ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Aberdeenshire Dementia Strategy

2015 – 2018

Local Implementation Plan for Delivery of Scotland's National Dementia Strategy

Aberdeenshire Dementia Strategic Outcomes Group

Final Version 12.1
19 July 2016

This document is also available in large print and other formats and languages, upon request. Please email: integration@aberdeenshire.gov.uk or telephone: 01224 664601.

Contents

Section		Page
Foreword		2
1.	A Better Tomorrow – Introduction and Vision	3
2.	Where We Are Now	5
3.	Our Approach to Make Things Better	11
4.	Involving the Wider Community	12
5.	Early in the Dementia Pathway	15
6.	Later in the Dementia Pathway	17
7.	Late Stage / Palliative Phase	19
8.	Action Plan	22
9.	Appendices	30

Acknowledgements

Thanks are extended to all contributors to this document and in particular members of the Aberdeenshire Dementia Strategic Outcomes Group (SOG).

Implementation and Review Process

The Aberdeenshire Dementia SOG will have responsibility for overseeing performance management of the strategy and its supporting action plan.

This strategy will be reviewed on an annual basis by the Aberdeenshire Dementia SOG with the first review due in March 2017.

Foreword

I am pleased to introduce the Aberdeenshire Dementia Strategy which has been developed as a supporting implementation plan to Scotland's National Dementia Strategy.

This local strategy is a product of collaboration between colleagues from across health, social care and the third sector, to provide a co-ordinated vision and action plan to deliver the best possible care for people with dementia, their carers and families within Aberdeenshire.

In developing the strategy it has reinforced the range of high quality care and support already provided by a number of different services across Aberdeenshire for people with dementia. In moving forward we will continue to strive towards achieving a co-ordinated, person-centred care pathway for people with dementia so that they feel informed, involved and supported throughout every stage of their condition.

In constructing the strategy we have attempted to ensure that each section can serve as a standalone leaflet which will be of relevance to both the public and professionals. Continued meaningful engagement with people with dementia and their carers will be integral to achieving the vision and aims of this strategy.

Mike Ogg
Chair, Aberdeenshire Dementia Strategic Outcomes Group

Addendum to Strategy – June 2016

In the course of creating and consulting on this Aberdeenshire Dementia Strategy, the Scottish Government has in the interim produced a further proposal document for the 2016-19 National Dementia Strategy[1]. This has been based on consultation and feedback from a number of Dementia Dialogue events held nationally. The next review of the Aberdeenshire Dementia Strategy will take place following publication of the new Scottish strategy (expected later in 2016) and will be revised where appropriate to ensure our strategic direction remains congruent with the national direction of travel.

[1] http://www.gov.scot/Topics/Health/Services/Mental-Health/Dementia/March

1. A Better Tomorrow

1.1 Introduction

There were an estimated 4,105 people in Aberdeenshire with dementia in 2014.[2] It is a condition which is increasing, mostly affecting people over the age of 65, and current projections estimate that the number of people with dementia will double in the next 25 years.[3]

This strategy aims to provide a co-ordinated vision and action plan on behalf of the NHS, Local Authority and Third Sector partners in Aberdeenshire, to support local implementation of the National Dementia Strategy and to deliver the best possible care and outcomes for people with dementia, their families and carers.

There are a number of different types of dementia including, most commonly, Alzheimer's disease and vascular dementia (see previous reference). Whilst growing old is recognised as the biggest risk factor in developing dementia this strategy acknowledges the need for awareness of the wide-ranging and complex nature of the condition (including for example early onset dementia) which can impact on the individual and those around them in many different ways. There is an inequalities dimension which is also important to recognise. This includes consideration of the potential risk factors associated with the development of dementia.[4]

1.2 Process – Developing the Strategy

The sections within this strategy have been written with the intention that each can serve as a standalone leaflet available to both the public and professionals.

The strategy has been produced by the Aberdeenshire Dementia Strategic Outcomes Group, a multi-disciplinary forum with responsibility for ensuring we deliver against our aims and objectives.

A public consultation process was also undertaken as part of this strategy's development, the key messages from which were:

- The importance of services working together in the delivery of multi-disciplinary, person-centred care, ensuring access to information and support from health and care professionals when needed and care packages tailored to the needs of the individual (including the 'social aspects' of care).

---

[2] Alzheimer Scotland (2014) 'Statistics: Number of people with dementia in Scotland 2014'. Source: http://www.alzscot.org/campaigning/statistics Date accessed: 22/07/14

[3] Alzheimer Scotland (2013) 'About dementia: some facts and figures', Information Sheet IS 16 October 2013 Source: www.alzscot.org.uk. Date accessed: 22/07/14

[4] Alzheimer's Society (2013) 'What is dementia?' Source: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=106 Date accessed: 24/06/15

- Ensuring a range and consistency of care and support for people with dementia and their carers, and access to a variety of local activities and services (maintaining the carers' health and wellbeing as well as the person being cared for).

- The need for health and social care to work with local communities to develop sustainable, mainstream initiatives to support people with dementia, their families and carers to remain independent and at home for as long as possible. In this regard the value of engagement across all parts of the community, including schools, businesses, local community centres etc was also identified, and allowing the opportunity for 'inter-generational projects'. The importance of appropriate housing and accommodation was also identified as a key issue.

- Recognition of the different types of dementia including, for example, alcohol-related dementias, and the specific care and support required to effectively diagnose and treat people with such conditions.

- The need to recognise the significant demands on General Practice when considering the future role of GPs in the diagnosis and management of people with dementia, and the importance of a multi-disciplinary approach in diagnosis, post-diagnostic support and the ongoing stages of care.

The Aberdeenshire Dementia Strategic Outcomes Group will strive to support regular and meaningful engagement with people with dementia and their carers, and staff and stakeholders, in the ongoing development and implementation of this strategy.

1.3 Vision

Our vision for people with dementia is consistent with the wider Aberdeenshire Health and Social Care Partnership (H&SCP) vision for all people, as described below:

> **Building on a person's abilities, we will deliver high quality person centred care to enhance their independence and wellbeing in their own communities.**

Appendix 1 provides the full vision, philosophy and principles of the Partnership.

The key outcomes of the National Dementia Strategy[5] are also fully endorsed and provide the main aims and outcomes for the Aberdeenshire Dementia Strategy. These are:

- more people with dementia living a good quality life at home for longer.

- dementia-enabled and dementia-friendly local communities, that contribute to greater awareness of dementia and reduce stigma.

- timely, accurate diagnosis of dementia.

[5] The Scottish Government (2013) 'Scotland's National Dementia Strategy 2013-16'. Source: http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316 Date accessed: 19/06/2014

- better post-diagnostic support for people with dementia and their families.
- more people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness.
- better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment.
- people with dementia in hospitals or other institutional settings always being treated with dignity and respect.

2. Where We Are Now

2.1 Policy and Strategic Context

The development of the Aberdeenshire Dementia Strategy has been informed and shaped by the wider policy context for dementia services in particular Scotland's National Dementia Strategy.

A range of other policies and initiatives are also in place at national and local level to support the provision of high quality care for people with dementia, described further below. [This is not an exhaustive list of policy drivers but rather attempts to provide a high-level summary of some of the key influences on the future delivery of dementia services across Aberdeenshire.]

2.1.1 Scotland's National Dementia Strategy

Since 2007 dementia has been identified by the Scottish Government as a national priority. The National Dementia Strategy, updated in 2013, set out 17 commitments to support the transformation of services and to improve and maintain high quality dementia care.

