BOARD MEETING 27.06.18

Agenda Item: 7.2.1

Purpose: For Assurance

Dementia Strategy Operational Plan

Name/Title	Associate Director of Mental Health and Learning Disabilities	Associate Medical Director	Service Manager, Alzheimer Scotland	Chief Officer IJB	Consultant Clinical Psychologist	Director of Nursing	Director of Public health	Head of Health Intelligence
Colour Code								
Name/Title	Head of Locality Services	Head of Partnership Services	Lead Nurse, Acute	Lead Nurse, IJB	Lead AHP	Nurse Consultant Older people and dementia	Spiritual care lead	
Colour Code								

Objective One	Rag Status
Embed a whole life approach to dementia prevention on the risk factors in four key domains: developmental, psychological and psychosocial, lifestyle and cardiovascular risk factors.	

Actions	How	Evidence	Timescale	Outcome	Lead
Raising awareness with people who have a long-term condition around the risk factors which can lead to the development of dementia	Ensure availability of information about risk factors links to LTCs Public education campaign on middle age risk factors. Currently Cardiac Specialist Nurses discuss in detail risk factors for cardiovascular disease, and risk factor modification. However dementia is not specifically discussed but will now be included going forward.	Inclusion in CSN discussion with patients on risk factors	~~March 2018~~ Ongoing commitment	Improved detection and treatment of diabetes and hypertension	MCN leads
Targeting of smoking cessation to those in areas of deprivation and those at highest risk of developing dementia	Source data for the numbers stopped smoking via Smoking Cessation NHS ISD report http://www.isdscotland.org/Health-Topics/Public-Health/Publications/data-tables2017.asp?id=2025#2025. Identify areas of deprivation and those people most likely at risk .Using deprivation as a proxy for risk	Numbers stopped smoking Data on geographic distribution Success rates at 3 and 12 months for stopping smoking are the highest in Scotland Smoking is discussed, and strategies offered to current smokers with all those who are seen in any of the Cardiac Specialist Nursing services (i.e.	~~March 2018~~ Ongoing commitment	Reduced risk factors for brain injuries due to vascular damage	Director of Public health

		chest pain service, heart failure service, cardiac rehabilitation service (and in WI this includes people at high risk of developing CVD but who have not yet had an event) and Familial Hypercholesterolaemia, this is irrespective of areas of deprivation and is not specifically linked to those at risk of dementia, but overall CVD risk			
Aim to reduce overall consumption of alcohol	Source data by diagnosis in EMIS Check for population estimates from Scottish health survey	Numbers with Korsakoff's psychosis or alcohol related brain damage. The numbers are very small and will require 3-4 years of data for validity For all people under the care of the CSNs alcohol intake is assessed, and appropriate interventions offered where appropriate though not specifically linked to dementia risk	ongoing	Reduction in alcohol related dementia including Korsakoff's psychosis	Director of Public health

Awareness campaign about the benefits of physical activity and risk factors associated with obesity	Promotion of a range of activities that promote physical exercise across populations, Eg Paths to Health, Step Challenge, Move More and dance classes for older people	Numbers classified as obese though those will only be population figures for Obesity based on estimates from the Scottish Health Survey – questions around it's reliability due to sample. The numbers are very small and will require 3-4 years of data for validity The Cardiac Rehabilitation service (which includes those at high risk of developing CVD i.e. ASSIGN Score > 20%, chest pain service and FH Service) assesses current physical activity, and develops plan with patient to increase physical activity, personalised to patient (range from formal exercise programme to personalised home exercise programme). This is linked to target to reduce obesity where this is relevant to the individual. The heart failure service also offers an individualised exercise programme in this higher risk group. However, do not link any of this specifically to dementia.	ongoing	Reductions in population level of obesity	Director of Public health

Promoting access to secondary and further education to support the development of a second language, which is a protective factor against developing dementia	Intergenerational work completed linking school age children with residents in care homes using Gaelic and English and promoting the use of technology. Examples include production of sensory book and technological links between care homes and schools	Numbers of children and older people engaged in activities and the sensory book produced in Uist.	ongoing	Increased levels of bilingualism	Director of Public health or Spiritual Care
Increase opportunity for cognitive activity such as group discussion and book clubs in later life, both pre and post diagnosis		Book clubs, social events – list Erisort Ceilidh	Partly initiated	Improved resilience	AZ Scotland
Comments:					

Objective Two	Rag Status
Provide equitable access, standards and services for disadvantaged groups.	

