CYNGOR SIR CEREDIGION COUNTY COUNCIL

Report to:	**Cabinet**
Date of meeting:	**3 October 2023**
Title:	**To present to Cabinet the outcome of the Ceredigion Dementia Implementation Plan**
Purpose of the report:	**To agree the outcome of the public engagement and the Dementia Implementation Plan developed**
For:	**Decision**

Cabinet Portfolio and Cabinet Member: Councillor Alun Williams, Deputy Leader of the Council and Cabinet Member for Through Age and Wellbeing

Background:
In March 2021, Improvement Cymru published the All-Wales Dementia Care Pathway of Standards. The high-level strategy provides a programme governance structure and the foundation on which to fund services, in line with the Improvement Cymru delivery framework. Significant work has already been done within the West Wales Regional Partnership Board (WWRPB) to develop dementia services. Attain worked with the WWRPB to co-design a Regional Dementia Strategy and model service pathway of care. People living with dementia and their carers were at the centre of the work. Alongside this, Attain, carried out a review of the dementia related projects funded by the Regional Integrated Care Fund. which provided a steer as to what services should continue to be funded, as well as an indication of any additional initiatives that should be undertaken.

A priority area for Ceredigion County Council is to develop a local dementia Implementation Plan to support the Regional Dementia Strategy. On the 6th of December, 2022 Attain were appointed to undertake and facilitate engagement sessions to explore what actions were needed to support people living with dementia in Ceredigion. The engagement period took place over a 6 week period from 13.02.2023 to the 31.03.2023. Over the engagement period, Attain spoke with a wide remit of stakeholders, from individuals living with dementia, their careers, and professional from across Health and Social Care, including support networks in the 3rd sector. As part of this work Attain have developed a report and an Implementation Plan that will support Ceredigion County Council and Hywel Dda University Health Board to address some of the challenges and gaps identified.

Current Situation:
The finalised report and Implementation Plan have now been drafted and these can be found in Annex A and B of the report.

The key finding of the report are as follows:

Data

- The current number of People living with Dementia (PLWD) in Ceredigion is approximately 1,260.
- By 2040 the predicted growth of PLWD ranges from 600 to 2000, so there will be a significant increase.

Key Themes

Analysis of the engagement phase activities resulted in the identification of 20 key themes which represents “pinch points” in current service provision and opportunities to provide improved experiences:

- Referral process / route
- Pre-clinical diagnosis
- No appropriate sign-posting
- Fragmented pathway
- Lack of crisis support
- Multi-Disciplinary Team (MDT) approach
- Day Services
- Transport
- Patient recording systems
- Access and information sharing
- Funding
- Misinformation around 3rd sector providers
- Silo working
- Lack of nursing-based beds
- Communication
- Recruitment and staffing
- Skills mix and training and development
- Education
- Respite Care
- Confidentiality

Recommendations:

The following recommendations have been incorporated into the implementation plan (Annex B), with some of the recommendations already being progressed through designated Regional Workstreams. Ceredigion Officer actively participate in the Regional Dementia Steering Group and the themed workstreams, with the Ceredigion Implementation Plan underpinning the overall Strategic Improvements required to support PLWD in Ceredigion.

A fundamental element of delivering the implementation plan, will be to ensure that the Welsh language is an integral element in the care and support of Welsh speakers living with dementia. This will be required to be considered throughout the dementia pathway.

- **Dementia Wellbeing Connector Roles (Regional) -** The vision for the Dementia Wellbeing Connectors service is that PLWD and their carers will

have access to consistent, coordinated wrap-around support to enable efficient and effective navigation through health, social care, and third sector services, with support for their wellbeing throughout their journey.

- **Exploration and feasibility study to explore a virtual service and dementia health advice line (Regional) -** Virtual health checks would enable professionals to monitor situations remotely. Access to a dementia health advice line would also support PLWD and their families and care givers. This would give them easy access to health advice and may prevent emergency attendances at acute hospitals. Currently untested and requires further feasibility and research work to understand the functions.

- **Enhanced transport options Regional/Local) -** Exploring options for additional transport, involving public, private and charitable organisations is essential to support local communities and ensure equitable health and social care access for PLWD.

- **Bespoke day services that act as community hubs (Local) -** Renewed emphasis on the importance of day services, but the need to transform these vital services to better meet the needs of PLWD.

- **Dementia-friendly services in everyday life (Local) -** Capitalising on the success of Dementia Friendly Towns and a growing public understanding of dementia, Ceredigion County Council is well placed to act as a champion to support small, positive action across the wider community and in everyday life.

- **A joined-up approach to learning and development (Regional)-** A joint regional approach to dementia learning and development for health and social care staff at all levels.

- **A new model of care consisting of the following (Regional/Local – Integrated and collaboration required to further develop this area of work):**
    - Dedicated dementia community team and referral pathway;
    - Introduce an MDT approach across the dementia pathway;
    - Specialist education clinician roles;
    - Integrated IT referral system;
    - Patient centred decision making;
    - Increase in dementia specialist care units in the area.

- Presented to Healthier Ceredigion Strategic Group (18.09.2023) and create an integrated Health, Social Care and 3rd Sector Development Group to oversee the delivery of the implementation plan.

- To communicate the initial findings of the engagement with the public, and to develop a Communication and Engagement Plan ensuring that the public are aware of the on-going progress relating to the delivery of the implementation plan.

- To return to the Healthier Communities Overview and Scrutiny Committee with an Annual Progress report.

Wellbeing of Future Generations:
Has an Integrated Impact Assessment been completed? If, not, please state why.

Will be developed as part of the initiation of the implementation plan.

Summary of Integrated Impact Assessment:

Long term:	The Regional Strategy will provide a blue print for the development of Dementia support and services for the future.
Collaboration:	The implementation plan requires collaboration across agencies and with local communities, individuals living with dementia and their careers.
Involvement:	There will be involvement required from professionals across the authority, Health Board, third sector and the communities.
Prevention:	Prevention is a key focus of the implementation plan, and we will be working with Public Health Wales to ensure that prevention underpins the implementation of the strategy.
Integration:	The implementation plan is an integrated plan.

Recommendation(s):
- **To create an Intergrated Ceredigion Dementia Development Group to oversee the delivery of the implementation plan.**
- **To communicate the initial findings of the engagement with the public, and to develop a Communication and Engagement plan ensuring that the public are aware of the on-going progress relating to the delivery of the implementation plan.**
- **To provide the Healthier Communities Overview and Scrutiny Committee with an Annual Progress report.**

Reasons for decision:
To support and develop an integrated approach in meeting the needs of individuals living with dementia and their carers through a range of health, social care and 3rd sector resources.

Overview and Scrutiny:
Healthier Communities Scrutiny Committee, 18 September 2023

Policy Framework:
Corporate Strategy
Regional Dementia Strategy

Corporate Well-being Objectives:
Creating Caring and Healthy Communities

Finance and Procurement implications:
To be reviewed as part of the initiation work relating to the implementation plan.

Legal Implications:
None

Staffing implications:
To be reviewed as part of the initiation work relating to the implementation plan.

Property / asset implications:
None

Risk(s):
To be reviewed as part of the initiation work relating to the implementation plan.

Statutory Powers:
None

Background Papers:
None

Appendices:
Appendix A- Phase 1 Report
Appendix B- Phase 2 Service Implementation Plan

Corporate Lead Officer:
Donna Pritchard, Corporate Lead Officer, Porth Ceredigion

Reporting Officer:
Nerys Lewis, Corporate Manager – Direct Services, Porth Gofal

Date:
15 September 2023

Appendix A

Ceredigion County Council – Dementia Engagement and Service Implementation Plan Project

Phase 1 Report - Data analysis and key themes from the engagement activities

April 2023

Cyngor Sir CEREDIGION County Council

Document control

Owner	Ceredigion County Council
Document Title	Dementia Engagement and Service Implementation Plan Project
Version	15
Reference	1001073
Author	Aoife Mulcahy/Joseph Middleton
Date	10/07/2023

Document history

Version	Date	Author	Comments
1.0	27/03/23	Aoife Mulcahy	Draft
2.0	03/04/23	Martin Wilson	Review and edits
3.0	04/04/23	Aoife Mulcahy	Draft - Edited
4.0	05/04/23	Martin Wilson	Draft - Reviewed and Edited
5.0	05/04/23	Aoife Mulcahy	Draft - Edited
6.0	11/04/23	Martin Wilson	Draft – Reviewed and Edited
7.0	12/04/23	Joseph Middleton	Reviewed and Edited
8.0	13/04/23	Cherie Cope	Amended data section, report format
9.0	27/04/23	Joseph Middleton	Survey analysis, additional engagement and lived experience
10.0	28/04/23	Martin Wilson	Review and Edited
11.0	12/05/23	Joseph Middleton	NL Comments CCC Performance and Research Team Edits
12.0	25/05/23	Joseph Middleton	Regional comments as per MBF
13.0	13/06/23	Joseph Middleton	Added Appendix on engagement
14.0	15/06/23	Joseph Middleton	WWRPB Changes

15.0	10/07/2023	Martin Wilson	Hafan y Waun development
16.0	11/07/2023	Joseph Middleton	Hafan y Waun Adjustment

CONTENTS

1. Introduction 5
2. Data Analysis 7
3. Stakeholder Engagement 13
4. Survey Analysis 14
5. Lived Experience & Context 18
6. Key Themes 21
7. Main Service Gaps 31
8. Conclusions 34
9. Appendices 38

1. INTRODUCTION

1.1. Background

In March 2021, Improvement Cymru published the All-Wales Dementia Care Pathway of Standards. The high-level strategy provides a programme governance structure and the foundation on which to fund services, in line with the Improvement Cymru delivery framework. Significant work has already been done within the West Wales Regional Partnership Board (WWRPB) to develop dementia services. Attain worked with the WWRPB to co-design a Regional Dementia Strategy and model service pathway of care. People living with dementia and their carers were at the centre of the work. Alongside this, Attain carried out a review of the Regional Integrated Care Fund projects concerning dementia, which provided a steer as to what services should continue to be funded, as well as an indication of any additional initiatives that should be undertaken.

A priority area for Ceredigion County Council is to develop a local dementia action plan to support the Regional Dementia Strategy. Attain has been appointed to undertake engagement sessions with a wide remit of professional and lay stakeholders to understand what is important to the service users of Ceredigion and to then proceed to develop an implementation plan to address the challenges and gaps identified. This will assist Ceredigion County Council in the development of future services which will be aligned with the regional dementia strategy and national policies and drivers.

Ceredigion is a predominantly rural county with an urban concentration around the principal city, Aberystwyth. The region is served by a range of residential care homes and GP surgeries as well as a memory clinic at Bronglais hospital (with a satellite clinic once per week in the south of the county).

Service Map of core providers for Dementia Care

The map shows the distribution of these facilities that are core to a dementia care pathway and highlights some of the geographic challenges of a large and unevenly populated county.

1.2. Purpose

This report covers Phase 1 of the project and provides an overview of data analysis and the key themes which have emerged from stakeholder engagement activities. Further details are provided in the appendices.

1.3. Data analysis

The data interrogation stage involved in depth analysis of the "data dashboards" which are comprised of health and social data provided by Ceredigion County Council. This established the extent to which issues identified through stakeholder engagement were borne out by the data and so helps identify problem and solution areas.

1.4. Stakeholder engagement

Stakeholder engagement was as wide-ranging as possible; meeting people living with dementia (PLWD) and their carers was central to the exercise. During the engagement phase, Attain held drop-in sessions, focus groups within care and residential accommodation, conducted over 50 interviews and attended provider sessions to gather experience and perspectives relating to people living with dementia in Ceredigion.

Opinions and perspectives were obtained from a wide range of professional backgrounds, ranging from front-line staff to senior management. This included those from within the local authority, managing social care, housing and substance misuse. Health teams from both primary and secondary care, charitable organisations such as Alzheimer's Society and other public bodies such as the Fire and Rescue service. See Appendix 1 for a full list of engagements.