This included a new national 'HEAT' target in relation to dementia. HEAT stands for **H**ealth Improvement, **E**fficiency, **A**ccess and **T**reatment.[6] HEAT targets are agreed annually by the Scottish Government and measure NHS Boards' performance in relation to a range of targets under the aforementioned 4 areas.

For 2014/15, this has required NHS Boards to 'deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan' (see previous reference).

[6] Scottish Government 'NHS Performance Targets'. Source: http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets Date accessed: 09/09/14.

Three Link Workers have been appointed in Aberdeenshire funded for 3 years through the Change Fund. Central to this target is the **5 Pillars Model** developed by Alzheimer Scotland[7]. This sets out the following key areas of post-diagnostic support to be provided to a person diagnosed with dementia:

1. Help to understand the illness and manage its symptoms
2. Support to stay connected to their community
3. Peer support from other people with dementia and their families and carers
4. Help to plan for their future decision-making
5. Support to plan the shape of their future care from their own perspective.

As a person progresses through the stages of their illness, it is recognised that more intensive support will be required through community services to enable that person to remain at home for as long as possible.

A national commitment has been made to testing and evaluating the Alzheimer Scotland **8 Pillars Model of Community Support**[8] as an approach to support this, the key components of which are summarised in Appendix 2. Part of this model includes the role of a Dementia Practice Co-ordinator to lead the care and support of the person and their carer; this is currently being implemented in a number of test sites across Scotland including Moray.

2.1.2 Standards of Care for Dementia in Scotland[9]

The Standards of Care for Dementia describe the range of rights people with dementia and their carers are entitled to whilst also providing guidance and direction for care providers in the standards to be met by all professionals involved in the care of people with dementia.

These are:

---

[7] Simmons, H. (2011) 'Getting post-diagnostic support right for people with dementia'. Source: http://www.alzscot.org./assets/0001/1226/Getting_post_diagnostic_support_right.pdf Date accessed: 24/7/14

[8] Alzheimer Scotland (2012) 'Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support'. Source: www.alzscot.org.uk Date accessed: 24/07/14

[9] The Scottish Government (2011) 'Standards of Care for Dementia in Scotland - Action to support the change programme', Scotland's National Dementia Strategy June 2011. Source: www.scotland.gov.uk Date accessed: 22/07/14

- I have the right to a diagnosis
- I have the right to be regarded as a unique individual and to be treated with dignity and respect
- I have the right to access a range of treatment, care and supports
- I have the right to be as independent as possible, and to be included in my community
- I have the right to have carers who are well supported and educated about dementia
- I have the right to end of life care that respects my wishes.

These rights are central to the aims and values of the Aberdeenshire Dementia Strategy and our aspirations for how dementia care should be delivered in the future.

2.1.3 Promoting Excellence[10]

The Promoting Excellence framework is a further key driver for dementia services in Scotland. This defines the different levels of skills and knowledge health and social care staff should aim to achieve depending on the type of role and responsibilities they have in supporting people with dementia, their families, and carers. There are 4 levels, described in Appendix 3.

The framework also sets out a number of quality of life (QoL) outcome indicators for people with dementia, their families and carers, the aim of which are 'to encourage workers and services to consider the impact and end result of the support, care, interventions and treatments they provide against these indicators' (see previous reference). These map closely with the Standards of Care for Dementia and again are detailed in Appendix 3.

2.1.4 Health and Social Care Integration

In terms of wider government policy, the integration of health and social care services for adults and older people, supported by The Public Bodies (Joint Working) (Scotland) Act 2014, represents a major influence on the future provision of services.[11]

---

[10] The Scottish Government (2011) 'Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers'. Source: http://www.scotland.gov.uk/Publications/2011/05/31085332/0 Date accessed: 23/07/14

[11] The Scottish Government (2012) 'Integration of Adult Health and Social Care in Scotland – Consultation on Proposals, May 2012'; 'Health and Social Care Integration Narrative', April 2014. Source: http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration Date accessed: 21/8/14

This will see the formation of new 'Health and Social Care Partnerships', jointly accountable to the NHS and Local Authorities for the delivery of nationally agreed outcomes, the integration of budgets and a strengthened role for clinicians, care professionals and the third and independent sectors in the strategic commissioning of services and service planning at locality level.

The Scottish Government has set out 9 Health and Wellbeing Outcomes for health and social care partnerships to achieve (see Appendix 4). [12] These include: to enable people, including carers, to look after their own health and wellbeing; to support people to live independently at home and/or within their communities as far as possible; and a specific commitment for partners to work together to address health inequalities.

Within Aberdeenshire work is already underway on the transitional arrangements for health and social care integration, to be implemented from April 2015 onwards with all integrated arrangements to be in place and operational by April 2016.

Such legislation, alongside other significant developments in the provision of health and social care services such as the introduction of Self Directed Support, all have the potential to impact positively on the experience of people with dementia, their families and carers, ensuring we deliver a person-centred, integrated approach between services.

2.1.5 Aberdeenshire Joint Commissioning Strategy[13]

The Joint Commissioning Strategy sets out plans for the development of local care and health services over the next ten years to provide the best possible outcomes for older people.

This builds on the Scottish Government's strategy 'Reshaping Care: A Programme for Change 2011-2021' which set out the national vision for reshaping care and support for older people, supported by the Change Fund programme of investment. This has enabled Aberdeenshire to drive forward a number of initiatives and service redesigns to support more preventative and anticipatory care approaches to the care of older people, working jointly across all partners.

Improving support for people with dementia is a key priority of the Aberdeenshire Joint Commissioning Strategy, in particular supporting timely diagnosis and access to information, treatment and care to enable people to 'live well with dementia'. It further emphasises the importance of early intervention and prevention, supporting people and communities to keep active, involved and to maintain healthy lifestyles, and reducing health inequalities.

---

[12] The Scottish Government (2014) *National Health and Wellbeing Outcomes*. Source: http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes. Date accessed: 24/06/15

[13] 'Ageing Well in Aberdeenshire – Joint Commissioning Strategy for Older People 2013-2023'. Source: http://www.aberdeenshire.gov.uk/about/departments/JointCommissioningStrategyforOlderPeople.pdf Date accessed: 20/08/14

2.2 What We Do Now

The Grampian Integrated Care Pathway has been developed to provide consistency in the care and treatment for people with dementia from the point of referral/diagnosis and as their condition progresses, ensuring they have access to the appropriate services, information and support at each stage of their illness.

The provision of care for people with dementia is complex and wide-ranging involving a number of services from across health, social care and the third sector and at different levels. Some services will have a specific remit for dementia care/support, such as dementia day care services, Link Workers etc.