Actions	How	Evidence	Timescale	Outcome	Lead
Include care provision for people with Young Onset Dementia in care pathways	Draft ICP to be fully developed and published. Diagnosis and treatment will be age appropriate and promote independence Expertise within Old Age psychiatric services will extend to all age groups including those with learning disabilities. Red flag system in diagnosis pathway for people with possible young onset (under 65)	Pathway published on NHS and LW intranets.	March 2017	Clarity of pathway to support and assist all ages	Nurse Consultant Older people and dementia
Implement Dementia screening programme for people with learning disabilities as part of wider healthcare support	Establish baseline assessment of functioning for people with LD Access to assessment tools such as NTG-EDSD. **Psychologist and LD nurses are exploring what screening tools are available.**	Screening programme embedded in Learning Difficulties Nursing Activity.		Effective monitoring of high risk individuals	Associate Director of Mental Health and Learning Disabilities

Develop information and advice to those with dementia from LGBT groups and communities	Community workers will be trained in dementia in order to raise awareness of dementia Work with Sexual Health BBV Group		~~September 2017~~ March 2019	Reduced isolation and improved awareness	Director of Public Health Nurse Consultant Older people and dementia
All service providers will evidence awareness training of the needs of BME groups and communities		BSC in place for all		Equality and diversity needs met	Spiritual care lead
Provide translator facilities for people with dementia if English is not their first language		Translation service available and audited for use by over 65s		Facilitates holistic and person centred assessment	Spiritual care lead
Provide accessible information for people who have sensory impairments		Education and advise information available in large print, Braille and recorded book format		Physical impairments are no impediment to information	Spiritual care lead
Comments: Meets national commitment: 15. We will support implementation of NHS Health Scotland's report recommendations on dementia and inequalities					

Objective Three	Rag Status
Continue improvement for dementia diagnosis rates to facilitate earlier diagnosis and uptake of post diagnostic support	

Actions	How	Evidence	Timescale	Outcome	Lead
Introduce Primary Care diagnostic service based on accredited assessment tools which meets target time of 4 weeks for first appointment	Improvement programme includes accredited training on assessment tools. NICE guidelines as basis for memory clinic format.	Numbers of people seen within 4 weeks of diversion to memory clinic after appropriate screening	Initiated	Reduce barriers to access for memory assessment and reduce anxiety about process of diagnosis	Nurse Consultant Older people and dementia
Utilise the Primary Care Transformation Fund to pilot change of model.	Use data from trial clinics to optimise service across all areas. Use data from Old Age Psychiatry for period July 2016 – July 2017 to estimate demand for reviews	Numbers of memory clinics in GP surgeries .	End of December 2017	Strengthens primary care interface with people affected by cognitive impairment	Nurse Consultant Older people and dementia
Support team approach to community diagnostic service across localities in primary care	Agree protocol with GPs for memory service and agreement of diagnosis. Supervision of Memory clinic activity by Nurse Consultant. Supervision of practice by clinical psychologist.	Memory clinics available for all GP surgeries and meeting 4 week WT target	End of December 2017	Equality of access to all localities	Nurse Consultant Older people and dementia

Review the effectiveness and sustainability of innovative models around diagnosis within Primary care	Costs analysis against traditional model. 360degree feedback on service.	6 monthly reports for transformation funds. Learning from model of provision feedback to Focus on Dementia	Initiated and ongoing	Promote inclusion	Nurse Consultant Older people and dementia
Raise awareness of benefits of early diagnosis to encourage assessment and planning for the future	Public awareness campaign using media. Education sessions 4 times a year for lay people via adult education.	Percentage of people being diagnosed in mild stage increases to 25% of new diagnoses.	Initiated	Earlier diagnosis for service planning and people supported to self-manage in all localities	Nurse Consultant Older people and dementia
Comments: Meets national commitment: 15. We will support implementation of NHS Health Scotland's report recommendations on dementia and inequalities					

