Healthy Ageing: a life course approach to health improvement

Meaning and purpose: Being able to exercise choice and control, through access to good information about dementia and how it is related to age supporting self care; opportunities for social, educational, leisure and physical activity.

Healthy lifestyle: Establishing healthy behaviour, giving up smoking, taking regular exercise, eating a balanced diet, keeping mentally active.

Connected and cohesive communities: Strengthening personal support networks; reducing social isolation.

Staying safe: Falls prevention; freedom from discrimination and harassment with positive and de-stigmatising messages of people living with dementia.

Sustainable Communities for the Future: Warm safe homes; sufficient income; accessible transport.

A Positive Start in Life: Laying the foundations for health.
Clarification of what is wrong

Person with memory problems

Source of Information
- Websites
- GP
- Care Direct
- Acute hospital staff
- Community matron
- Community nurse for older people
- Social worker
- Friends and family
- Alzheimer’s Society
- Books
- Short term assessment and reablement team
- Intermediate care

Go to GP?

- Yes
  - Start of pathway to receive a formal diagnosis
  - Start “This is Me” document
  - Discussion with other services on benefit of diagnosis

- No
  - Will not receive a formal diagnosis

GP Needs Assessment (home visit if appropriate)
- Of: needs, symptoms, clarification of what can/can’t be done, exclude other conditions, safeguarding issues, pre diagnostic counselling
  - Memory assessment using GP COG or other.

Formal diagnosis by GP – added to dementia register, Dem3 and Dem1

Referral to secondary care (this could include Memory Service, Learning Difficulties Service, Community Mental Health Team and Neuropsychiatry)
- For: diagnostic uncertainty, symptoms of possible non-Alzheimer’s Dementia, complex care needs: young people, people with learning difficulties

Formal diagnosis made – Letter to GP (add to dementia register)

Ongoing follow up as appropriate

Stays with Primary Care

Referral

Shared Care Protocol with GPs for prescribing??
Primary Care Management

Not clinical dementia but at risk or mild cognitive impairment (especially people of history with Parkinson's Disease, stroke, delirium, learning difficulties, alcohol abuse)

Stay under the care of the GP. Review in one year.

Dementia. Full explanation to patient and carer

Added to the GP register of people with dementia with appropriate coding. (Dem1). Commence dementia prescribing if appropriate

Consider primary care liaison

Carer referred for carers assessment

People to support patient and carers to live well with dementia (see detailed other sheet)

Dementia Link Worker
Primary care support (practice and at home as appropriate)
Complex case management via primary care liaison service

15 monthly review, by suitable member of the primary care team for all people with a diagnosis of dementia (Dem2)

If on dementia medication, 6 monthly review by GP

Other support available as needs require

Good information
Peer support
Carers line
Community nurses for older people
Community matrons
Occupational therapy
District nursing
Continence care
Speech and language therapy
Physiotherapy
Intermediate care
Primary care liaison
Social work
Community learning difficulties team
Community mental health team
Day care
Home care
Respite care
Short term assessment and reablement team
Sitting service
Assistive technology
Very sheltered housing
Care homes
Nursing home
End of life care co-ordinator
Out of hours support
<table>
<thead>
<tr>
<th><strong>Primary Care Support</strong></th>
<th><strong>Primary Care Liaison</strong></th>
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<tbody>
<tr>
<td>GP practice or Community nursing team depending on needs</td>
<td>Responsive advice and reviews for complex cases</td>
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<tr>
<td>Hold all the relevant information on services available</td>
<td>Complex case management</td>
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<tr>
<td>Provide advice via telephone and face to face (home visit/at the practice)</td>
<td>Training for professionals on dementia</td>
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<tr>
<td>End of life care information</td>
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<tr>
<td>Signposting for: Benefits, Lasting power of attorney, Living wills, Advanced care planning, Advocacy, Driving, Signposting to voluntary sector</td>
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<td>Post diagnostic information</td>
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<tr>
<th><strong>Link Worker</strong></th>
<th><strong>Generic counselling Psychology</strong></th>
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<tbody>
<tr>
<td>Named point of contact</td>
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<tr>
<td>Support the person with dementia and the carer</td>
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<td>Hold all the relevant information on services available</td>
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<td>Facilitate post diagnostic support groups</td>
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<td>Facilitate peer support groups such as groups for people without a carer</td>
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<td>Facilitate ex-carer support groups</td>
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<td>Regular contacts (as appropriate) for people without a carer</td>
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<tr>
<td>Signpost to relevant voluntary and statutory organisations</td>
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<td>Promote and raise awareness of dementia with professionals and the public</td>
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<tr>
<td>Provide advice via e-mail, telephone and face to face</td>
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