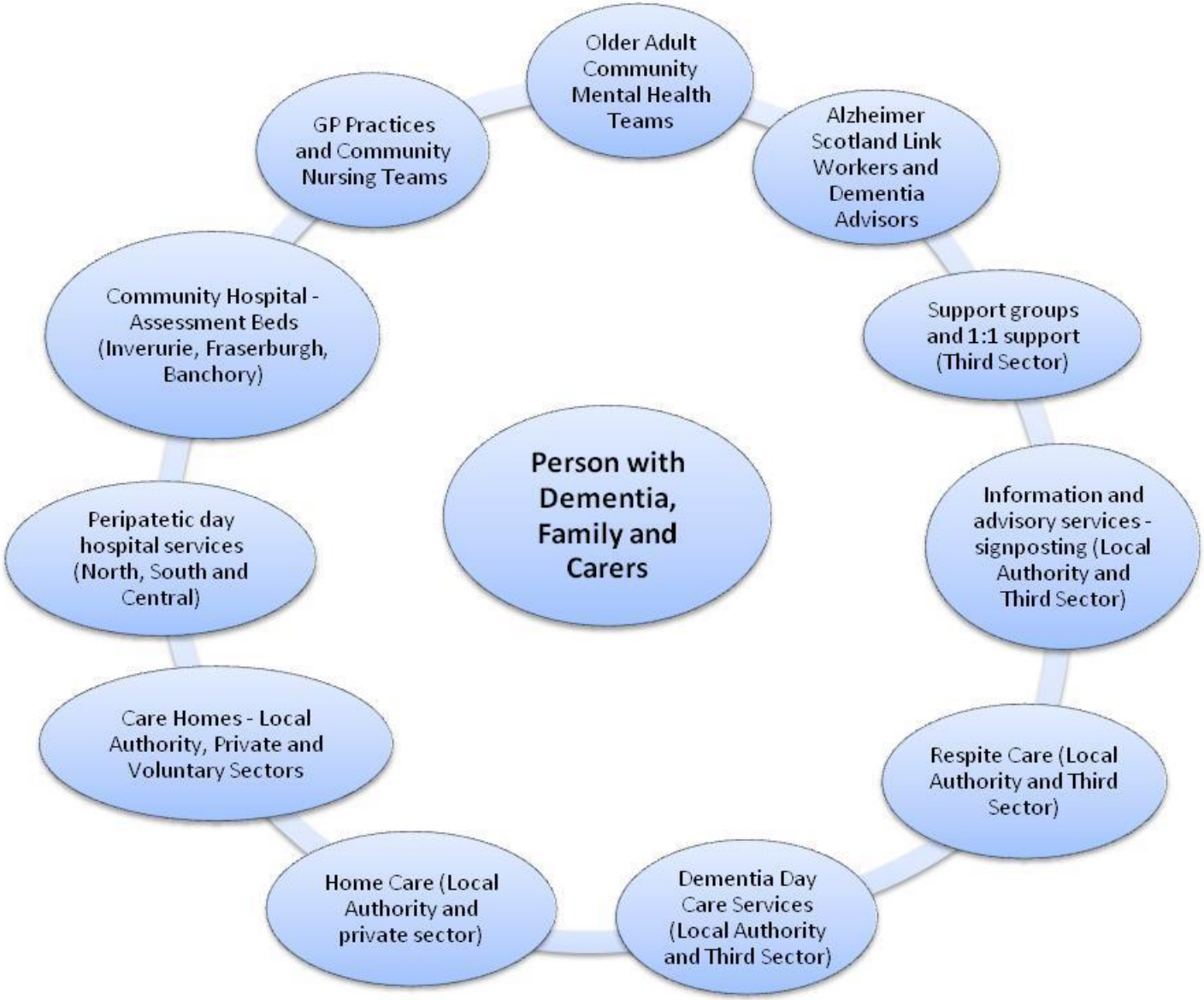
Others will have a broader remit but nonetheless will still play a very important role in the provision of day to day care for people with dementia, their families and carers. The multi-disciplinary Older Adult Community Mental Health Teams (CMHTs), for example, will provide specialist support to the over 65s age group for all mental illness, not just dementia, although dementia care represents a significant proportion of their activity.

Diagram 1 attempts to illustrate this broad provision of services (see following page). This is not an exhaustive list, but demonstrates the type of care and support a person with dementia, their family and carers, may have access to depending on their care needs and their stage in the care pathway. It should be noted that the range of services provided locally varies.

Locally within Aberdeenshire a range of training programmes and other initiatives have also been implemented recognising the importance of maintaining and improving our provision of dementia care, including for example the Best Practice in Dementia Care course for care home, health care and other staff. Appendix 5 provides a glossary explaining some of the key roles, support and training in place for dementia across health, social care and the third sector.

The remainder of this document describes examples of work already underway whilst also identifying new areas to be taken forward within Aberdeenshire to deliver the relevant commitments within the National Dementia Strategy.

Diagram 1: Range of Services and Support for People with Dementia, their Families and Carers, in Aberdeenshire



3. Our Approach to Make Things Better

Within Aberdeenshire the key objectives we have agreed to deliver in relation to providing the best possible care and outcomes for people with dementia, their families and carers, are as follows:

1. We will support the timely diagnosis of dementia. We aim to have most cases of dementia diagnosed within your local community by a general practitioner.

2. We will continue to support general practitioners to develop advanced skills in dementia through a GP Scholarship scheme. These GPs will provide local leadership and expertise to their other colleagues.

3. When a person receives a diagnosis of dementia they will be given the help and expertise of a “link worker” for at least a one year period. This link worker will help the individual understand the condition and signpost to other appropriate support mechanisms that they wish to pursue. The link worker will help build a person-centred support plan and use the Five Pillars model.

4. We will evaluate and support the move from the pilot phase of the Link Worker model to roll out within Aberdeenshire, as part of an integrated model of post diagnostic support including Primary Care, Older Adult Mental Health Services, Third Sector and Local Authority services.

5. We will support and promote the development of dementia friendly communities across Aberdeenshire, by involving the wider community in reducing the stigma associated with dementia, heightening awareness about the condition and the experience of people with dementia and their families, and creating neighbourhoods, environments, and spaces that are inclusive, welcoming and safe places for people with dementia and their families.

6. By engaging with communities, service providers, community planning and public health partners, we will work to ensure promoting health/disease prevention are recognised as fundamental to addressing the risk factors associated with dementia. This will include engaging with communities to support self-care and healthy lifestyles, and working directly with service providers to support new and existing preventative interventions, reinforcing the ethos that ‘every health contact is a health promotion opportunity’.

7. For people diagnosed with dementia, as their disease progresses we will provide support to them and their family by ensuring all appropriate information, support and treatments/ therapies are provided to meet their needs and help them live well with their condition. We will support people with dementia to be able to live in their own homes for as long as possible and prevent unnecessary admission to hospital, and facilitate integrated working between health, social care and Third Sector partners to ensure a person-centred and joined-up care pathway.

8. We will work to deliver appropriate palliative care services for people with dementia to ensure the individual, their carer and family receive the support, dignity and treatment needed to have as positive an experience as possible of their end of life care.

9. We will ensure the ethos that 'dementia is everyone's business' is actively promoted within our own health and social care organisations by taking forward the delivery of the Promoting Excellence Framework as appropriate to staff members' roles and responsibilities.

10. We will continue to recognise the invaluable contribution of carers through ensuring they receive appropriate information on the services available to support them in their caring role, and in looking after their own health and wellbeing in line with the government's National Health and Wellbeing Outcomes.

These reflect and support the commitments set out in the National Dementia Strategy. They have been summarised into a set of defined objectives and supporting action plan provided in Section 8.

4. Involving the Wider Community

4.1 Background

Scotland's second National Dementia Strategy for 2013-2016 identified a number of outcomes that were seen as key priorities. Among these was the creation of "dementia-enabled and dementia-friendly local communities that contribute to greater awareness of dementia and reduce stigma".[14]

In addition, the Standards of Care in Dementia, which were published on the back of the first National Dementia Strategy, are based on six over-arching statements of individual rights, one of which is: **The right to be as independent as possible and to be included in my community.**

In the words of the National Dementia Strategy, 'Nurturing and supporting dementia-aware and dementia-friendly local communities is important in creating and sustaining a society where people with dementia and their families and carers feel included and at the heart of the community' (see previous reference).

Delegates to a workshop in October 2013 to commence development of Aberdeenshire's Dementia Strategy agreed that two out of three priority areas for action in Aberdeenshire should be, firstly, the promotion of awareness about dementia and provision of good information about dementia for the general public and communities, and, secondly, the reduction of stigma and the creation of communities that were inclusive of people with dementia.