Objective Four	Rag Status
Ensure quality and consistency of post-diagnostic support for every person diagnosed with dementia	

Actions	How	Evidence	Timescale	Outcome	Lead
Develop, implement and distribute new criteria around accessing post-diagnostic services	Consider PDS leads information Complete data set consultation for ISD Implement changes to data set	Criteria set and published on clinical guidelines and Intranet	End of November 2017	Ensures compliance with best practice in promoting independence	Nurse Consultant Older people and dementia
Ensure continuity of support from primary care- led diagnosis to post-diagnostic services	Primary care diagnosis supported by verbal handover of information to PDS worker. Referral to PDS discussed during assessment process and agreed at diagnosis	PDS waiting times evidence uptake of service from all diagnosis pathways. 3 monthly reports for ISD	End of November 2017	Getting a diagnosis and accessing post-diagnostic support is easier and less daunting	Nurse Consultant Older people and dementia
Embed specialist drug treatments for dementia in Primary Care	Short life working group set up to agree local prescribing use. Treatment initiation guidelines agreed via Area Drug and Therapeutics Committee.	Treatment initiation guidelines published on Clinical guidelines. Data on prescription patterns	June 2018	Treatment and care of people with dementia is focused in primary care	Nurse Consultant Older people and dementia Associate Medical Director

Introduction and embedding of Alzheimer Scotland 5 pillars model for PDS across localities, ensuring Power of Attorney is considered by every person with dementia who retains capacity	PDS is delivered to person centred model and uses patient held record and Anticipatory care planning as standard procedure for all service users.	Number of ACPs completed for people with mild to moderate stage dementia who retain capacity.	Initiated and ongoing	Ensures consistency of service for benchmarking and ongoing delivery, Reduces need for Guardianship applications	Nurse Consultant Older people and dementia
Post-diagnostic support will be available for every individual until they are no longer able to self-manage and they are better supported by the 8 pillar model	Service users will only be discharged after one year at their request or if moved to more complex care packages	PDS waiting times evidence uptake of service from all diagnosis pathways. 3 monthly reports for ISD	Initiated and ongoing	Continuity of care and reduced crisis presentations	Nurse Consultant Older people and dementia
Use waiting times and PDS criteria to monitor and evaluate effectiveness	Complete waiting times return monthly for local data run and for quarterly ISD run.	Audit every 6 months using Health Improvement Scotland self evaluation tool	Initiated and ongoing	Ensures complete compliance with best practise in promoting independence	Nurse Consultant Older people and dementia
Comments: Meets national commitments: 1: we will revise the national post diagnostic service offer to enhance its focus on personalisation and personal outcomes in the delivery of PDS. 2: We will test and independently evaluate the relocation of PDS in primary care hubs as part of the modernisation of primary care					

Objective Five	Rag Status
People with dementia will be supported fully to remain at home and be fully involved in their communities	

Actions	How	Evidence	Timescale	Outcome	Lead
Develop a range of intermediate care options to respond to health changes which maximises resilience and promotes independence	Provide Re-ablement service step up step down facility to prevent admission and provide early discharge. START operational from 100518 though bed based service pending recruitment	Numbers who are admitted to facility. Decrease in length of stay for over 65s who have no care package.	End of January 2018 June 2018	Reduction in avoidable admissions to the acute hospital settings and delays in discharge	Head of Locality Services
Implement Alzheimer Scotland's 8 pillar model to ensure holistic care coordination across statutory and non-statutory services	Via the ACP process, care managers are identified for nursing and social care teams. Education in 8 pillars model for all teams providing care management. Review of evidence for 8 pillar model to provide agreed guidelines for role of care managers. Shared protocol agreed for health and social care partners.	ACP data collection for reviewer. Number attending education sessions Protocol published on parent body intranet	June 2018	Coordinated holistic care for people in a more advanced stage of the disease supports care at home	Chief Officer, IJB