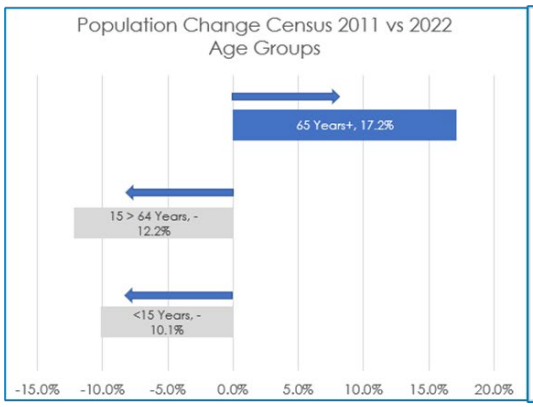
In addition, Ceredigion County Council ran an online and paper survey throughout the engagement period. This was open to the public and invited responses from across the county. A series of public awareness messages, including press releases and social media posts encouraged as many responses as possible.

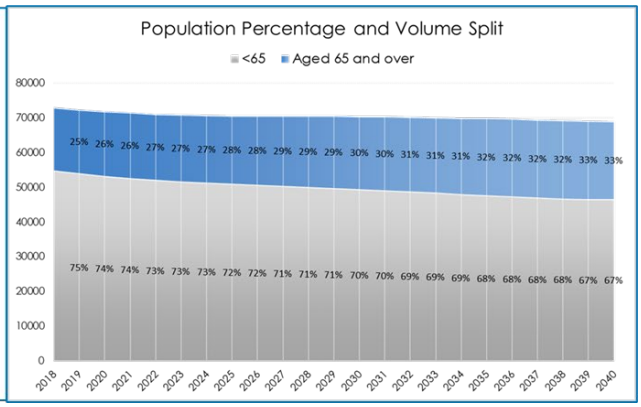
2. DATA ANALYSIS

2.1. Population and people living with dementia

The 2021 Census data indicates that there has been a general decrease in Ceredigion's population of 5.8%. This is fuelled primarily by a decrease in the number of people under the age of 65. However, most people diagnosed as living with Dementia in Ceredigion are over 65 years of age (97%). This is the age group that has seen a dramatic increase in population change with 2,700 more 65+ people in Ceredigion than in 2011, leading to a 17.2% increase in 10 years.

The data suggests that, although Ceredigion's population is shrinking, the region's elderly population is growing at a substantial rate.

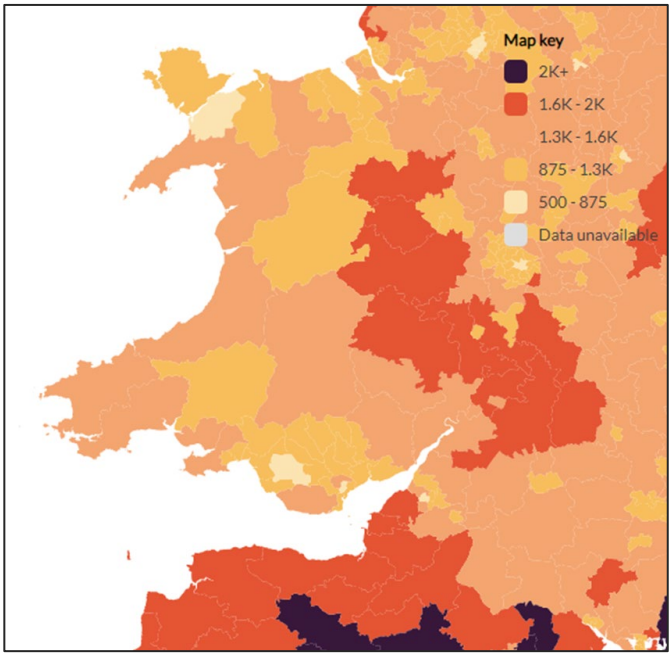




Modelled demographic predictions expect that the region will continue to face a steady decline in general population. However, it is expected that the population of people 65 years and older will increase both numerically and as a proportion of the total population. We can see that between the census findings in 2021 (26%) and the predicted position of 2040, the proportion of 65+ will have increased by a further 7 percentage points to 33% of people living in Ceredigion.

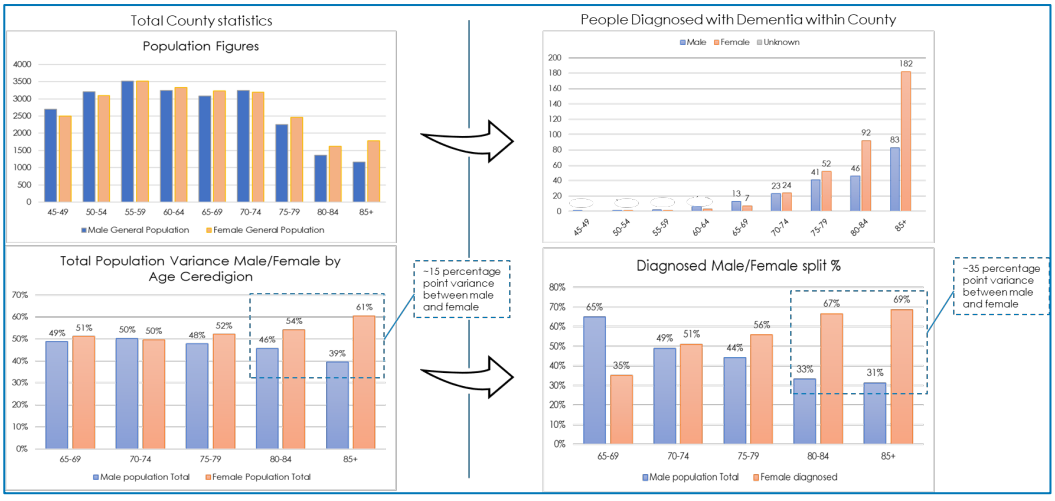
There is, therefore, an expectation that, although the population is shrinking, the elderly proportion is increasing at a constant rate. This will inevitably lead to further demand pressure on older people's services in Ceredigion. This includes dementia care, of which 97% is delivered to the 65+ age group.

By population Ceredigion is below the UK average sitting at approximately 1,260 PLWD, while the UK averages 1,302. However, proportionally, the percentage of the region's population living with dementia is slightly higher than the UK average sitting at 1.69% vs 1.33% for UK constituencies on average.



It is also known that dementia is under diagnosed across the world; Wales and Ceredigion are no exception with the Hywel Dda diagnosis rate estimated to be only around 53% (although some estimates have suggested this could at one point have been as low as 45%). All of this points to a substantial population need, which is growing over time. There is a regional commitment to an annual increase of 3% in diagnosis rates which is on target.

Dementia disproportionally affects older people. Circa 97% of those diagnosed with dementia in Ceredigion are over 65 years old. With regard to gender, despite what appears a stark difference between male and female diagnosis rates – there is some correlation to the fact that there are proportionally more females within the 65+ age group at a regional level. The exception is with 80+ year olds where the data suggests that more females are diagnosed proportionally than males comparing the total population for the same age range.



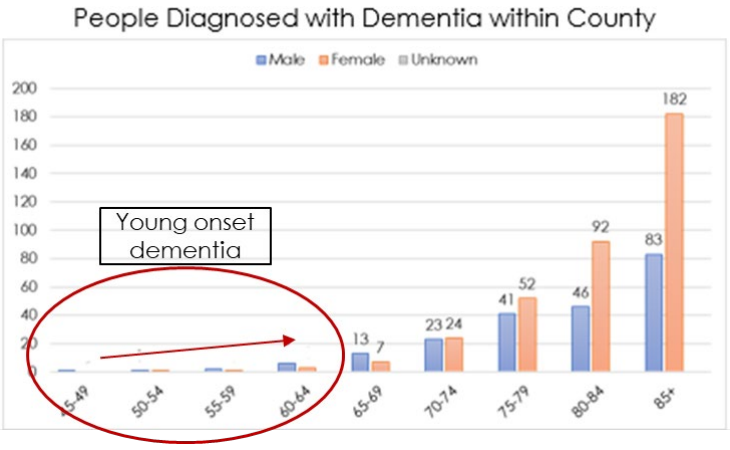
The predicted growth of PLWD ranges anywhere from 600 more PLWD in 2040 to 2000. If correct, this is at least a 49% increase in prevalence on current volumes. When compared to other Welsh counties, Ceredigion has a slower growth rate, but it is still substantial given the aging population. The comment below from the Assessment of local Wellbeing, published in 2022 explains the situation well - Sadly, Dementia and Alzheimer's were 'the third most common cause of death in the county between 2013 and 2020 – equating to 8.2% of deaths each year, or 65 people per year (Abbreviated from the Assessment of local wellbeing 2022 – p19).

2.2. Young Onset Dementia

Although the growing older people population and the increasing incidence of dementia in this age profile is the core and bulk of all dementia cases, there is a not insubstantial level of young onset dementia (sometimes referred to as working age dementia) both nationally and across Ceredigion.

It is estimated that roughly 1 in every 1,000 people in Wales have early onset dementia. Further estimates suggest that the figure is slightly higher in West Wales, and particularly so in Ceredigion. The numbers on GP registers are much lower than that would suggest, with <20 people with a formal diagnosis. According to the predicted levels, this number should be closer to 70-100 people.

Young onset, or working age, dementia has a profile that follows the pattern of other diagnoses, in that incidence increases with age.



As noted, the above graph shows an under diagnosis on GP registers; numbers are predicted to be higher than this but the pattern of increasing with age can be seen. The Ceredigion MSR from 2022 says there are gaps "either geographically or for more specialist services such as younger onset dementia" and so it is recently acknowledged that there is more need for services in this area.

It is likely that a larger proportion of people in this younger cohort are undiagnosed, particularly given that this group of people often have rarer forms of dementia. In 2013 The Care Quality Commission (England) reported that unrecorded cases of dementia were

three times more common in people between the ages of 18 and 54 compared with those over the age of 75. Statistics are not always well publicised for the younger age groups, however, the average time to diagnosis is estimated to be circa 4.4 years in younger people compared with around 2.2 years for people over 65. The young onset dementia website suggested that, across England in 2018, the estimated dementia diagnosis rate for the younger age profile was just 41%. With general diagnosis rates in Wales sitting lower than the that across the UK, it is logical to assume that the same is true for young onset dementia diagnosis rates. Looking at the GP register data for this age group versus what might be expected (around 20 people on the register compared to an expected ~75) this gives a rough diagnosis rate for young onset dementia of 20-30% in Ceredigion.

Another important point in respect of diagnosis challenges in this younger age cohort is the higher likelihood of the person with dementia having learning disabilities. It is well known that up to three-quarters of people with Down's syndrome over the age of 50 may develop dementia. It can also be more difficult to diagnose within this group because of the challenges involved in assessing thinking-skill changes in those with learning disabilities (Alzheimer's Association). This has been recognised in the All-Wales Dementia Care Pathway of Standards, with Standard 4 outlining an expectation for regions to ensure that people with learning disabilities are offered regular cognitive wellbeing checks to support earlier identification of symptoms that may indicate dementia.

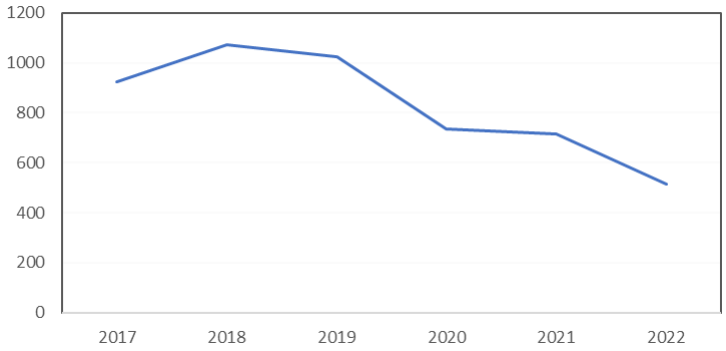
2.3. Other Data and Data Quality

Ceredigion County Council information leads embarked on a task as part of this work to extract data from their systems where there is a mention of dementia. The data was provided and analysed. There are substantial gaps in the data, particularly from 2020 onwards, where numbers of referrals and individual persons has decreased substantially.