Hence, fundamental to our Strategy is the involvement of the wider community in reducing the stigma associated with dementia, heightening awareness about the condition and the experience of people with dementia and their families, and creating neighbourhoods,

[14] The Scottish Government (2013) 'Scotland's National Dementia Strategy 2013-16'. Source: http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316 Date accessed: 19/06/2014

environments, and spaces that are inclusive, welcoming and safe places for people with dementia and their families.

Aberdeenshire is characterised by a range of diverse settlements, varying in size from large towns such as Inverurie, Stonehaven, Peterhead and Fraserburgh to small rural villages. Levels of disposable income and income deprivation also vary considerably across Aberdeenshire, and although Aberdeenshire is generally one of the most affluent areas of Scotland there are some areas with significant levels of deprivation.

Our vision is that in all communities, irrespective of size or affluence, people with dementia and their carers feel included, and able to participate in all aspects of community life wherever and whenever they wish, confident that should they require help or assistance, there will be people available who have sufficient understanding of dementia to provide that help or who know of someone who can.

4.2 Developing Dementia-Friendly Communities

Age UK and International Longevity Centre – UK (ILC-UK) in their report 'Making Our Communities Ready For Ageing'[15] argue that communities must change and adapt for an ageing population (which will include greater numbers of people with dementia). They argue communities need to work for all ages. Central and local government, the voluntary sector and community groups need to work together. Barriers between different groups need to be broken down.

They include recommendations on housing, getting out and about, and ensuring communities offer what older people want. A range of initiatives on transport, including car sharing, public transport information, community transport, road crossings, buddies for walking to community meetings, public benches, availability of and access to toilet facilities are highlighted.

Access to green spaces, provision of outdoor fun and leisure equipment accessible for all ages, wide availability of information on activities, development of free meeting spaces including the use of empty shop premises are also among the recommendations. Buildings and premises that are accessed by the public, such as shops, businesses, banks, restaurants etc should ensure that they are designed to be 'dementia-friendly' and accessible for people with mobility difficulties (see previous reference)).

Community and voluntary groups should be welcoming of people with dementia, encourage their involvement, and be aware of some of the issues that can face the person with dementia. Indeed, it is important that people with dementia still feel able to make a contribution and opportunities for volunteering should be available. However, because of the variation in size, population density, and relative affluence and deprivation across Aberdeenshire, different approaches may be required in different communities to achieve this vision.

[15] Sinclair, D. And Watson, J. (2014) 'Making our Communities Ready for Ageing - a call to action'. Source: http://www.ilcuk.org.uk/index.php/publications/ (Age UK and International Longevity Centre – UK) Date accessed: 06/08/14

4.3 Support and Resources

We will apply learning from other areas in Scotland and England, and indeed overseas, about developing dementia-friendly communities. These focus on areas of communities that are heavily used by the public, in particular, town centres, and shopping areas.

Two pilot areas have been selected, in Huntly and Stonehaven, where local shops, businesses, voluntary groups and services are invited to 'register' as 'dementia-friendly'. Development of these types of dementia-friendly communities requires the input from project teams or community development workers who are able to reinforce and engage with local networks.

The Aberdeenshire Community Planning Partnership is also developing a project, 'Inclusive Inverurie', to make Inverurie Town Centre accessible and 'friendly' to all people with a disability, which will include people with dementia. Evaluation of these two pilot projects, and learning from Inclusive Inverurie, will be used to develop similar initiatives in other areas of Aberdeenshire.

We will work with community planning partners in raising awareness and making information about dementia available, promoting inclusion, reducing stigma and enabling involvement by people with dementia and their carers in their communities across Aberdeenshire. We will develop the use of all public information routes to deliver this, including further development of the website, 'DementiaAberdeenshire', and other digital methods of communication. This should also include working across age groups and promoting opportunities for inter-generational dialogue and learning.

Our Joint Commissioning Strategy for Older People, 'Ageing Well', which also covers older people with dementia, outlines the belief that the use of small amounts of funding in a co-production approach with the third sector and communities is effective in involving the community, particularly in developing early intervention and prevention approaches.

For people with dementia, this will support them to remain independent for longer, to remain connected, active, alert, involved in learning and contributing to their community. We will continue to develop this approach, exploring different sources for funding, including any resource available through the Reshaping Care for Older People policy, through the integration of health and social care services, and through the Life Changes Trust.

Involvement in health promotion is also another way that communities can be involved. Diabetes type 2, hypertension, obesity, depression, physical inactivity, and smoking have all been identified as risk factors for dementia[16]. Promotion of public health messages and taking action on lifestyle and diet to reduce the incidence of diabetes type 2, hypertension, obesity, depression, lack of exercise, and smoking will all play a part in reducing the incidence of dementia in the future.

In all these ways, people with dementia, their families and carers, will continue to be active members of their communities, engaged in and supported by them, throughout their journey.

[16] International Longevity Centre - UK (2014) 'Preventing dementia: a provocation'. Source: http://www.ilcuk.org.uk/index.php/publications/ Date accessed: 06/08/14

5. Early in the Dementia Pathway

5.1 Timely Intervention

The process of realising that a person has memory problems that are affecting their daily lives is often a gradual one and it can take some time before they initially present to health care. There is a spectrum of severity at presentation and it has been well recognised that a timely assessment and diagnosis of dementia is of overall benefit to both the person affected and their family. The assessment of cognitive decline requires a multifaceted and team based approach.

The Scottish Intercollegiate Guidelines Network (SIGN) guidelines define dementia as:

> 'A generic term indicating a loss of intellectual functions including memory, significant deterioration in the ability to carry out day-to-day activities, and often, changes in social behaviour.'[17]

As the population ages and becomes better informed about dementia the prevalence of people diagnosed with the condition will continue to rise. As things stand the diagnosis of dementia is made by Older Adult Psychiatrists however much of the ongoing management of the condition is already being done by Primary Care.

The Grampian Integrated Care Pathway for Dementia paves the way for appropriately trained GPs to confidently make the initial diagnosis and to instigate the appropriate treatments and supports.

As we move forward with the Aberdeenshire Dementia Strategy we will be looking to develop the services available and their accessibility in a positive and person-centred direction by:

- Increasing the training of GPs around the diagnosis, treatment, management and support of people with dementia by offering Dementia Scholarships. These are funded and dedicated training opportunities for doctors in primary care that offer them the opportunity to enhance their understanding of the conditions.

- Enabling direct referral to appropriate scanning from primary care without an initial assessment by Older Adult Psychiatry for suitable patients. This will streamline the assessment process and cut out an unnecessary step for more straightforward cases and allow more timely access to the specialist clinics for more complex cases.

In extending the role of GPs in relation to the diagnosis and management of people with dementia in primary care, it is recognised that there are currently significant workforce pressures on General Practice with the challenge made even greater by the projected growth in dementia. Aberdeenshire H&SCP will support practices to take on this role by resourcing a Local Enhanced Service contract model for dementia care. It is of course

[17] Scottish Intercollegiate Guidelines Network, 'Management of patients with dementia – A national clinical guideline' (Guideline No. 86), February 2006. Source: www.sign.ac.uk Date accessed: 22/07/14

recognised that this model of care must be implemented as part of a multi-disciplinary approach involving the GP, wider health and community care team, and the specialist older adult mental health service. There is a need to ensure all health and social care services locally are equipped to respond to the significant challenges presented by the increasing incidence of dementia, and to work as part of a pluralistic model which harnesses all available skills and resources.