Embed anticipatory care planning for people who live at home with a range of long-term conditions including dementia	Education and training in ACPs are provided via learnpro and face to face sessions. Teams identify service users who would benefits from a reviewed ACP which connect to the GP Key Information Summary. Public awareness sessions to encourage uptake of the national ACP format.	Number of people who attend training. Number of KIS that link to an ACP. Number of public awareness sessions	Initiated and ongoing	Strong community and primary care responses to the health needs of people with dementia	Lead Nurse, Acute
Encourage communities to develop local response to reduce social isolation	Social Navigator programme forms effective partnerships with local resources. **Alzheimer Scotland deliver a wide range of support services and community activities for people with dementia and carers including those living in care homes and in the community in rural locations. We are currently piloting a model for reducing social isolation for people with dementia and carers who are unable to access this wide range of services. We deliver regular dementia friends information sessions and activity in rural communities and are supporting our colleagues in the Southern Isles.**		Initiated and ongoing	Communities strengthened	**Head of Health Intelligence and** And Alzheimer's Scotland

We will consider what local action is required to support further improvements in transport for people with dementia	Review transport hubs environment Offer dementia friendly training to bus, ferry and flight operators.	This work is ongoing as part of regular Dementia Friends information sessions and Upstream travel. **Marion to ask Andy Hyde for a report on the work complete by Upstream Travel**.	June 2018	Reduced social inclusion	**Service manager, Alzheimer Scotland**
Ensure access to a wide range of psychological therapies for people affected by dementia	Develop programme for the NES range of psychological interventions and identify resources via the Clisham reprovisioning.	Programme available	June 2018	Increased well-being of people with dementia and carers	Consultant Clinical Psychologist

Comments:
Meets national commitments:
3. We will support the integration Authorities to improve service and support people with dementia as part of our implementation of key actions for delayed discharge, reducing unscheduled bed days, improving palliative and end of life care and strengthening community care
4. We will consider the learning from the independent evaluation of the 8 pillars project on the benefits and challenges of providing home-based care coordination and proactive, therapeutic integrated home care for people with dementia
7. We will continue to implement national action plans to improve services for people with dementia in acute care and specialist NHS care, strengthening links with activity on delayed discharge, avoidable admissions and inappropriately long stays in hospital.
13: We will consider what national action is required to support further improvements in transport for people with dementia.
14**:** As part of supporting local activity on dementia-friendly communities, we will work with partners to explore the potential to promote and support increased participation in dementia befriending.

Objective six	Rag Status
Home environments will be safe and supportive with the maximisation of adaptations and assistive technology	

Actions	How	Evidence	Timescale	Outcome	Lead
Plan in partnership with people affected by dementia, their broader housing and accommodation needs.	Lewis Residential Care project includes the input of carers and users networks and dementia services to inform the design and accommodation schedules.	Design development documents, project governance reports and stirling university feedback	Ongoing	Most people with dementia can stay at home and be involved in their communities.	**Head of Partnership Services**
In partnership with housing providers, agree prioritisation of adaptations as detailed in the online guide *Improving the Design of Housing to assist People with Dementia*	Adaptation policy is approved and will be subject to review in line with the policy	Adaptation policy	Sept 2018	Maintain the independence and quality of life of people with dementia and their carers	**Head of Partnership Services**
Promote telecare, aids and adaptations for people with dementia by embedding in PDS.	PDS staff trained and confident in technology awareness		Initiated and ongoing	Cost-effective adaptation of housing for people with dementia	Nurse Consultant Older people and dementia