It is really important to note that, although the below does attempt to draw some conclusions from this data, the findings should be taken in the context of concerns about data quality.

The below graph shows the aforementioned fall in recorded numbers, showing that we do not know the reasons for the drop (change of recording, data quality or lower referrals/ mentions of dementia).

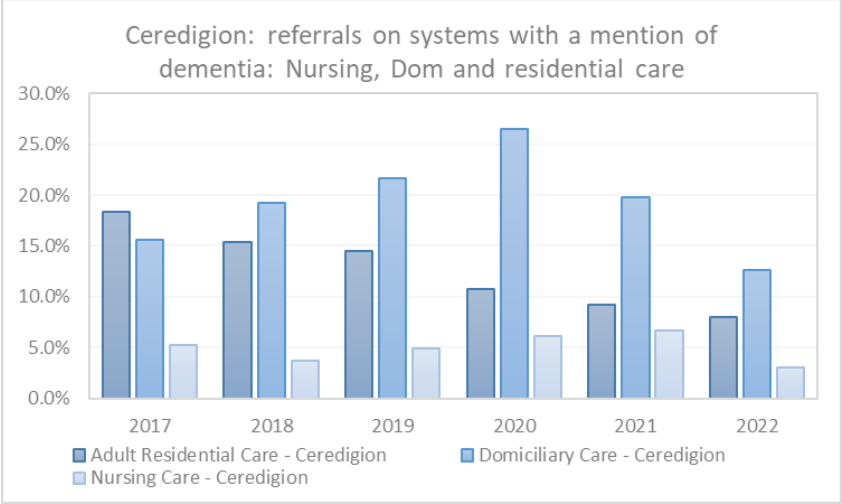
Ceredigion LA Systems – Individual people with a mention of Dementia referred to services on systems



The numbers of referrals with a mention of dementia show a similar pattern and the average number of referrals per person has decreased from 2.08 to around 1.7 between 2017 and 2022. It is difficult to know from reviewing the data whether there was a change in services during Covid that has persisted or whether there has been a reduction in recording (of individuals who self-refer and from people taking referrals.

Either way, the data does provide some interesting, if unsurprising, insights:

- Referrals mentioning Residential, nursing and/or domiciliary care make up between one fifth and one quarter of all individuals in the data set
    - They make up over a third of all referrals
- In 2018 domiciliary care took over from residential care as having the most referrals with a mention of dementia. It has remained highest since.
- Despite the reduction in overall numbers across all services, domiciliary care referrals increased substantially in 2020, during Covid. The proportion also increased from 19-21% to over 26% of all referrals. This suggests that, rather than a recording change, there was a genuine change in either preference or service provision due to the pandemic.
- Over 90%, sometimes as high as 94%, of the people referred with a mention of dementia were over 65 (NB: all those under 40 were removed as they are likely correct, but carers or family members making referrals and recorded as such, rather than the person being referred).
- The median age of referrals is 81, the mean 79.



It is important to note that over half of the records in the dataset had no service recorded against them, so it is entirely possible that those 'blanks' should fit into one of the other categories. The overarching categories are shown below, with most having very small numbers and being inconsistently coded across the years.

Adult Residential Care	Direct Payments	Carers Service	Breaks
Domiciliary Care	Meals	Information	Innovation Partnership
Nursing Care	Day Care	Supported Living	Not recorded
Assistive Technology	Equipment & Adaptations	Transport	

Other than 'Not recorded' as described above (which come through in the data as blank) everything aside from Residential, Domiciliary and Nursing care has low numbers.

Assistive Technology had similar numbers to Nursing Care until 2019, when it dropped significantly and has never returned to the higher levels. Direct Payments has, and continues to have, similar numbers recorded to that of Nursing Care. The numbers across these are quite low.

The data tells us that recording has changed in some way, and so all results need to be interpreted with that in mind. It also doesn't give a reason for referral against the ones that are blank.

What is does show, however, in the years 2017-2019, which look the most complete, there were around 1,000 individuals in the Local Authority systems that included the mention of dementia.

Irrespective of limited data, the fact remains that dementia is a current and growing challenge for the people of Ceredigion. As the average age in Ceredigion gets gradually older, services will need to expand and adapt to meet the needs of a larger elderly cohort. As part of implementing a dementia strategy it is important to consider how data is recorded and reported back by services, in order to better evaluate change and to showcase good work.

3. STAKEHOLDER ENGAGEMENT

3.1. Approach

Far reaching and deep engagement with stakeholders was the foundation of Attain's approach, putting service users (and their families and carers where appropriate) at the centre. The approach used was based on the principle of combining insight and experience of international, national, and local best practice with in-depth engagement with system leaders and key stakeholders, including users and carers. To ensure appropriate delivery rigour, Attain followed project and programme management approaches familiar to the public sector, specifically PRINCE2 and Agile. Our team has worked with senior leads, clinicians, care providers, service users and carers to map current service provision. We have worked closely with key members of the client team, drawing upon their local knowledge, contacts, and expertise, and securing their ownership of the objectives and outcomes for this work.

3.2. Methodology

Adopting a flexible range of communication methods enabled maximum reach. Engagement was conducted through telephone calls, Microsoft Teams online 1:1 sessions, Microsoft Teams online group provider sessions, face to face meetings, drop-in sessions, survey distribution online and in hard copy and through email correspondence.

A key avenue was hosting provider forums which gave an opportunity for professionals in similar work areas to come together and share similar experiences or share collective challenges.

4. SURVEY ANALYSIS

The concurrent survey carried out by Ceredigion County Council provided additional reach and captured viewpoints across the county.

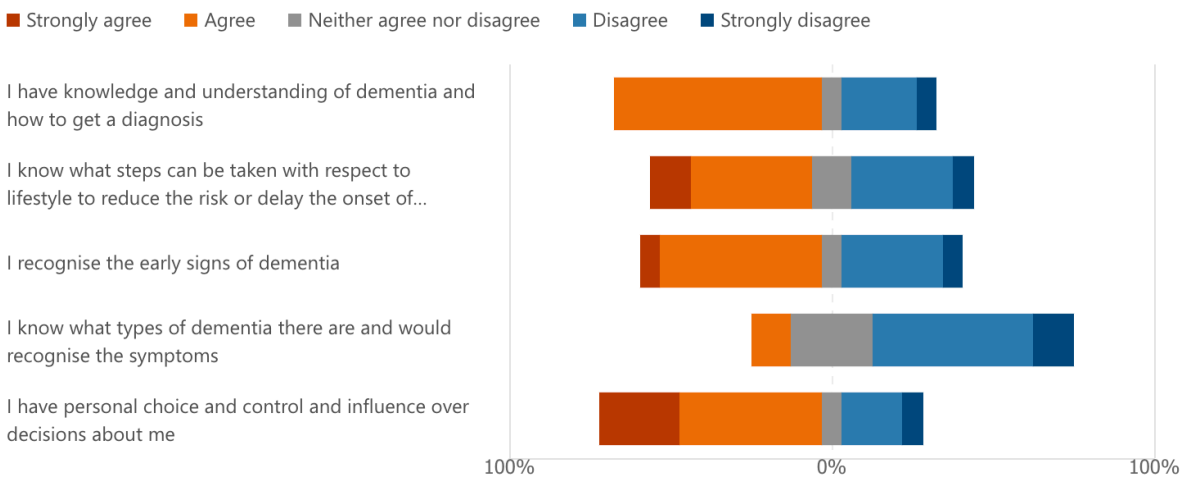
44 responses were received in total. Of those who provided information on where they lived, 4 were from North, 12 Mid and 14 from South of the county.

The age range was predominantly from the over 65 category which is in keeping with typical age ranges of dementia onset (see section 2.2) with no responses relating to those with early onset dementia.

The majority of respondents were interested residents of Ceredigion, but there were also responses from unpaid carers, health and social care professionals and a limited number completing it on behalf of someone who has dementia.

Sections 1-5 of the survey dealt with demographic and diagnosis information.

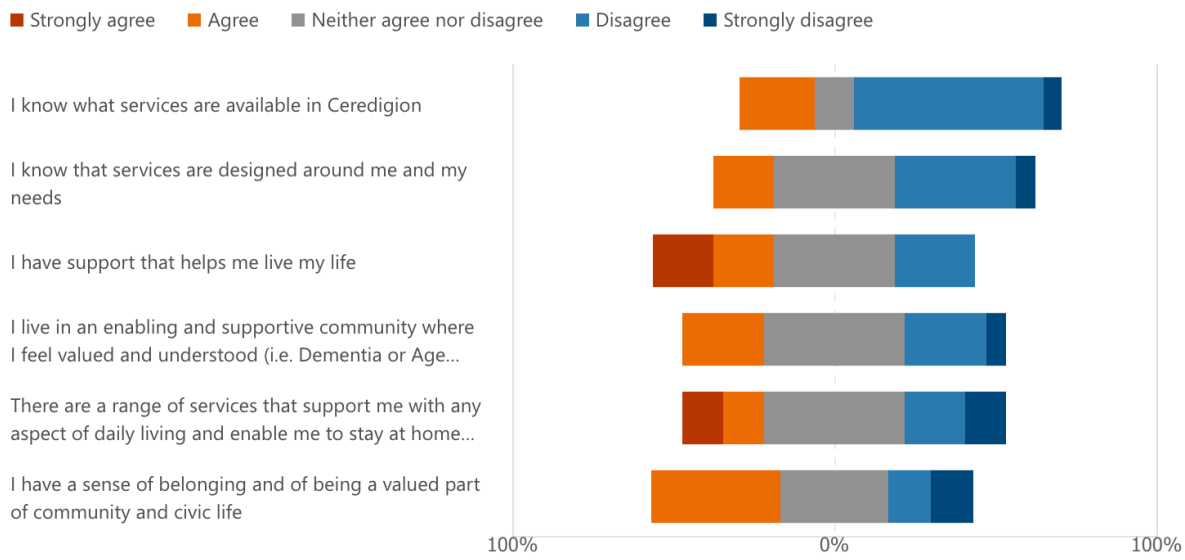
6. Your knowledge



Section 6 questions review the extent of public understanding and knowledge around dementia. Generally, respondents report a solid understanding of diagnosis and a sense of control over life decisions.

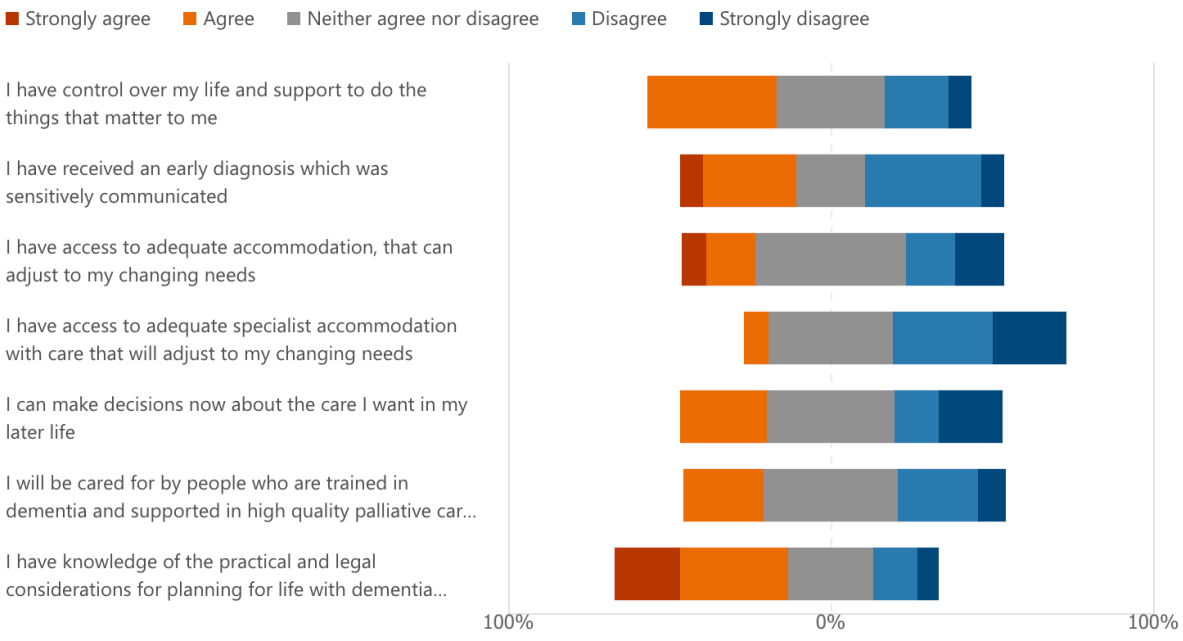
This may reflect an increasing profile of dementia in the public domain, strengthened by awareness campaigns by prominent charities such as the Alzheimer's Society. However, in addition, our qualitative evidence suggests that stigma remains around the diagnosis of dementia.

