are taken into account. • Ensure that people with dementia have access to Independent Advocacy.	PLWD feedback that they experience better outcomes.	PLWD have the same access to Independent Advocacy as per population group. This can be measured by referral rates.
E1.	Reshaping care	Ensure participation in training for all staff caring for people with dementia in all settings • PLWD are supported by staff who have a good understanding of dementia and their associated support needs.	We have a well-informed workforce.	PLWD will experience good quality of life and person-centred care. This will be monitored by information on complaints, Care Inspectorate ratings, Adult Support and Protection referrals.

		• Develop local plans for delivering the "Promoting Excellence Framework" • Development of Stress and Distress training		All staff across the HSCP should be educated to the correct level of The Promoting Excellence Framework which is plotted against the level of input they have with PLWD and their family carers. This can be measure across TURAS and other HSCP training dashboards and by patient and carer experience. Reduction of referrals to secondary care. Patient and family carer experience Positive staff experience
E1.	Reshaping Care	Promote "Dementia: 10 Actions in rural hospitals" Community hospitals are well equipped to meet the needs of PLWD.	PLWD indicate that they have a positive experience of treatment within our community hospitals.	Collaborative work ongoing in Rothieden ward. Measured by Quality improvement methodology.

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Strategic Priority **F. CARING FOR CARERS**				
Key outcome – 1. During the process of diagnosis and through all parts of the care journey, the critical input of carers is encouraged and facilitated, and carers own needs are recognised and addressed. (Nationally identified)				
Outcome	**Link to AHSCP Priorities**	**Action**	**Milestones**	**Performance monitoring**
F1.	Reshaping Care	Support Carers of PLWD to have appropriate breaks from Caring in line with current COVID-19 pandemic limitations.	A range of support options are available for carers of PLWD.	Carers report that they are able to take appropriate breaks from their caring roles.

Fluidity and change is to be expected in all projects, this plan should be considered a live documents which will continue to be reviewed and where appropriate modified in consultation with the delivery group, including further definition of milestones against which progress will be reported back to IJB. Further national and local performance measures may also be added to this Delivery plan as they are developed and become available.