The Scottish Government has implemented a HEAT target to give all patients diagnosed with dementia access to 12 months of post diagnostic support. This is to provide information and allow people who have been diagnosed with dementia and their families the opportunity to engage with local services and support networks and plan for the future.

This is currently accessed through Older Adults Psychiatry however as part of our strategy we aim to facilitate access to this resource from primary care if that is where the diagnosis of dementia is made.

We will continue with our high standard of regular reviews in primary care for all people who are diagnosed with dementia with planned contact on an annual basis to holistically evaluate their situation including medication, activities of daily living, other medical conditions, health concerns and family/carer input. This often ties in with anticipatory care planning, another primary care initiative, aimed at reducing unnecessary hospital admissions.

5.2 Helping You to Live Well with Dementia – Support in the Early Stages

Improving support following a diagnosis of dementia is a key area of improvement in Scotland's National Dementia Strategy and we are committed to ensuring that all people diagnosed with dementia receive the help they need following diagnosis.

We will ensure that there is a clear and integrated pathway so that when a person is diagnosed with dementia, they receive the support and assistance they need at the time it is needed. In Aberdeenshire, support following diagnosis is delivered by a multi-agency partnership consisting of Older Adult Mental Health Services, Social Care, Primary Care and the Voluntary Sector.

When a person gets a diagnosis of dementia, we will offer them the help and expertise of a skilled and well-trained "link worker". This person will work with the individual, their partner and family in a flexible and personalised way for at least a year so that they are able to prepare for the future and live as well as possible with dementia.

Link workers have the capacity to link and liaise with other services and resources and over the 12 month period of post-diagnostic support, the link worker will help the person with dementia to:

- understand the illness and manage their symptoms
- keep connected to their community and develop new connections
- meet other people with dementia and their partners and families
- plan for future decision-making
- plan for their future support.

We will also ensure that they receive support from other health and social care professionals; for example they may be prescribed medication to help manage some of the symptoms of their illness or offered other therapeutic interventions to help them and their family cope.

We will also ensure that there is help and support for families and those close to and supporting the person with dementia. As noted later in this strategy, early awareness of the Adults with Incapacity Act and the option to put in place powers of attorney when the person with dementia still has capacity can be helpful for families. Following the initial year of post diagnostic support, each person with dementia will have a plan in place which sets out the resources, support networks and strategies that will help them live well with dementia for a period of time with minimal support.

6. Later in the Dementia Pathway

6.1 Information

It is important that information is provided to people with dementia, their families and carers, about the services and support available at all stages of the patient's journey of care, including receiving ongoing information about the progress of the disease and relevant therapies. Legislation is in place, including the Adults with Incapacity Act, to support and safeguard the interests of people with dementia and ensure appropriate decisions can be made on their behalf by the most appropriate persons should they require to do so in the later stages of their illness. This may be through the provision of a Power of Attorney or Guardianship arrangements.

Signposting to other relevant agencies in respect of services available is also critical such as Physiotherapy, Occupational Therapy, Housing, Benefits Agency, and Social Work. Other information resources can be found in DVDs and post-diagnostic support groups.

To assist staff to communicate with non-English speaking patients and their relatives, the "Language Line" telephone interpretation service is available. By prior arrangement, 'face to face' interpreters can also be provided. If the patient or their relatives have a communication disability, appropriate communication support such as British Sign Language (BSL) interpreters can be provided.

6.2 Self Management

Within Aberdeenshire we aim to support people with dementia to manage their illness and to continue, as independently as possible, to lead a lifestyle of their choice in the community. We will take a risk-enablement approach, supporting people to access community resources, to maintain community connections and to continue with valued activities. People with dementia will be supported to maintain the best physical and mental health and will be offered a range of supports from a multi-agency partnership. This may include dementia friendly environments, use of telecare, provision of therapeutic interventions such as cognitive stimulation therapy or physical activity and access to community activities and peer support.

There are also a number of publications and resources available to which people can be directed for further information and support, including Alzheimer Scotland

(http://www.alzscot.org/), VSA (https://www.vsa.org.uk/) and the 'DementiaAberdeenshire' website (http://www.dementia-aberdeenshire.org/).

Regular reviews will be carried out by the relevant agencies including Primary Care, Care Management, the Community Mental Health Team, Link Worker, Outreach Team or Alzheimer Scotland.

6.3 Support

Support to the person with dementia, their family and carers, can be provided in a variety of ways as previously described. Within Aberdeenshire we aim to facilitate integrated working between health, social care and third sector partners to ensure all people with dementia receive a person-centred and joined-up care pathway.

Allied to this, the Alzheimer Scotland **8 Pillars Model of Community Support**[18] (see Appendix 2) is currently being tested in a number of sites across Scotland, including the role of a Dementia Practice Co-ordinator to lead the care and support of the person and their carer. Personalised, flexible support can come from looking at areas such as offering the main carer an assessment in their own right. Respite can be provided through the short breaks or Creative Breaks schemes.

We also recognise the need to equip the main carer to deal with the person they are caring for on their journey, taking a person centred approach by looking at their skills and the resources available to help them cope. The national strategy 'Caring Together'[19] emphasises that carers should be seen as 'equal partners in the planning and delivery of care'. It further highlights the increasingly significant role that carers will have in supporting and caring for people with long-term conditions including dementia, and also the need to recognise the emotional impact on carers from caring for a family member or friend with a condition such as dementia.

It is known that the majority of people with dementia live at home and are cared for informally by family and friends, but that the experience of carers can be very stressful impacting on their own health and wellbeing.[20] There are a number of ways in which we must seek to provide support to carers both in terms of practical interventions and services (e.g. respite care, access to advice and support from health and social care professionals where required) as well as emotional and peer support (e.g. carer support groups).

A recent project in NHS Grampian has looked at the impact of providing a psychosocial programme of support for people with dementia living at home and their family care-givers, by supporting and training carers to provide Cognitive Stimulation and physical activities for the person they are caring for. This has been positively evaluated. Locally the NHS

[18] Alzheimer Scotland (2012) 'Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support'. Source: www.alzscot.org.uk Date accessed: 24/07/14

[19] Scottish Government (2010) 'Caring Together – The Carers Strategy for Scotland 2010-2015'. Source: http://www.scotland.gov.uk/Resource/Doc/319441/0102104.pdf Date accessed: 19/08/14

[20] Alzheimer Scotland (2013) 'About dementia: some facts and figures', Information Sheet IS 16 October 2013 Source: www.alzscot.org.uk. Date accessed: 22/07/14

Grampian Carers Information Strategy also set out the actions required of the NHS locally working jointly with its partners to ensure carers have the information and support they need to fulfil their role effectively.[21] Currently, the Carers (Scotland) Act 2016 is in the process of implementation. Carers are recognised as playing an invaluable role which needs to be supported.

Telecare, peer support, and future needs planning i.e. if care is to be provided at home or in a residential care setting, can also provide assistance to the person with dementia and their carer. Supporting people with dementia in relation to advance statements – setting out what the individual wants in terms of treatment and who will assist with this – is important, for when they are no longer able to make such decisions for themselves.

The importance of access to appropriate housing and accommodation is also recognised as key to helping people live well with dementia and within their communities. Technology solutions exist to further enable people to remain safe and supported within their own homes and communities.

It is also important to ensure that everyone gets the right support through the specialist teams in respect of a person's medication and health care needs. Help from medical and social work staff is critical to negotiate a person's journey through the disease. Risk management and support to notify the appropriate agencies if required (e.g. DVLA (Driver and Vehicle Licensing Agency), the Department of Work and Pensions) and guidance for considering a future placement are also important at this stage.