Post diagnostic support for early diagnosis includes future permissions for the range of assistive aids that could be used to help with safety such as GPS trackers	ACP encouraged for all people to document this. Permission form added to PDS documentation for people who do not wish to complete an ACP.		Initiated and ongoing	Assistive aids that help with safety are fully in line with individual consent	Nurse Consultant Older people and dementia
Promote the therapeutic and enabling role of Allied Health Professionals in community settings	Dementia information includes guidance on role of AHPs. Palliative care pathway based on MTD assessments and inputs	Alzheimer Scotland resources leaflet.	Ongoing	Multi-disciplinary approach to care at home	**Lead AHP**
Comments: Meets National commitments: 10. We will continue to support the implementation of the new AHP Framework Connecting People , Connecting Support. 11**:** We will implement the *Technology Charter for People inScotland with Dementia*, ensuring that everyone with a diagnosis of dementia and those who care for them are aware of, and have access to, a range of proven technologies to enable people living with dementia to live safely and independently. We will continue to explore innovative ways in which technology can be used and adapted for people living with dementia 12**:** We will work with national and local stakeholders to implement actions in the refreshed *Age, Home and Community: A Strategy For Housing For Scotland's Older People: 2012 – 21* to support people to live safely and independently at home for as long as possible					

Objective Seven	Rag Status
Provide integrated care and support on the basis of the 8 Pillars model	

Actions	How	Evidence	Timescale	Outcome	Lead
Consult on local Integrated Care Pathway and disseminate agreed pathway widely	ICP draft for consultation.	ICP draft at dementia MCN August 2016	Completed	Raised awareness	Nurse Consultant Older people and dementia
	ICP mapped against local service provision and access to psychological interventions	November 2017		Service planning structure visible	Nurse Consultant Older people and dementia
	Map development needs against ICP and utilise Clisham re-provisioning to resource community developments	March 2017		Service planning includes workforce development plan	Nurse Consultant Older people and dementia
Comments: Meets National Commitment 4 We will consider the learning from the independent evaluation of the 8 pillars project on the benefits and challenges of providing home-based care coordination and proactive, therapeutic integrated home care for people with dementia					

Objective Eight	Rag Status
Respond to Stress and Distress with psychological support	

Actions	How	Evidence	Timescale	Outcome	Lead
To ensure anti-psychotic medication is used appropriately, benchmarking level of prescribing across all sectors	Data collections for progress and review against national picture	Benchmarking toolkit GP records Care inspectorate reports residential	Initiated and ongoing	Meet national strategy guidelines on reduction of use	Nurse Consultant Older people and dementia
Introduce risk assessment and review protocol for initiation of antipsychotics for people with dementia for all prescribers	Short life working group to agree protocol Protocol for consideration via hospital pharmacist and GP cluster	Publish protocol in clinical guidelines	August 2018	Manage patient safety effectively	Associate Medical Director
Develop reporting tool for prescribers to identify numbers and patterns for use of antipsychotics	**Data from HI and had meeting with Clinical Psychologist, Nurse Consultant and Sergey (Title). Psychologist and Nurse Consultant working on training for staff so that there is a proactive management of behaviour. They were also working on developing a tool for decision making . Sergey felt that often**		August 2018	Ensure overview of prescribing activity and promotion of alternatives	Associate Medical Director

	patients present in crisis and his fire fighting. We need a team approach. We can monitor prescribing but need the intervention in place.				
Develop and embed a training plan for stress and distress to front line staff across all sectors	Embed non medical model of dementia within care home, wards and specialist settings. Develop training programme for all staff Liaison nurse post for one year to support reprovisioning of Clisham and to embed practice changes. Train up care home staff to become trainers so they can deliver the training in-house, building capacity. Develop a dementia page on both the health and social care intranet sites where we are hoping to put all information relating to training.	The training framework is now complete and training has commenced. In total 102 health and social care plus 3rd sector staff have been trained to the skilled level specific to understanding and preventing stress and distress in dementia (34 of these were Care Home staff).	March 2018	Wide range of staff trained to use non pharmacological interventions for S&D	Consultant Clinical Psychologist
Comments: Meets national commitment 18. We will commission and publish a renewed study on trends in the prescribing of psychoactive medications for people with dementia					

Objective Nine	Rag Status
Continue improvement in acute and specialist dementia health and social care settings	