8. Local Community and Services



Section 8 assesses the service provision in the county and the sense of belonging within local communities. Signposting and navigating services is a key challenge for people but the survey reflects evidence that local communities are well formed and close knit.

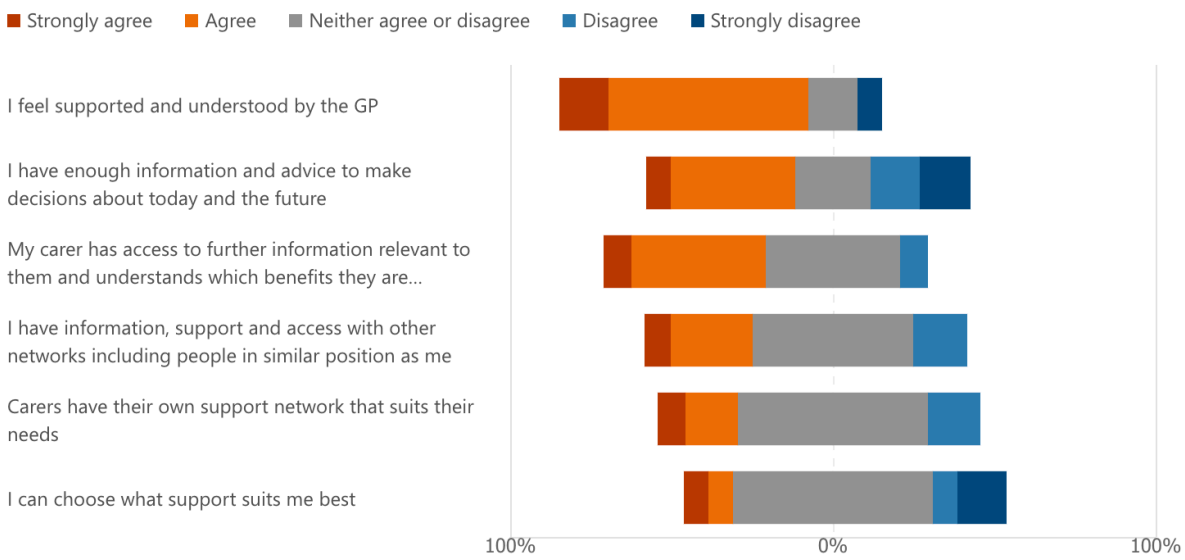
10. Me and my future



In section 10, questions assessed individual need, particularly around accommodation and future planning. In line with our engagement, respondents felt unable to access

specialist accommodation. In our conversations both professionals and the public repeatedly referred to the lack of nursing beds suitable for people living with dementia. A strong knowledge of legal matters is a positive example of a wider MDT supporting those living with dementia.

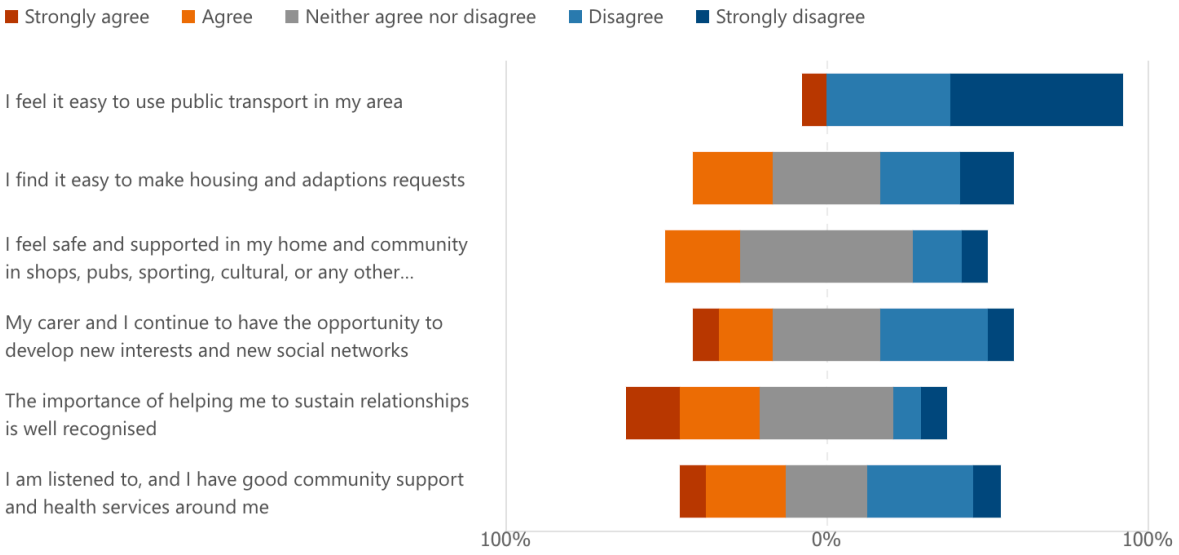
12. Your Support



Section 12 investigates support networks including services such as general practice. This matches with our learning that general practice is very well received in Ceredigion and, in most cases, people have regular contact with a familiar GP.

Similarly, carers are highly regarded and valued with some excellent examples of community and charitable groups supporting carers to identify benefits and rights.

14. Community Support



Issues around public transport were very apparent during our conversations and again reinforced in survey data. Rural communities in particular, appeared at risk of isolation and challenges accessing care and support.

5. LIVED EXPERIENCE & CONTEXT

We've highlighted some of the poignant stories that were captured during our public engagement. These rich sources of information have helped shape our thematic analysis and provides the lived experience of those in the county. Where there is a clear link to our thematic breakdown in section 6, we've referred to them below.

5.1. Joined up services at point of diagnosis

Linking Themes: 1-4, 10, 13

Janet is a retired lecturer and lives with her husband in Aberystwyth. Her mother has dementia and shows signs of memory loss but Janet's stepfather was against seeking help. Janet thinks this was due to a stigma around dementia diagnosis.

When the family did decide to seek support, they had a positive experience with their local GP and they were seen in Memory Clinic 2 months later, confirming a diagnosis of dementia.

"Nothing was joined up, I had to make multiple phone calls to be put in touch with the right people, explaining the situation over and over again".

District nurses visiting Janet's stepfather raised concerns about living conditions, Janet found it difficult to access services or knowing who to turn to.

5.2. The value of charitable groups like HAVHAV

Linking Themes: 5, 7, 12, 19

HAVHAV run a tea and cake session followed by singing or tai chi, which is open to those who are living with dementia as well as their partners and carers. HAVHAV benefits from a dementia lead, a former nurse who focuses on running activities and supporting carers for people living with dementia specifically.

We spoke to three unpaid carers, who were all highly experienced navigating the health and care system. They were articulate and shared their journey from diagnosis to seeking additional support. They all reported that lacking a key contact to centralise some of their needs was a key issue.

"The day centre gave us essential respite and time to ourselves. We were safe in the knowledge our loved ones were cared for."

They also described the need for crisis or stop-gap support that would step in if their scheduled carers did not arrive or if they themselves were unable to care.

5.3. Help living independently

Linking Themes: 11-12, 15, 19

Susanne's mother-in-law lives with her and her husband following a diagnosis of dementia 7 years ago. Susanne has noticed a gradual decline in her relative's cognition over the years.

She has noticed that the things her mother-in-law used to enjoy are no longer interesting, and Susanne struggles to find things to entertain her relative.

"I managed to secure carers twice a week for help with an evening shower, but otherwise it all falls on us. We got 14 hours of respite care through Crossroads but we have to use this sparingly as 2 hours per fortnight."

As time has progressed, her mother-in-law requires help with almost all activities of daily living (ADLs) and is compounded by hearing problems and they haven't had an opportunity to discuss future planning.

5.4. Building the MDT

Linking Themes: 3, 6, 15, 18

Wyn has been caring for his wife since her diagnosis of Multiple Sclerosis at the age of 60, 7 years ago. Wyn retired from his career at that point to become his wife's full time carer.

Wyn turned to his local councillor to seek help after struggling to navigate through the complex social care system.

> ***"With my local councillor's help, I was able to arrange things like Lasting Power of Attorney and Carers Allowance. Since her diagnosis of dementia during a stay in hospital she has waited three weeks for care to start at home".***

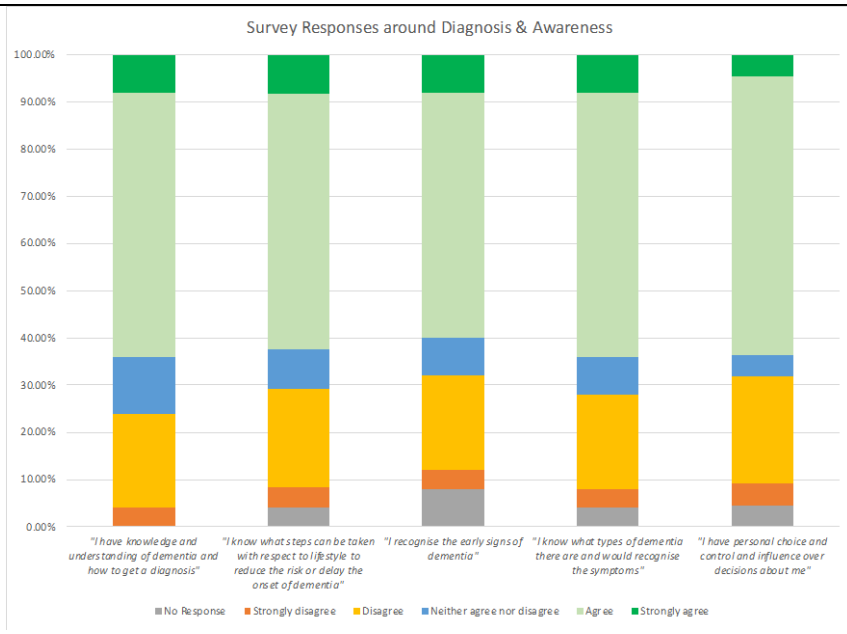
Wyn wasn't aware that there were local community connectors, but was fortunate to meet them as part of our project and was given various groups and contacts to make use of. He felt that if such a service was more well-known, it would be a great asset to the local community.

6. KEY THEMES

Distilling the extensive knowledge and insight gained across our Phase 1 engagement, we developed a set of Key Themes that bring together common strands and challenges across a broad range of areas.