7. Late Stage / Palliative Phase

7.1 Introduction

It is recognised that appropriate palliative care services for people with dementia are essential to ensure the individual, their carer and family receive the support, dignity and treatment necessary to have as positive an experience as possible of their end of life care.

Within Scotland the publication of 'Living and Dying Well' provided an action plan for palliative care emphasising the importance of person-centred care, advance care planning, communication and the need for an integrated approach across all care providers to ensure consistency and continuity of care for people.[22]

The aim of the strategy for dementia in Aberdeenshire is to ensure that people with dementia and their families experience 'a good death'. The Alzheimer's Society has set out some of the major issues, challenges and requirements for services in ensuring effective

[21] NHS Grampian (2011) 'Carers' Information Strategy 2011 – 2015'. Source: http://nhsgintranet.grampian.scot.nhs.uk/depts/Learning/Pages/CarersInformation.aspx Date accessed: 19/08/14

[22] NHS Scotland (2008) *Living and Dying Well – A national action plan for palliative and end of life care in Scotland*. Source: http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/Living-Dying-Well. Date accessed: 10/09/14

and dignified end of life care for people with dementia.[23] In particular it highlights the importance of engagement and communication around these issues particularly in relation to people with dementia:

> 'The lack of public understanding of dementia, and the 'taboo' about discussing death and dying combine to create a double stigma around dementia and death. This means that it is rarely thought about and conversations that could achieve positive outcomes for personal choice at the end of life do not take place. Planning care, even if it is an unstructured conversation about the person's wishes, makes decision making easier at the end of life.' (see previous reference)

It further highlights the Department of Health End of Life Strategy[24] which identified the key elements of a 'good death', namely:

- being treated as an individual, with dignity and respect
- being without pain and other symptoms
- being in familiar surroundings
- being in the company of close family and/or friends

The Alzheimer's Society identifies these needs as being just as relevant to people with dementia as for all other conditions.

In order to achieve the above we recognise that there are improvements that need to be made in the delivery of palliative care within the area of dementia.

7.2 How Can We Achieve a 'Good Death'?

A variety of systems and tools are already in place within Aberdeenshire to help deliver efficient, effective and proactive palliative care services. This includes the use of anticipatory care planning, palliative care registers and 'Just in Case' boxes within primary care to ensure the needs of patients and their families are effectively planned for.

The Aberdeenshire Dementia Strategy acknowledges the 'End of Life Care Strategy: Quality Markers and Measures for End of Life Care' (Department of Health)[25] in considering end of life care for people affected with dementia. This incorporates the seven end of life care quality markers:

---

[23] Alzheimer's Society, Position statement – *End of life care.* Source: http://www.alzheimers.org.uk/ Date accessed: 22/07/14

[24] Department of Health (2008) *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. Source: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. Date accessed: 10/09/14

[25] Department of Health (2009) 'End of Life Care Strategy: Quality Markers and measures for end of life care'. Source: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publications andstatistics/Publications/PublicationsPolicyAndGuidance/DH_101681. Date accessed: 10/09/14

- Public awareness
- Strategic planning through identification, communication and care planning
- Co-ordination of care across organisational boundaries
- Availability of services
- Care in the last days of life
- Care in the days after death
- Workforce planning.

These end of life care indicators will be achieved through:

- Training: Increased knowledge in families caring for someone with dementia and the professionals who support them.

- Support: Knowing what support is available for families and professionals and how to access that support.

- Forward thinking: Through the promise of a named person for one year after diagnosis more people will be able to plan their future care needs and the treatment they receive when they can no longer express their wishes.

8. Action Plan

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
1.0	We will support the timely diagnosis of dementia. We aim to have most cases of dementia diagnosed within your local community by a general practitioner.	1.1	Support more GPs to develop advanced skills in dementia through participation in the GP Dementia Scholarship scheme.	Aberdeenshire Clinical Leads and Older Adult Mental Health Services (OAMHS)	April 2015 - ongoing	Prevalence rates for diagnosis of dementia. Number of GPs completing Dementia Scholarship Scheme. Links to: Single Outcome Agreement (SOA); Aberdeenshire Change Plan Performance; HEAT target	Timely, accurate diagnosis of dementia. Better post-diagnostic support for people with dementia and their families.
		1.2	Enable direct referral to appropriate scanning from primary care for suitable patients.	Aberdeenshire Clinical Leads, OAMHS and Radiology	April 2016		
		1.3	Assess the feasibility of implementing a Local Enhanced Service for Dementia Care in Aberdeenshire for GP Practices following accreditation through the GP Dementia Scholarship scheme.	Aberdeenshire Clinical Leads/ Management Team	Sept 2016		
2.0	We will ensure effective post-diagnostic support for people with dementia in line with national targets	2.1	Support continued implementation and integration of Link Worker role locally, so that when a person receives a diagnosis of dementia they will be given	Alzheimer Scotland, OAMHS, Aberdeenshire Health and Social Care Partnership – locally	Dec 2016	% of people newly diagnosed with dementia who receive a minimum of 1	Better post-diagnostic support for people with dementia and their families.

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
	through a locally integrated model of post-diagnostic support including Primary Care, Older Adult Mental Health Teams, Third Sector, Local Authority and other care services.		the help and expertise of a "link worker" for at least a one year period. 2.2 Evaluate and facilitate the move from the pilot phase of the Link Worker model to roll out within Aberdeenshire, ensuring integration within local teams and maximising all resources available to achieve the best possible outcomes for people with dementia.	led through Area Mgt Teams As above	Jan 2016 onwards	year post-diagnostic support (HEAT target). Patient / service user feedback / outcomes. Links to: Aberdeenshire Change Plan Performance	
3.0	We will support and promote the development of dementia friendly communities across Aberdeenshire.	3.1	Implement and evaluate 3 pilot areas (Huntly, Stonehaven and Inverurie) where local shops, businesses, voluntary groups and services are invited to 'register' as 'dementia-friendly', supported by awareness raising and information about dementia for staff and the public, and advice on how to support people with dementia.	Dementia Friendly Communities Sub-Group	31 March 2016	Service user/patient feedback Pilot evaluations	Dementia-enabled and dementia-friendly local communities that contribute to greater awareness of dementia and reduce stigma.

Local Objective		Actions	Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
		3.2 Use evaluation of these pilot projects, and learning from Inclusive Inverurie (led by Aberdeenshire/ Garioch Community Planning Group), to develop similar initiatives in other areas of Aberdeenshire.	NHS/Local Authority/Third Sector working with Community Planning Partnerships	March 2016 onwards		
		3.3 Working with community planning partners, develop the use of all public information routes to support awareness raising and provision of information to communities, including further development of the D*ementia Aberdeenshire* website and other digital methods of communication.	As above	Ongoing for life of strategy		
4.0	By engaging with communities, service providers, community planning and public health partners, we will work to ensure promoting health/ disease prevention	4.1 Linking to Objective 3.0 and sub-actions, increase public awareness of key prevention messages around lifestyle and self-care related to specific risk factors associated with dementia.	Aberdeenshire Health and Social Care Partnership – with Community Planning Partners	Ongoing for life of strategy	Evaluations of pilots Service user/patient feedback Available public health data e.g.	More people with dementia living a good quality life at home for longer. Dementia-enabled and dementia-