Actions	How	Evidence	Timescale	Outcome	Lead
Use programme of OPAC inspections by Healthcare Improvement Scotland to effectively drive change and prioritise action areas		Inspection reports and self evaluation	Ongoing	Standards of Care for Dementia in Scotland are met	**Lead Nurse Acute**
Benchmark against the 10 Point National Action Plan and develop detailed plan to meet all standards by 2020		Self audit	Ongoing	When admission to hospital is unavoidable for people with dementia, the care experience is safe, coordinated, dignified and person-centred.	**Director of Nursing**
Effective discharge is fully supported by the required range of community services within a maximum of 72 hours of being fit for discharge	Work underway as part of delayed discharge action plan. Subject to community capacity, but improvement beginning to show.	Delayed discharge minutes	Ongoing	Discharges from hospital are safe and timeous	**Head of Partnership Services**

Develop Alzheimer Scotland Allied Health professional role to support Advanced practice model				Increased leadership in dementia at expertise level	**Lead AHP**
Comments: Meets national commitments: 6. We will work with stakeholders to identify ways to make improvements in palliative and end of life care for people with dementia 7. We will continue to implement national action plans to improve services for people with dementia in acute care and specialist NHS care, strengthening links with activity on delayed discharge, avoidable admissions and inappropriately long stays in hospital. 10. We will continue to support the implementation of the new AHP Framework Connecting People , Connecting Support.					

Objective Ten	Rag Status
Identify and promote the specific issues and needs of the dementia client group in residential care	

Actions	How	Evidence	Timescale	Outcome	Lead
Embed routine screening of admissions and at annual reviews of people living in care settings				Diagnosis of dementia and optimisation of interventions	**Head of Partnership Services**
Introduce case management in residential units with identified responsible professional	Social workers lead on this		Ongoing	Equity of case management provision	**Head of Partnership Services**
Include multi-disciplinary approaches to dementia in residential care within the Integrated Care Pathway	Finalise	Published ICP Audit of activity via Morse	Ongoing	Increase knowledge of response to stress and distress in care homes and elsewhere	Nurse Consultant Older people and dementia
Comments: Meets national commitment: 8 We will continue the National Group on Dementia in Care Homes to help ensure that the ongoing modernisation of care home sector takes account of the needs of people with dementia, and will consider the findings of the Care Inspectorate's themed inspections.					

Objective Eleven	Rag Status
Implement and extend *Promoting Excellence* dementia health and social services training and embed dementia in the education plan for all employees and volunteers	

Actions	How	Evidence	Timescale	Outcome	Lead
Workforce development plans for statutory services identifies the level of Promoting Excellence that all posts require and are assessed annually		Annual workforce plans		All staff have adequate skills and knowledge to support people.	Nurse Director
Prioritise training for staff who require the Enhanced level of Promoting Excellence training		KSF List of staff to be trained	December 2017	Staff are more confident and better aware of when to seek specialist advice.	Nurse Director
Provision of *Promoting Excellence* training and awareness raising in other areas of public life including schools and community groups			March 2019	Reduction of stigma supports early assessment and ongoing support in communities	Nurse Consultant Older people and dementia

Comments:
Meets national commitment:
9. We will continue to support the ongoing implementation of the Promoting Excellence dementia health and social care workforce framework

Objective Twelve	Rag Status
Respond proactively to the overall palliative and end of life care needs of people with dementia	

Actions	How	Evidence	Timescale	Outcome	Lead
Promote advanced care planning based on the wishes of the individual and taking account of carers' views	Raise general awareness and promotion of ACP's with staff and the general public, promote their use as early as possible utilising identified tools and triggers as prompts. Identify carers and involve them in the planning processes whilst supporting them in line with legislation of the carers act.	Awareness campaign, develop staff in ACP conversations through uptake of learn pro modules and advanced communication course being offered	June 2018	Ensures compliance with incapacity legislation	Lead Nurse, IJB
Develop a care pathway for palliative and end of life care that effectively supports the individual to a good life and a good death	Introduce and embed policies and procedures to promote best practice in end of life care with capacity assessments and DNACPR decisions.	Actions and recommendations from the PEOLC strategy. Implementation plan to be developed	Ongoing	Reduced variation for all conditions in remote settings	Chief Officer, IJB
Introduce and embed policies and procedures to promote best practice in end of life care with capacity assessments and Do Not Attempt Cardiopulmonary Resuscitation decisions				Greater awareness of agreed procedures for making decisions for people with dementia who lack capacity	**Lead Nurse Acute**
					Lead Nurse IJB