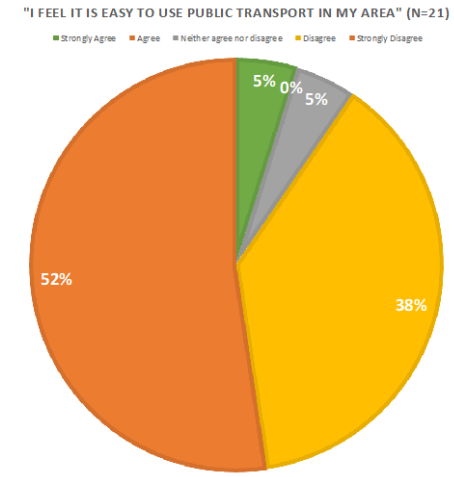
In each theme, we highlight pinch points and areas of untapped potential that represent opportunities to improve experiences for people living with dementia in the future.

Theme 1	Referral process/Route	• Alzheimer's Society receive 20 referrals a month and this indicates that they are an underutilised service that have capacity to accept more referrals by core health and social care providers. • Primary care does not refer to 3rd party provider organisations or charities routinely. • Incorrect referrals to charity organisations due to misunderstanding of what they provide. • Pharmacy for PLWD is often started by secondary care, routine medication reviews are sporadic and often don't include review of specialist dementia treatments. • Memory clinic incorrectly viewed as a 'gatekeeper' for diagnosis and onward support • Referral routes into end of life care are more established and well-rehearsed than those for pre-clinical dementia support
Theme 2	Pre-clinical diagnosis	• There is a lack of awareness, education and knowledge around the best course of action for pre-clinical presentations. • Some people only attend the GP once every few years when they are unwell, offering rare opportunities to capture those at risk or showing early signs of cognitive impairment. • Limited public awareness of support for 'staying well' in early stages of dementia and struggle to locate non-institutional sources of help (i.e non-NHS/LA services)

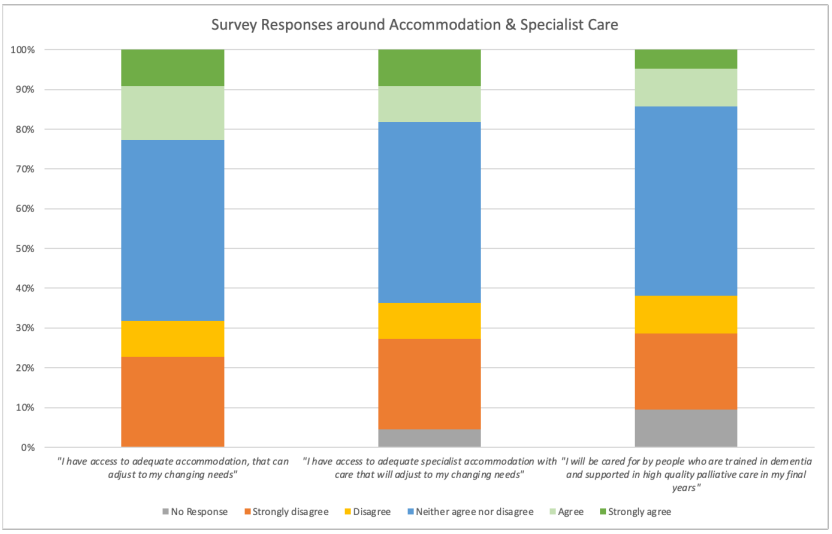
		 • Survey responses suggest a good understanding and awareness around dementia, with the caveat that those completing the survey may represent a more informed cohort
Theme 3	No appropriate sign posting	• Professionals and the public struggle to contact the right person, first time due to complexity and varying responsibilities • It is difficult to understand what people in each part of the pathway do and who's role it is and what services they provide in each organisation. • After people are seen in the memory clinic, where they get their diagnosis, they are not subsequently reviewed by the memory clinic, so there is no information on changed diagnosis status. PLWD may start medications from that point, if suitable, but are generally left without planned follow up and no signposting as to where to go next. • High turnover of social care and 3rd party staff - carers do not know who to contact to escalate issues to

Theme 4	Fragmented pathways	• Delays in being seen (and therefore diagnosed) in memory clinic leads to a 'limbo' period where people may deteriorate further without interim support • The documentation, monitoring, and evaluation of variances and outcomes, the coordination of the care process and sequencing the activities of multidisciplinary care is not currently happening in a cohesive and shared way causing pathway fragmentation • "No MDT approach that provides cohesive care to anybody throughout the pathways. There are varying degrees of efficiencies within the pathways but no one person is held accountable to signpost or complete the review of a handover." • "Due to fragmentation in the pathway one service is often seen to fire fight against the lack of resources in the areas of service provision in the current pathways." • There is an overuse of the Frailty nurse service to meet the needs of PLWD in the locality who should otherwise have been seen by DNs and this creates side stepping and scope creep • Memory clinic is an integral part of the pathway but often misinterpreted as a 'one stop shop' rather than a 'cog' in a wider machine
Theme 5	Lack of Crisis Support	• High social admissions due to lack of respite care or domiciliary carers. • No team available while waiting for the memory clinic or care while at home during challenging times. • PLWD require more support and input if they display challenging behaviour and family cannot manage the risk. • A need for dementia support workers to support in nursing homes during crisis times. • Ambulance service often the 'option of final resort' without advanced plans or access to joined up information
Theme 6	MDT approach	• Inconsistent MDT approach in primary care • Not common practice that an MDT approach is used to link up the management of people's care. • The MDT and Pathway must reflect roles and responsibilities and what each agency can and cannot provide for better integrated approaches. • MDT approach can align early conversations, people's preferences, and PLWD's wishes.

Theme 7	Day services	• Day services are seen as an integral part of tackling social isolation and loneliness when delivered effectively • Particularly positive experiences are had when carers and PLWD are engaged and catered for together e.g afternoon tea, singing groups • Separately, day services are seen as a valuable source of respite during the day for carers • Charitable groups such as HAVHAV and Ray Ceredigion operate highly valuable services that are well regarded in the local community • HAVHAV benefit from a dedicated dementia lead, a former nurse who actively identifies needs/wants from her community and works to arrange such activities • PLWD and their carers rely on self-transporting to an increasingly limited number of locations to access day services, some of which have not reopened post-covid and others are being refurbished which has led to large gaps • Ingenuity and novelty are needed to expand the activities for people using day services, particularly those that may interest men living with dementia (e.g woodwork classes) • Day services provide a community networking opportunity for carers to share problems and get support from others, this is even more effective when professionals are at these locations (eg Ray Ceredigion) • An important cohort of PLWD attend day services for carer respite and carers acknowledge that their loved ones are not necessarily interested in social interaction but there is no other source of respite during the week
Theme 8	Transport	• It is difficult for family members to transport PLWD in their own cars to hospital appointments or charity groups as family do not have the support in place to move and handle PLWD who are unable to mobilise independently. • Family members are not able to go in hospital transport with PLWD and they must travel separately. This is frustrating and can cause anxiety for PLWD to travel without their loved ones. • Hospital transport is not always reliable and after an appointment in an outpatient department the family must wait with the PLWD to be collected and this can cause frustrations and anxiety for the family due to delays.

		 • A county-wide consensus on transport challenges was reflected in survey responses with the overwhelming majority reporting difficulties with accessing public transport.
Theme 9	Patient recording systems	• EPR systems are different between social, primary and secondary care. • Inconsistencies in coding for PLWD in primary care, including informal carer status • There is no shared access between the hospital or community teams to understand the PLWD's journey. • When PLWD attend hospital, it is difficult for clinicians to understand the persons previous baseline when being examined. If there was joined up EPR systems, instead of handwritten notes that get misplaced, it may be easier to understand a person's past medical history and past deterioration levels upon being able to read consistent notes on EPR systems. • No access to E advanced care planning documents online.
Theme 10	Access and information sharing	• Other statutory organisations like the police and Fire and Rescue service would like to have a seat at the table when reviewing dementia services. • Providers such as care homes can feel excluded from decision making not being clinical or from local authority • Single point of access is consistent but 'faceless' – callers speak to a different agent each time with no continuity or named person • Consenting to share information amongst 3rd party organisations makes working collaboratively very

		difficult. While there are many organisations in Wales to support dementia service users the infrastructure to support them is not available. • There are good initiatives run by the council, but people are unaware how to access what is available to them. People are unaware that they could apply to receive carers allowances for their family and often do not know this entitlement exists. • Peripheral organisations like WAST lack access to highly useful information to support decision making
Theme 11	Funding	• Funding in respite care or socialisation budgets is rigid and offers no flexibility for carers. • Enormous complexity often deters those rightfully entitled to financial support without specialist guidance or help • Income support and attendance allowance is just as important as the statutory assessments for care and direct payments. Funding mechanisms by national government limits the collaborative efforts of 3rd sector involvement. • Commissioning and funding adversely impact the inter-agency working and the retention of staff on teams.
Theme 12	Misinformation around 3rd sector providers	• A lack of clarity between organisations as to what services they provide and how to access their services. • Information sharing across 3rd sector organisations is difficult and it is difficult for CCC to open the gates to sharing information as they are bound by data protection. • GPs do not refer on to charities or 3rd party providers routinely. • "The process of identifying the dementia service user's trajectory throughout the pathways needs to be known by all professionals. The significance of a person's identity gets lost in the pathway. Data protection issues means that vital information on vulnerable people in the community who are house bound cannot be shared with all community parties"
Theme 13	Silo Working	• Initiatives often run in silo and people are unaware of what groups are running and how PLWD can access groups and activities or training. • Admiral nurses are not linked up to the pathway and find the lack of joint working a barrier to providing service users with better interventions to cope.

		• Education and training opportunities missed out due to silo working. • Memory clinic acts as an isolated component of the pathway and faces criticism for failing to provide follow up despite not within agreed remit
Theme 14	Lack of nursing-based beds	• Shortage of nursing beds specialist enough to support those with complex dementia-related needs in the county requires some PLWD to be cared for out of region • Challenges in future care planning hampered by lack of local nursing beds • Lack of specialist beds result in PLWD remaining in current placements that struggle to fully meet needs or are correctly trained and equipped  • Survey responses suggest uncertainty around accommodation access and trained carers • Providers express concern at level of risk against training and limited escalation options
Theme 15	Communication	• Domiciliary care providers would like more transparent lines of communication with council staff and better signposting of who to contact and increased visibility of senior leaders. • Communication between departments is lacking. • CCC's web presence for Dementia information is poor • Public messaging around dementia, particularly around stigma is insufficient
Theme 16	Recruitment and staffing	• A recognised national issue of workforce recruitment and retention across health and social care with specific local challenges such as rurality, transport and Welsh language

		• It is difficult to recruit domiciliary care staff. "The care visits do not get paid for if the care is cancelled at the last minute and even though the agency has paid for the carer it's the care agency takes the hit financially." • High turnover of council staff affecting the continuity of care in the community. When people contact social services to get an assessment it is never the same social worker that reviews the person or you must wait a few weeks to be seen by a social worker. • "We just can't recruit staff, we are currently recruiting for OT but can't, so the senior OT that we currently have, well she was supposed to retire over a year ago and she is still with us." • The lack of onward capacity for care at home and domiciliary care staff results in a loss of flow for acute discharge lounges, hospital bed blockages and families awaiting care packages to start.
Theme 17	Skills mix and training and development	• Specialist teams may benefit from specific dementia training to provide their expertise in the context of dementia (e.g a PLWD being able to communicate pain to palliative nurses) • There is a huge need for a dementia link workers who would be a champion in the GP surgery to link the surgery to the community. "I just think that every GP practice needs someone who's has training around dementia awareness and is able to approach patients who are coming to the GP surgery with concerns." • Fire and Rescue Service provide a wide range of services to the public and professionals to improve safety, especially for PLWD, they lack the necessary channels to disseminate their services
Theme 18	Education	• Admiral nurses provide education around Mild Cognitive Impairment and are frustrated that GPs or social services do not send them referrals and feel they should be part of the pathways for PLWD. • Admiral nurses provide education to dementia service users and professionals for free and most people in the pathway are not aware of the MCI training. • Education and knowledge around pre-clinical diagnosis and the lack of education around dying with dignity. • Repeated, updated and timely refresher training in place throughout pathway design and training and awareness of this for all health and social care professionals.

