Dementia – Long term plan

Carers support
- Evidence based interventions for carers

Primary care networks
- Improve dementia diagnosis pathways
- Improve diagnosis in frail/housebound
- Monitoring equipment

Getting people home without unnecessary delay
- People with dementia stay in hospital twice a long as other older people
- Support delayed discharges for people with dementia

Reducing unwarranted variation
- Targeted work on some CCGs to improve diagnosis rates
- Memory service audits
- BAME groups
- NICE guidance implementation – access to post-diagnostic treatment and support
- Work to reduce discrimination against the oldest old

Community MDTs
- Equitable access for people with dementia
- Staff training in dementia/personalised care delivery

"We will go further in improving the care we provide to people with dementia and delirium, whether they are in hospital or at home"

Other considerations
- Primary **prevention** – what's good for your heart is good for your head
- Transforming **outpatients** – difficulties for people with dementia to attend
- **Stroke** rehab – ensure dementia diagnosis is embedded in pathway
- **Waste** reduction – streamlining memory service pathways
- **Volunteers** – specific support / training
- **Workforce** training – use national Dementia Standards

Care homes
- Improve diagnosis rates and advance care planning
- Support new models of treatment – specialist intervention for behavioural and psychological symptoms -as well as primary care models

Joined up coordinated care and inter Trust collaboration
- Integrated working: neurology, neuroradiology and psychiatry in assessment of young onset dementia and Parkinson's Disease Dementia
- Personalised care planning and care coordination
- **Digital** - CMC