Develop a workforce skilled in end of life care by use of national improvement programmes	Lead Cancer Nurse establishing multi-agency training programme to up-skill health and social care staff around palliative care		August 2017	Generalist palliative skills are available across all localities	Chief officer IJB
Develop a specialist dementia workforce to support Advanced Care service model with obligate network if required to enhance provision			August 2017	Specialist and generalist palliative skills are available across all localities	Consultant Clinical Psychologist
Comments: Meets national commitments: 5. We will test and evaluate Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model. 6. We will work with stakeholders to identify ways to make improvements in palliative and end of life care for people with dementia					

Scottish Government Dementia Strategy National Commitments

1. We will revise the national post diagnostic service offer to enhance its focus on personalisation and personal outcomes in the delivery of PDS.

2. We will test and independently evaluate the relocation of PDS in primary care hubs as part of the modernisation of primary care

3. We will support the integration Authorities to improve service and support people with dementia as part of our implementation of key actions for delayed discharge, reducing unscheduled bed days, improving palliative and end of life care and strengthening community care

4. We will consider the learning from the independent evaluation of the 8 pillars project on the benefits and challenges of providing home-based care coordination and proactive, therapeutic integrated home care for people with dementia

5. We will test and evaluate Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model.

6. We will work with stakeholders to identify ways to make improvements in palliative and end of life care for people with dementia

7. We will continue to implement national action plans to improve services for people with dementia in acute care and specialist NHS care, strengthening links with activity on delayed discharge, avoidable admissions and inappropriately long stays in hospital.

8. We will continue the National Group on Dementia in Care Homes to help ensure that the ongoing modernisation of care home sector takes account of the needs of people with dementia, and will consider the findings of the Care Inspectorate's themed inspections.

9. We will continue to support the ongoing implementation of the Promoting Excellence dementia health and social care workforce framework

10. We will continue to support the implementation of the new AHP Framework Connecting People, Connecting Support.

11. We will implement the *Technology Charter for People in Scotland with Dementia*, ensuring that everyone with a diagnosis of dementia and those who care for them are aware of, and have access to, a range of proven technologies to enable people living with dementia to live safely and independently. We will continue to explore innovative ways in which technology can be used and adapted for people living with dementia.

12. We will work with national and local stakeholders to implement actions in the refreshed *Age, Home and Community: A Strategy For Housing For Scotland's Older People: 2012 – 21* to support people to live safely and independently at home for as long as possible.

13. We will consider what national action is required to support further improvements in transport for people with dementia.

14. As part of supporting local activity on dementia-friendly communities, we will work with partners to explore the potential to promote and support increased participation in dementia befriending.

15. We will support implementation of NHS Health Scotland's report recommendations on dementia and inequalities.

16. We will consider Police Scotland Missing Persons report for the dementia client group.

17. We will commission and publish a renewed study on trends in the prescribing of psychoactive medications for people with dementia

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The following commitments have no specific local objectives but will be met as part of overall dementia service improvement and linkage to national workstreams

18. We will support the clinical and non-clinical research community in Scotland, including supporting linkages to the UK-wide research institute, linking policy and research in Scotland, and showcasing examples of dementia research in Scotland

19. We will commission fresh work to assess dementia prevalence, and consider which current prevalence model applies best.

20. We will assess if there is any need for updated dementia clinical guidelines or guidelines on specific elements of clinical dementia treatment.

21. We will establish a national policy governance structure for monitoring and implementing the 3rd national strategy.