		• There is a lack of knowledge of what good practice is currently when supporting PLWD and how to manage risks with this cohort. • More awareness of what is available for carers and family in terms of training. For example, there are free manual handling training courses run by the local authority for carers. • Specialist and specific training for PLWD is required to really understand the home environment and to support carers. • Non-clinical, frontline staff like receptionists at GP practices lack training to communicate effectively with PLWD and their families • A charity called TIDE - Together in dementia every day offer a training session dealing with managing difficult behaviours, but people are unaware of this. • Support for carers to be able to have cover and or transport in order to attend training
Theme 19	Respite care	• There is a lack of respite care and respite placement flexibility in the area, and this really impacts the quality of life for family and carers of PLWD. • Family of PLWD cannot book holidays or time off spontaneously if they have not got confirmation of agreed periods of respite. • Family of PLWD are unable to test out the environment before the PLWD go into the respite or slowly introduce the PLWD into the environment and this creates anxiety for the family while the PLWD is in the respite centre. They feel due to the lack of respite care availability, they have no control over how the PLWD is going to respond to the environment. • New environments can invoke anxiety in PLWD, phased or gradual introduction to new settings often very difficult to arrange.

Theme 20	Confidentiality	• 3rd party organisations face resistance in the past from getting access to service users due to confidentiality issues and shared learning agreements with the patient recording systems. • It is very difficult for a family member to ring the GP and tell them they are worried if the family member does not have power of attorney of their health, as ultimately the PLWD still has control of their care and the GP must talk to the PLWD and not the family • Conveying concerns must be met with a degree of confidentiality as it can affect a person's ability to drive, ability to live independently and manage their own finances and control their life and this can deter a family member who assumes their loved one has a mild cognitive impairment to intervene with services if it triggers a negative response

7. MAIN SERVICE GAPS

7.1 There is no one community model of care for PLWD. There are various pathways that operate but are not currently joined up to provide a patient centred approach to PLWD, who are at risk of unwarranted health outcomes. An anticipatory care approach would reduce health inequalities improve patient and family experience which would promote PLWD to live well and independently for longer.

7.2 There was mention of good examples of MDT working in end-of-life care but it is not consistent throughout the journey. There was agreement that no one could confirm that staff are working in an interdisciplinary way consistently. There is a need for a consistent approach to supporting PLWD after discharge from memory clinic to ensure crisis admissions are avoided.

7.3 A screening service in GP surgeries or primary care could capture people living in the community with pre-clinical diagnosis. This is currently not in place and the assessment protocols are not set up to understand and support the needs of PLWD before they end up with moderate dementia. An efficient screening service would help primary care develop a database of all PLWD in the community. It could be evolved to reduce the waiting times of being seen in the memory clinic with mild to moderate stages of dementia.

7.4 Currently there is only limited care planning and annual reviews of medications. Care plans and annual reviews present an opportunity for optimisation of care for PLWD. Care plans will require information input from multidisciplinary teams and help reduce the focus on medical tasks and increase the holistic care for PLWD. Care plans need to be accessible to all patients, families, the voluntary sector, primary care, secondary care, and emergency care providers which can in turn avoid hospital admissions, errors, or duplications in care.

7.5 There is no current focus on workforce development that includes specialists that link and work collaboratively across the system. There are no specialist dementia co-ordinated services within the council or primary care at present. When a PLWD receives a diagnosis of dementia from the memory clinic, the person is discharged back into the community without a specialist dementia support worker or clinician. A dementia specialist who can prescribe medications and provide continuity of care can link and collaborate with other services. This person would be aware of all the services in the charitable sector and be able to refer to community services, provide annual care plan reviews and be a point of contact for the carer or family.

7.6 Education and training for families and carers is scarce and with limited capacity. Those that have had an opportunity to receive training report high levels of satisfaction, such as experience on the Dementia Bus, but this is limited to a select

few. Further training and packages that address specific challenges and needs must be developed to better support those that informally care for PLWD.

7.7 Training for health and social care staff in dementia is disjointed. This gap has been partially filled by ad-hoc training for experts and enthusiastic specialists, but a cohesive and progressive training pathway remains elusive. Training is typically 'front-loaded' as part of new starter inductions but rarely revisited, updated or enhanced during a staff member's career. It is equally difficult for managers to identify suitable and impactful training as well as finding capacity to release staff to undertake professional development.

7.8 The current arrangements for storing and sharing information are not supporting staff to provide integrated holistic care. To improve communication between the council and primary care a specific email address could be used to ensure faster access to GPs or social care staff within the council. Improved electronic communication with a solution of a shared care record or email address. Through increasing touch points with health and social care staff can improve experiences for PLWD in accessing care and other available supports.

7.9 Families, carers and PLWD are not currently involved in dementia decision making. Caring situations are under increasing pressure and carers need to be able to access support to help them to continue caring. When carers struggle to care, families turn to health and social care services for help. PLWD with carers tend to access GP and acute services out of having nowhere else to turn to in crisis. There are opportunities through primary care to identify and support carers early, in part by effective use of carers registers, to help them navigate complex systems and prevent avoidable breakdown and prevent social care admissions.

7.10 Relationships with patient transport need to be developed to ensure patients are transported in a timely manner to appointments with their family members. Currently family must travel in a different vehicle and are unable to support the PLWD in the ambulance. This adds to anxiety and frustration when the PLWD enters the acute setting. In addition, there is no transport available to bring people to groups like Ray Ceredigion which omits people from attending and adds to social isolation.

7.11 Many PLWD and their carers highlighted the impact of the Covid Pandemic on their lives and the social isolation it caused. Restrictions continue to inhibit socialisation via strict visitor rules at care homes and limitations on day services for example.

The redeployment of staff and the suspension of services has also generated backlogs in many areas and swelled waiting lists, this is especially true for respite care.

7.12 The voluntary sector is still adapting to the effects of the pandemic and the impact on its workforce and the community. Many schemes had folded due to the impact

of social distancing measures and lockdown. Whilst it had in many ways strengthened, with stronger partnerships and recognition, and having recruited many new volunteers, they had also lost many long standing and older volunteers who had been clinically vulnerable. This has changed the profile of the workforce and whilst there was optimism and some untapped capacity the 3rd sector is still adapting since the pandemic.

7.13 In some services the lack of capacity was compounded by vacancy rates. There are high domiciliary care vacancy rates, where higher wages were available for less demanding roles within manufacturing, retail and logistics. In addition, low job security was another factor due to short term commissioning and the absence of defined career pathways in some areas.

7.14 Access to services is still an issue. For example, access to the memory clinic and older adult mental health services was raised as problematic for PLWD. The perception was that the criteria for the memory clinic or for involvement with mental health left a growing gap for PLWD to access respite or other services. There has been increased pressure on caring situations resulting in carer strain and breakdowns and this has also led to increased admissions to hospital.

7.15 There has been understandable concern about the prospective closure of the Hafan y Waun care home in Aberystwyth. This has capacity to care for 50 dementia residents. Ceredigion County Council recently announced plans to take ownership of the home and to compete this transaction by September 2023. This provides an opportunity for integrated health and social care to collaboratively explore approaches to meet the needs of the population.

7.16 Lack of specialist nursing beds or care homes that provide specialist care for PLWD. There are currently no dementia specialist units within Ceredigion that provide enhanced care. When PLWD get placed in a specialist unit, it is usually out of the county and family may have to travel long distances to see their loved ones.

8. CONCLUSIONS

The engagement conducted by Attain has confirmed the need for more structured and integrated services for PLWD across acute and community services with oversight for more specialist staff to support patients out of hospital and prevent avoidable admissions.

8.1. High Impact Actions

8.1.1 Dementia Wellbeing Connector

The West Wales region is currently in the process of finalising plans to introduce a Dementia Wellbeing Connector role. The vision for the Dementia Wellbeing Connectors service is that people living with dementia and their carers will have access to consistent, coordinated wrap-around support to enable efficient and effective navigation through health, social care, and third sector services, with support for their wellbeing throughout their journey to enable them to live as well as possible with dementia. This role will be a 'named' or 'designated' point of contact for a caseload of people living with dementia, from pre-diagnosis through to end of life, providing specialised and tailored dementia advice, information and support, as well as supporting the promotion of a personalised rights-based approach whilst navigating access to holistic care across primary, secondary and tertiary services within the health, social and third-sector community care system. These roles will support the person living with dementia, ensuring proactive lifestyle and care planning through a multi-agency and multidisciplinary approach to ensure support is centred on what matters to the PLWD and their families/carers at the right time.

Ensuring that this incoming service is shaped by the needs of PLWD in Ceredigion is essential and that given the regional scope of the service, that cultural, language and geographical specifics of Ceredigion are factored into local delivery.

8.1.2 A virtual service and dementia health advice line

Virtual health checks would enable professionals to monitor situations remotely, particularly as Ceredigion is a large and predominantly rural county. This would allow professionals to review PLWD in a timely way who have been recently discharged to help prevent readmissions.

Access to a dementia health advice line would also support PLWD and their families and care givers. This would give them easy access to health advice and may prevent emergency attendances at acute hospitals.

A virtual-supported dementia health advice line is a service based on a hospital at home model of care and provides a supported discharge service for dementia patients. This could also extend to being an advisory telephone/video call line for other older adult co-morbidity illnesses that are encountered in the community. Family and care givers benefit from this provision, whom otherwise may require acute inpatient care to seek the expertise required. The service is performed through both virtual technology and phone calls. The

virtual supported dementia hotline could support discharge options primarily for PLWD who are deemed suitable for discharge but require additional monitoring.

Successful delivery is achieved by increasing integration between acute and community services and enabling care closer to home through virtual methods. This service would have fast track access to the palliative teams. Benefits for PLWD include being able to recuperate in their own environment with both family support and that of the outreach support. As the clinical path for PLWD during crisis can be unpredictable with patients at risk of deteriorating, all team members would need to have expertise of dealing with such events and escalating care when needed.

8.1.3 Enhanced transport options

Patient transport for hospital appointments is a well-established provision by Welsh Ambulance Service, however gaps remain for access to other appointments and social activities.

Exploring options for additional transport, involving public, private and charitable organisations is essential to support local communities and ensure equitable health and social care access for PLWD. Particular attention should be made to those with dementia and/or learning disabilities that may require additional support or adaptation to make use of transport services.

8.1.4 Bespoke day services that act as community hubs

Renewed emphasis on the importance of day services, but the need to transform these vital services to better meet the needs of PLWD who use them. Acting as community hubs at the heart of local centres, they need to identify the local needs of PLWD, with particular attention to what men living with dementia might like from these services.

In addition, these services provide a hub for carers and PLWD to come together and socialise, seek advice and tackle problems, this is even more effective where there are experienced, knowledgeable people on hand to signpost and support.

In cases where day services are seen solely as respite for carers and there may be reluctance from PLWD to attend, novel approaches and alternative respite options must be explored.

8.1.5 Dementia-friendly services in everyday life

Capitalising on the success of Dementia Friendly Towns like Aberaeron, The Union of Welsh Independents adoption of a dementia-friendly churches initiative and a growing public conscience and understanding of dementia, Ceredigion County Council is well placed to act as a champion to support small, positive action across the wider community and in everyday life.

Those who wish to learn more or undertake change to support PLWD, be it the cornershop, teachers in local schools or a taxi firm, all should have readily available access to high

quality guidance and support to provide adaptations to better serve PLWD. This takes place alongside continued public awareness campaigning from leading organisations such as the Alzheimer's Society.

8.1.6 A joined up approach to learning and development

A joint regional approach to dementia learning and development for health and social care staff at all levels is a key aim of the All-Wales Dementia Care Pathway of Standards, and this work is being developed through a regional working group which includes Hywel Dda University Health Board and the three local authorities. A regional programme of training and support for local authority care homes, delivered through the health board's Dementia Community Wellbeing Team, is currently being trialled. In addition the health board are working on a 5-year dementia learning and development plan for all staff and the working group will be looking at how similar work can be done across the local authorities.