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
	are recognised as fundamental to addressing the risk factors associated with dementia. This will include engaging with communities to support self-care and healthy lifestyles, and working directly with service providers to support new and existing preventative interventions, reinforcing the ethos that 'every health contact is a health promotion opportunity'.	4.2	Identify opportunities to up-skill the health and social care workforce in providing brief advice on key lifestyle issues relevant to the risk factors associated with dementia, including signposting to local support (consider piloting approach in one Health & Community Care Team).	Aberdeenshire Public Health team	April 2016	Keep Well anticipatory health checks. Integrated Care Fund 'Making Every Opportunity Count' initiative	friendly local communities that contribute to greater awareness of dementia and reduce stigma.
		4.3	Explore available research/ data to understand associations between risk factors for dementia and health inequalities/need within Aberdeenshire.	Aberdeenshire Health and Social Care Partnership	April 2016		
5.0	For people diagnosed with dementia, as their disease progresses we will provide support to them and their family by ensuring all	5.1	Once completed, consider outcomes from the 8 Pillars Model test sites (including the Dementia Practice Co-ordinator role) in relation to a possible model for Aberdeenshire, in accordance with any	Older Adult Mental Health Services, Aberdeenshire Health and Social Care Partnership, Alzheimer Scotland	April 2016		More people with dementia living a good quality life at home for longer. More people with dementia

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
	appropriate information, support and treatments/ therapies are provided to meet their needs and help them live well with their condition. We will support people with dementia to be able to live in their own homes for as long as possible and prevent unnecessary admission to hospital, and facilitate integrated working between health, social care and third sector partners to ensure the individual receives a person-centred and joined-up care pathway.		nationally agreed outcomes/actions.				and their families and carers being involved as equal partners in care throughout the journey of the illness.
		5.2	Support continued awareness and adoption of the Grampian Integrated Care Pathway within Aberdeenshire, to ensure consistency and a continuity of care pathway for people with dementia.	Dementia Strategic Outcomes Group (SOG) and at local level through Areas	Ongoing for life of strategy		
		5.3	Continue to support anticipatory care planning within primary care, linking to Emergency Care Plans for carers and encouraging the involvement of carers.	Aberdeenshire Clinical Leads	Annual review	Number of anticipatory care plans [Options for recording ECPs to be considered]	
		5.4	Encourage the provision of appropriate home environments for people with dementia to support them to remain at home for as long as possible, including telecare/assistive technologies.	Aberdeenshire Health and Social Care Partnership	Ongoing for life of strategy	Number of people with dementia supported at home with telecare. Links to: SOA; Aberdeenshire Change Plan Performance	
		5.5	Ensure provision of a range of therapeutic interventions	NHS/Local Authority/Third Sector			

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
			and supports for people with dementia (e.g. day care, activities groups, home support).		Ongoing for life of strategy		
6.0	We will work to deliver appropriate palliative care services for people with dementia to ensure the individual, their carer and family receive the support, dignity and treatment needed to have as positive an experience as possible of their end of life care.	6.1	Support all relevant training and other resources to be made available to families and professionals in caring for people with dementia to ensure appropriate, person-centred end of life care.	Aberdeenshire Lead Nurse – linking to Palliative Care services	Ongoing for life of strategy	Number of training programmes accessed/ participants in training.	More people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness.
		6.2	As per action 2.1, through the promise of a named person for one year after diagnosis support more people to be able to plan their future care needs and the treatment they receive when they can no longer express their wishes.	Alzheimer Scotland, OAMHS, Aberdeenshire Health and Social Care Partnership – locally led through Area Mgt Teams	Dec 2016	% of people newly diagnosed with dementia who receive a minimum of 1 year post-diagnostic support (HEAT target). Links to: Aberdeenshire Change Plan Performance	

Local Objective		Actions		Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
7.0	We will ensure the ethos that 'dementia is everyone's business' is actively promoted within our own health and social care organisations by taking forward the delivery of the Promoting Excellence Framework as appropriate to staff members' roles and responsibilities	7.1 7.2	Agree local plan for delivering Promoting Excellence framework. Continue to support the roll out of other appropriate training programmes to staff in the health, social care and third sectors to improve and maintain quality of dementia care services, including evaluation of the impact on provision of care.	Dementia SOG with implementation at local level through Area management structures	April 2016 Ongoing for life of strategy	Proportion of staff participating in training framework (% measure of eligible workforce). Proportion of staff participating in training reporting an improvement in practice following training. Proportion of service users reporting increased satisfaction with quality of care provided. Links to: SOA; Aberdeenshire	Better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment. People with dementia in hospitals or other institutional settings always being treated with dignity and respect.

Local Objective		Actions	Lead Responsibility for Implementation	Timescale	Local Performance Measure(s)	Link to National Dementia Strategy Outcome(s)
					Change Plan Performance	
8.0	We will continue to recognise the invaluable contribution of carers through ensuring they receive appropriate information on the services available to support them in their caring role, and in looking after their own health and wellbeing in line with the government's National Health and Wellbeing Outcomes, and the Aberdeenshire Health and Social Care Partnership Strategic Plan.	8.1 Working jointly between the Local Authority, NHS and Third Sector, maximise initiatives and opportunities for creative breaks, respite services, carer training, and other locally identified support services that will enable carers to maintain their health and wellbeing and continue in their role. 8.2 Work with the Scottish Government to progress the Carers (Scotland) Bill and ensure that we are ready for implementation of the new legislation in 2017. 8.3 Support information and signposting for carers to be made available through a variety of routes and at the appropriate stage of the person's pathway.	Carers Strategic Outcomes Group	Ongoing for life of strategy	Number of carers of people with dementia accessing creative breaks funding. Number of carers identified and offered a carer assessment/ support plan. Service user and carer feedback *Links to:* SOA; Aberdeenshire Change Plan Performance.	More people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness.

9. Appendices

Appendix 1

Aberdeenshire Health and Social Care Partnership Vision, Philosophy and Principles

Vision

'Building on a person's abilities, we will deliver high quality person centred care to enhance their independence and wellbeing in their own communities.'

Philosophy

We believe the best outcomes for an individual in terms of their health and wellbeing result from them always being at the centre of our focus.

People are entitled to expect the best possible advice, care and support from our staff, in a timely way and in the right place.

Every individual is able to contribute to their own health and wellbeing, and participate positively in their own care. In order to fully understand and support the whole person within their own community, and to provide effective and efficient care and support, we believe a range of perspectives are required.

A person's capabilities, needs and desired outcomes can only be fully understood and realised in the context of their family, significant networks, and community.

All views have value, particularly those of the individual, their informal carers and support networks. A single team approach will embody respect and recognition of all the unique perspectives that contribute to a holistic understanding of the right outcomes for the individual.

We believe care and support is at its most efficient and effective when agreed upon, planned, and delivered collectively and collaboratively.

Principles

Every individual is treated with dignity and respect at all times.

Health and social care staff will promote and maintain a person's independence as much as possible, building on and developing an individual's abilities to self care.

This principle includes a single assessment of risk to the person, to themselves, from others and to others that includes appropriate positive risk taking by the individual.

Nothing is concluded or decided about a person's care or support without the individual's involvement and agreement, and that of their significant others, unless considerations of capacity or risk intervene.

All discussions and decisions about treatment, support, and risk are made collaboratively and consensually by the team of appropriate practitioners, respecting differences. Accountability for decisions is held collectively by the team.

A 'one team' approach is fostered where we trust each team member to deliver on their unique contributions and respective obligations confident that the combined effect of all team members will deliver the best outcomes for people.

Information is shared freely by professionals within the team/partnership and without restrictions that could inhibit the best interests of the individual.

Health and care practitioners will provide the right support for the person at the right time and in the right place, making the best use of available resources.

Appendix 2

Alzheimer Scotland – The 8 Pillars Model of Community Support for Dementia

1. **Dementia Practice Co-ordinator** – a named, skilled practitioner who will lead the care, treatment and support for the person and their carer on an ongoing basis, co-ordinating access to all the pillars of support and ensuring effective intervention across health and social care.