8.2. A new model of care consisting of the following:

Dedicated dementia community team and referral pathway - This team would relieve pressure on other services, avoiding preventable readmittance to hospital and enhance the care provided in the community.

Introduce an MDT approach across the dementia pathway - Provide a more integrated cohesive service that ensures care and monitoring is in place to reduce hospital admissions and prevent readmissions. Increase opportunities for mutual learning between acute and community professionals.

Specialist education clinician roles - Champion and promote best practice of dementia care across Ceredigion, driven by passionate dementia experts. Continue to grow this small pool of subject matter experts to increase their reach and influence, particularly within non-dementia specific services.
In communities, continue to promote wellbeing for PLWD and their carers by sharing knowledge, mitigating the feelings of carer vulnerability for PLWD, especially early in diagnosis and co-ordinate quality improvement and service transformation in an integrated fashion.

Integrated IT referral system – A range of IT and referral improvements would enhance operational performance issues and reduce cost. Improve shared care and transition arrangements across providers to reflect complexity and overlap in responsibilities.

Patient centred decision making - Enable PLWD to be discharged to a setting of their choice but appropriate to their need. The establishment of more formal links between care providers so that when a PLWD's condition becomes more complex

there will be clarity on how to access specialist skills as close to the community as possible. Improved linkages with the GPs, social services, and community providers.

Increase in dementia specialist care units in the area - The current lack of more specialist residential and nursing beds in the area means that PLWD with complex needs are sent out of area and family are required to travel long distances to see them. This is especially true for complex nursing needs, where there are currently no specialist dementia nursing care beds in the county. It would be advisable to increase dementia specialist beds in the current array of residential and nursing homes in the vicinity. For example, Hafen Deg care home are trialling a 4 bedded specialist dementia unit, and this is something that may be trialled in other homes with input from local experts in health and social care.

9. APPENDICES

APPENDIX 1 – List of Engagement Activity

Name	Job	Organisation
Taniya Jarrams	Corporate Manager for Triage and Assessment	CCC
Emily Daglilar	Representative	Castell Ventures
Helen James	District Nurse Service Manager	Hwyel Dda University Health Board
Meinir Harris	District Nurse	Hwyel Dda University Health Board
Hana Edwards	Police Officer	Dyfed Powys Police
Simon Wright	CEO	Age Cymru Dyfed
Caroline Davis	Business Development Lead	Age Cymru Dyfed
Natasha Fox	Chief Officer	Advocacy Wales
Lis Cooper	Direct Payments Officer	CCC
Peggy Spooner	Project Development Officer	Advocacy Wales
Jay Crouch	Dementia Lead	Mid and West Wales Fire and Rescue Service
Gwenda Jenkins	Dementia Lead	Mid and West Wales Fire and Rescue Service
Sally Bathurst	Representative	Mirus
Helen Buckley	Admiral Nurse	Hwyel Dda University Health Board
Michelle Hopewell	Representative	Primary Care
Rhianon Copeland	Representative	Primary Care
Marita Kehoe	Physican Associate Trainee	Primary Care
Llinos Trotman	Representative	Marie Curie
Rhian Evans	Representative	Marie Curie
Bethan Howell	OT	CCC
Tracy Evans	Housing Adaptations Team Leader	CCC

Ruth Wilson	Service Lead	Adferiad
Carys Steven	Care Team Leader	
Hayleigh Southall	Care Team Leader	Voyage
Penny Lamb	Senior Nurse Manager	Hwyel Dda University Health Board
Altun Evans	Representative	The Care Society
Non Davies	Corporate Manager for Culture	CCC
Kim Parry	Support Worker in Older Adult Mental Health	Hwyel Dda University Health Board
Sarah Pask	Frailty Nurse	Hwyel Dda University Health Board
Sion James	Deputy Medical Director	Primary Care
Jackie Roberts	Team Manager, SPoA	CCC
Emma Thomas	Care of Older Adults	Hwyel Dda University Health Board
Jina Hawkes	Service Manager for Primary Care	Hwyel Dda University Health Board
Kirsty Morgan	Regional Lead	Alzheimer's Society
George Riley	Commissioning Services Manager	CCC
Rebecca Johnson	Commissioning Services Officer	CCC
Charlotte Duhig	Admiral Nurse	Hwyel Dda University Health Board
Becca Stillwell	Clinical Psychologist	Hwyel Dda University Health Board
Sara Humphries	Carers Lead	CCC
Cathryn Morgan	Lead	Disability Forum/CAVO
Martin Gilliard	Housing Support Officer	Housing Support Group
Llyr Hughes	Housing Support Officer	Housing Support Group
Karen Thomas	Head of Dietetics	Hwyel Dda University Health Board
Karen Shearsmith-Farthing	Dementia Lead OT	Hwyel Dda University Health Board

Suzanna Crompton	OT Service Lead	Hwyel Dda University Health Board
Nikki Murray	Team Manager	Hwyel Dda University Health Board
Guto Davies	Ennli Ward Manager	Hwyel Dda University Health Board
Cheryl Groom	Continence Nurse Specialist	Hwyel Dda University Health Board
Lydia Haward	CMHT Team Leader	Hwyel Dda University Health Board
Mair Davies	Lead Community Pharmacist	Hwyel Dda University Health Board
Neil Mason	Head of Frailty/Older Adults	Hwyel Dda University Health Board
Gemma Emille	Memory Clinic Operations Manager	Hwyel Dda University Health Board
Steven Magee	Regional Manager, Unplanned Care	Welsh Ambulance Service
Donna Robson	Head Pharmacist, Bronglais Hospital	Hwyel Dda University Health Board
Monica Bason-Flaquer	Programme and Change Manager	West Wales Regional Partnership Board

Provider groups online:
Primary care group
Hospital Allied health professional group
Private Residential Care Home providers
Council Residential Care Home providers
Domiciliary care providers
Private Residential Care Home providers / part 2
Carers Alliance provider session

Care home and groups visited:
Barcud housing association
Ray Ceredigion Charity
HAHAV bereavement association
Hafan Y Waun care home
Hafan Deg care home

Drop-in sessions:

Mid Ceredigion

13.03.23 11.00-14.00 Aberaeron -Feathers Royal Hotel
13.03.23 16.00-19.00 Llandysul - Porth Hotel
16.03.23 11.00-14.00 Tregaron - Memory Hall
16.03.23 16.00-19.00 Lampeter - Victoria Hall

North Ceredigion

14.03.23 14.00-19.00 Aberystwyth -Morlans centre

South Ceredigion

17.03.23 14.00-17.00 Cardigan- Guildhall

Appendix 2 – Press Releases and Social Media Plan

Date of Activity / Deadline	Action	Led by	Completed
February 13th 2023	Press Release (PR) Press- Ceredigion Action Plan – Engagement announcement.	LLJ	PR issued on 10.02.2023 Cambrian news 22.02.2023 Tivyside 20.02.2023
Feburary 13th 2023	Create friendly URL to use in PR, website and social media bit.ly/CCCDementiaSurvey bit.ly/CCCDementiaSurvey	LLJ	English link: 102 link clicks Welsh link: 53 link clicks
13th February 2023	Community Council – email with links (Press Release)	LLJ	10.02.2023 (same time as PR publication)
13th February 2023	Elected Members – email with links (Press Release)	LLJ	10.02.2023 (same time as PR publication)
February 2023	Carers Notifications: - Email, facebook, post, newsletter, website–inviting to online survey:- Unpaid Carers (Young & Adult) Carers and community support team (SH) Ceredigion Unpaid Carers Commissioned Service Carers Alliance Ceredigion Connectors Invite carers from dementia bus.	SH	
February	Communication with Staff :- (14/2/2023 Team news 1 liner – not seen by CM's) – ANR Team Ceredigion Teams – NL Posted Announcement).	HH/ ANR	
February	Communication with Residential Settings Staff (On line focus group)	Attain	Planned 28.02.2023
February 15th	Ceredigion Website	LLJ	10.02.2023 News webpage
February 15th 2023	Social media post on engagement	LLJ	15 February 22 March

	Facebook, Twitter, Instagram		29 March
February 17th 2023	Carers – align communication with Respite & Day Services.	SH	
TBC	Press - Regional Communication relating to Dementia Strategy	LLJ	Strategy circulated via LA's on 10.05.2023, CCC Councillor quote provided to strategy.
February 21st 2023	Create posters for engagement events to use on social media and in person at venues.	LLJ	Created and shared with team 22.02.2023, Shared on social media the following dates.
February 27th	Social media post re engagement events Facebook, Twitter, Instagram	LLJ	28 February 8 March 14 March – Instagram boost. Stats below.
February 28th 2023	Social media post – send to stakeholders to share on their social media Pages.	LLJ/ JFJ / NL / SH	Hywel Dda shared on their socials 01.03.2023 & 15.03.2023

Appendix 3 – Communications Statistics

Cyfathrebu ymgysylltu â dementia
Dementia engagement communications

10 Chwefror – 29 Mawrth / 10 February – 29 March

- **Datganiad i'r wasg / Press release**
- **Bitly**
- **Dadansoddeg Google / Google analytics**
- **Cyfryngau cymdeithasol / Social media**

1. Datganiad i'r wasg / Press release

Cyhoeddwyd ar 10 Chwefror 2023 / Issued on 10 February 2023.

Cyfryngau / papur Media / press / outlet	Dyddiad / Date
Cambrian News (papur /paper)	22 Chwefror / February 2023
Tivyside (ar-lein/ online)	20 Chwefror / February 2023
Gweithredu dros Iechyd Meddwl Gorllewin Cymru (WWAMH) / West Wales Action for Mental Health (ar-lein / online)	21 Chwefror / February 2023

2. Bitly

Cynllun Gweithredu Dementia Ceredigion - - Cyngor Sir Ceredigion

February 13, 2023 12:46 PM GMT by llinosjones

53 Total engagements

Ceredigion Dementia Action Plan - - Ceredigion County Council

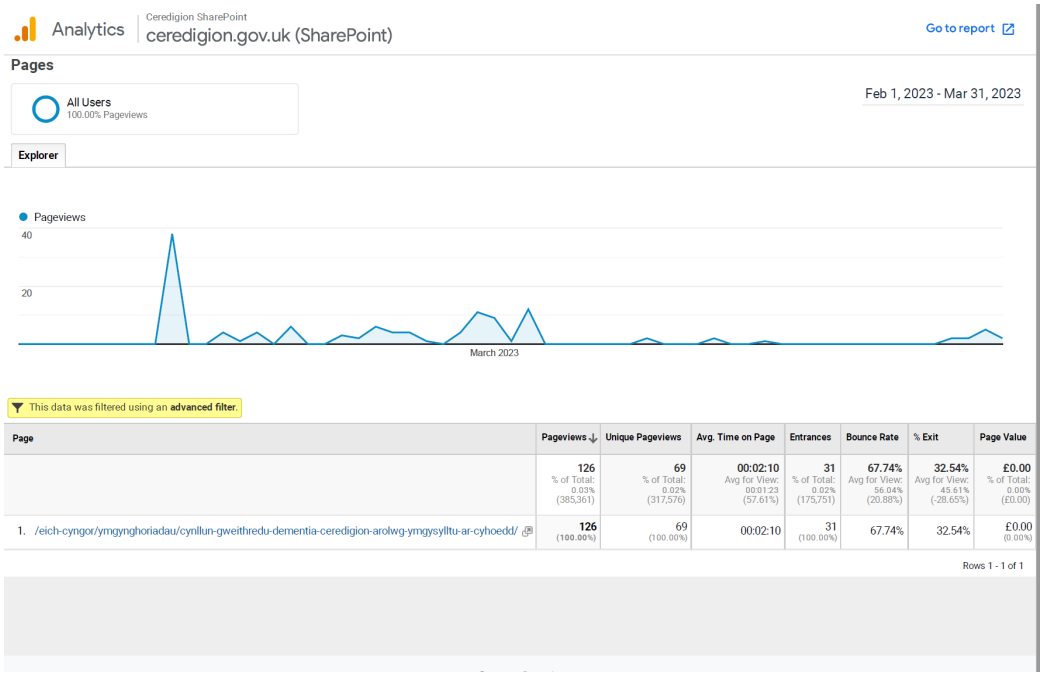
Edit ...