2. **Therapeutic interventions to tackle symptoms of the illness** – dementia-specific therapies to delay deterioration, enhance coping, maximise independence and improve quality of life.

3. **General health care and treatment** – regular and thorough review to maintain general wellbeing and physical health.

4. **Mental health care and treatment** – access to psychiatric and psychological services to maintain mental health and wellbeing.

5. **Environment** – adaptations, aids, design changes and assistive technology to maintain the independence of the person and assist the carer.

6. **Community connections** – support to maintain and develop social networks and to benefit from peer support for both the person with dementia and the carer.

7. **Personalised support** – flexible and person-centred services to promote participation and independence.

8. **Support for carers** – a proactive approach to supporting people in the caring role and maintain the carer's own health and wellbeing.

Source: Extract from Alzheimer Scotland (2012) 'Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support'. Source: www.alzscot.org.uk Date accessed: 24/07/14

Appendix 3

Promoting Excellence Framework - Levels of Knowledge and Skills

‘Each level defines the knowledge, skills and behaviours specific to the worker's role in relation to dementia. Rather than being hierarchical, the levels are concerned with levels of responsibility in relation to working with people with dementia which will vary greatly across organisations and sectors. Each level defines the expertise, specific to their role in relation to dementia, that a worker must have, rather than in relation to their seniority within the organisation or their profession.

The **'Dementia Informed Practice Level'** provides the baseline knowledge and skills required by all staff working in health and social care settings including a person's own home.

The **'Dementia Skilled Practice Level'** describes the knowledge and skills required by all staff that have direct and/or substantial contact with people with dementia and their families and carers.

The **'Enhanced Dementia Practice Level'** outlines the knowledge and skills required by health and social services staff that have more regular and intense contact with people with dementia, provide specific interventions, and/or direct/manage care and services.

The **'Expertise in Dementia Practice Level'** outlines the knowledge and skills required for health and social care staff who by virtue of their role and practice setting, play an expert specialist role in the care, treatment and support of people with dementia.’

Knowledge and Skills Framework Quality of Life Outcome Indicators:

- People with dementia have access to a timely and accurate diagnosis of dementia.
- People with dementia feel empowered and enabled to exercise rights and choice, maintain their identity and to be treated with dignity and equity.
- People with dementia maintain their best level of physical, mental, social and emotional wellbeing.
- People with dementia have access to individuals, groups and organisations that can support their spiritual or personal beliefs and reflect their cultural wishes.
- People with dementia have access to quality services and can continue to participate in community life and valued activities.
- People with dementia feel safe and secure and are able to be as independent as possible.
- People with dementia are able to maintain valued relationships and networks, and have the opportunity to develop new ones both personal and professional.

- People with dementia, their families, friends and carers, have access to the information, education and support that enhances the wellbeing of the person with dementia and those that support them.

Source:

Both extracts from The Scottish Government (2011) ‘Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers’. Source: http://www.scotland.gov.uk/Publications/2011/05/31085332/0 Date accessed: 23/07/14

Appendix 4

National Health and Wellbeing Outcomes

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5: Health and social care services contribute to reducing health inequalities.

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Outcome 7: People using health and social care services are safe from harm.

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Source:

The Scottish Government (2014) *National Health and Wellbeing Outcomes*. Source: http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes. Date accessed: 24/06/15

Appendix 5

Glossary of Terms – Who's Who

Best Practice in Dementia Care – A six month course developed by the Dementia Services Development Centre at the University of Stirling and delivered at the UWS or by locally trained facilitators. The course is designed to support staff to consider how to respond to a person with dementia in a person-centred approach which focuses on the needs of the individual.

Dementia Advisors – Employed by Alzheimer Scotland, Dementia Advisors provide information and advice, help people find the dementia support they need, connect people to local groups and services, help local communities to be more dementia-friendly, and support people to influence policies and services that affect them.

Dementia Ambassadors – Supported by the Scottish Social Services Council, Dementia Ambassadors promote and distribute information about Promoting Excellence learning resources and opportunities, hold small awareness raising sessions offering peer support and signposting to sources of information and support, and develop confidence in using the Promoting Excellence framework to improve practice. Dementia Ambassadors are generally local practitioners and can work in any appropriate social care setting. SSSC run regular workshops to train prospective ambassadors and support learning networks including seminars and day conferences.

Dementia Champions (NHSG) - A six month course provided by the University of West Scotland in partnership with Alzheimer Scotland on behalf of NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC). The course is part of a wider initiative to support change and improvements in the care and treatment of people with dementia particularly in the acute and community hospitals. This course is available for attendance by multi professional groups - Medical Staff, Allied Health Professionals, Nursing etc. Trained Dementia Champions undertake the lead to improve the experience, care, treatment and outcomes of people with dementia and their carers and families in general hospital settings and at the interface between hospital and community settings.

Dementia Practice Mentor – Key staff members within social care services who have additional skills and knowledge in the care of people with dementia. Their role is to support the promotion of good practice, disseminate knowledge to colleagues, enable services to provide the best possible care for people with dementia, their families and carers, and act as 'mentors' to colleagues within the same team or service.

Dementia Practice Co-ordinator – Within the Alzheimer Scotland 8 Pillars model, a named, skilled practitioner who leads the care, treatment and support for an individual and their carer(s) on an ongoing basis. They co-ordinate access to all pillars of support and ensure effective intervention across health and social care.

Link Worker – Employed by Alzheimer Scotland, but working within the 3 post-diagnostic peripatetic day hospital teams in Aberdeenshire, to link with other services and resources. Over a 12 month period following diagnosis, they help the person with dementia understand the illness, manage symptoms, keep connected to their community, meet other people with dementia and their families, and plan for the future.

Appendix 6

Aberdeenshire Dementia Strategic Outcomes Group – Membership 2015

Name	Designation
Mike Ogg	Chair / Head of Integration & Strategy, Aberdeenshire H&SCP
Lesley Alexander	Practice Education Facilitator, Aberdeenshire H&SCP
Jean Anderson	Team Leader / District Nurse
Gladys Buchan	Lead Nurse – Operations
Lyn Irvine-Brinklow	Alzheimer Scotland Dementia Nurse Consultant
Edith Criggie	Area Manager – Marr
Linda Downie	GP – Turriff / Area Clinical Lead - Formartine
Julius Essem	Consultant, Old Age Psychiatry
Jane Graham	Area Manager – Garioch
Alison Haddow	Consultant, Old Age Psychiatry
Rhoda Hulme	Social Work Manager - Care Homes, Day Care & VSH
Christine Lawrie	CPN – Old Age Psychiatry
Martin McCrone	GP – Banchory / Deputy Clinical Lead, Aberdeenshire H&SCP
Eleanor McNiven	CPN – Old Age Psychiatry
Angela MacLeod	Programme Manager, Aberdeenshire H&SCP
Campbell Mair	Head of Operations, Alzheimer's Scotland
Jill Matthew	Senior Practitioner, Older People and Physical Disability Service, South Care Management Team
Iona Parkinson	Head Occupational Therapist, Older Adult & Learning Disabilities Directorates
Geraldine Peel	CPN Phoenix Service Manager
Iain Ramsay	Head of Healthcare, Aberdeenshire H&SCP
Rosie Smith	Team Manager, Care Management Central North
Alison Spencer	CPN, Old Age Psychiatry

Bill Stokoe	Strategic Development Officer, Aberdeenshire H&SCP
Agnes Taylor	Area Manager – Banff & Buchan
Alasdair Walker	Clinical Directorate Manager, Old Age Psychiatry