February 13, 2023 12:54 PM GMT by llinosjones

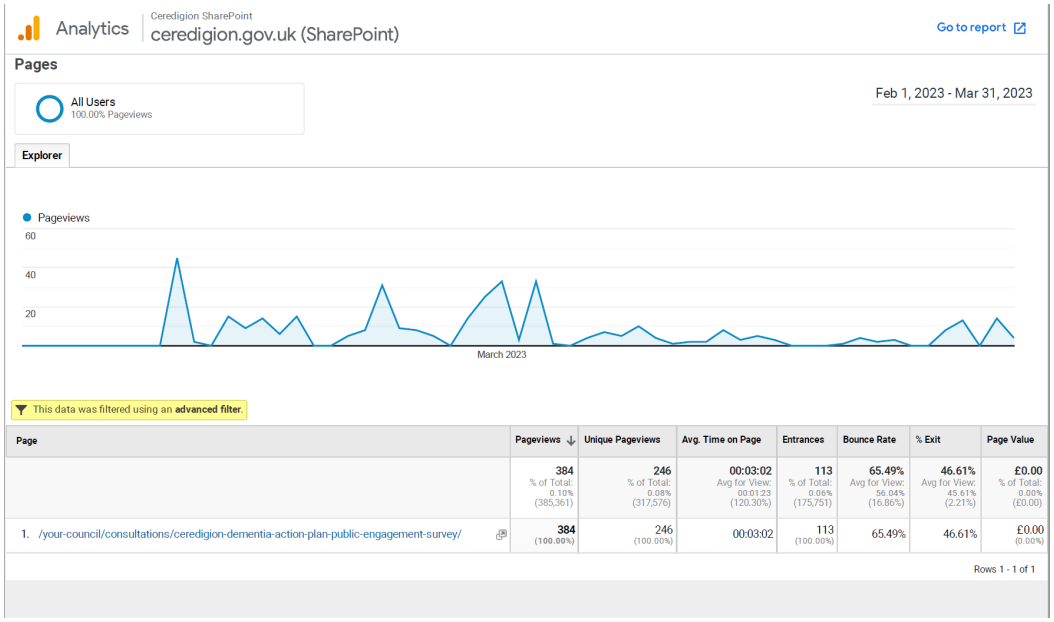
102 Total engagements

3. Dadansoddeg Google/ Google analytics

Cymraeg, 126 (nifer sydd wedi edrych ar y dudalen)
www.ceredigion.gov.uk/eich-cyngor/ymgynghoriadau/cynllun-gweithredu-dementia-ceredigion-arolwg-ymgysylltu-ar-cyhoedd/



English, 384 page views (nifer sydd wedi edrych ar y dudalen)
www.ceredigion.gov.uk/your-council/consultations/ceredigion-dementia-action-plan-public-engagement-survey/

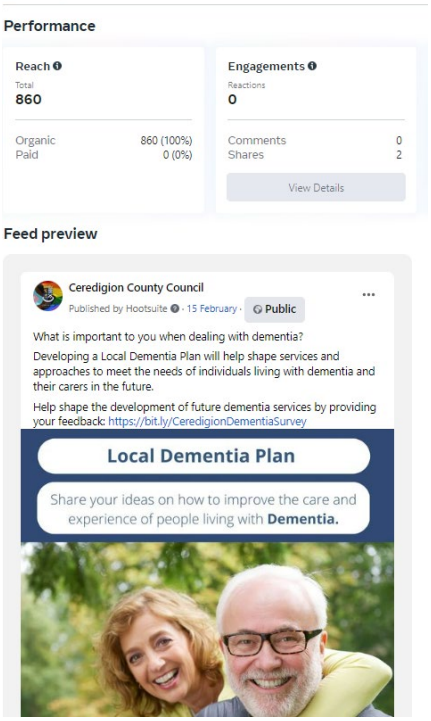


4 Cyfryngau cymdeithasol / Social media

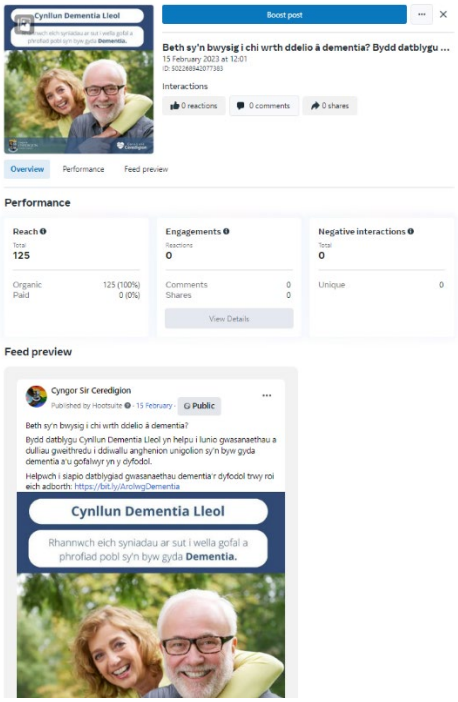
(Yn cynnwys ffigurau ymgysylltu, cyrhaeddiad, rhannu, hoffwyr a sylwadau.
Includes engagement figures, reach, shares, likes and comments)

Facebook, English & Cymraeg

15 February

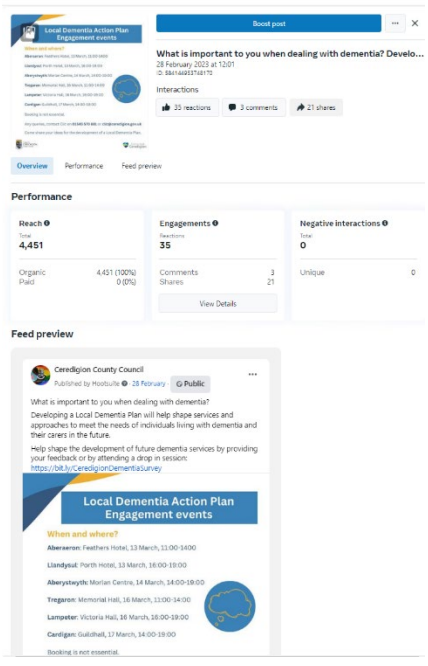


15 Chwefror

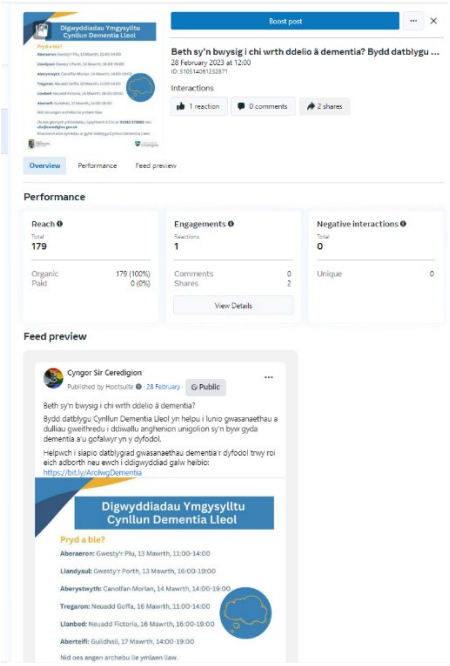


28 February

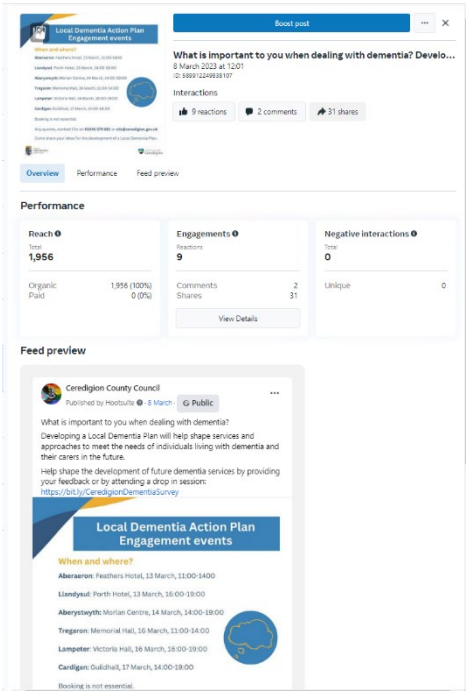
28 Chwefror

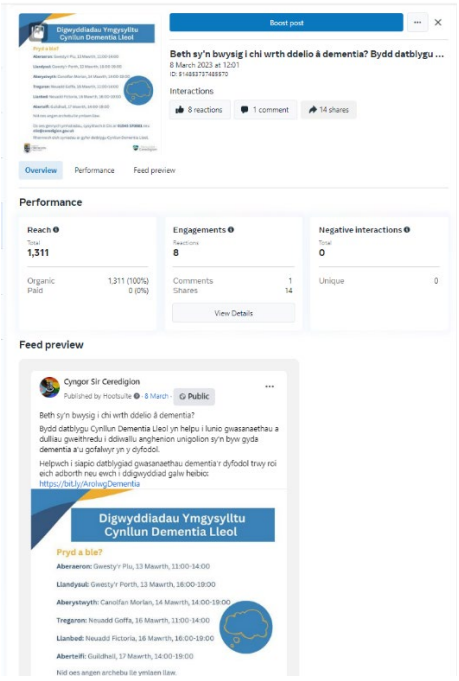


8 March

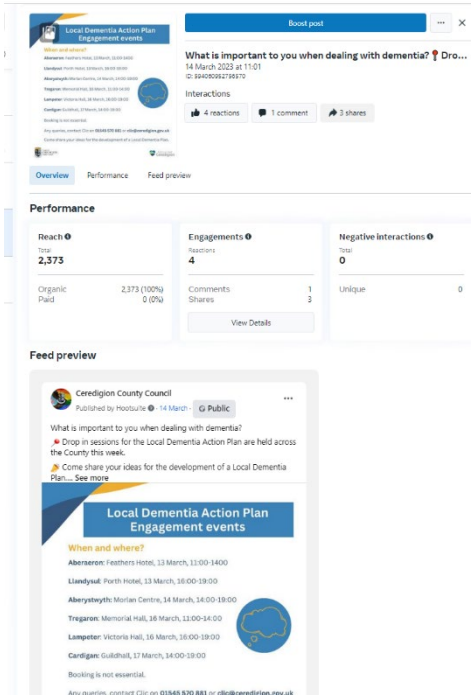


8 Mawrth

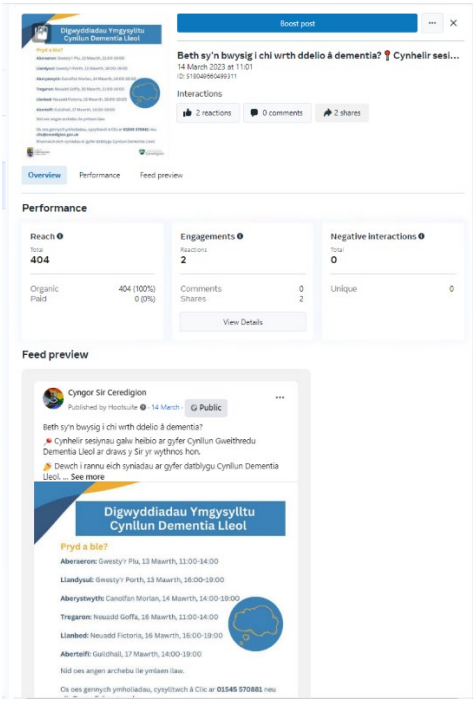




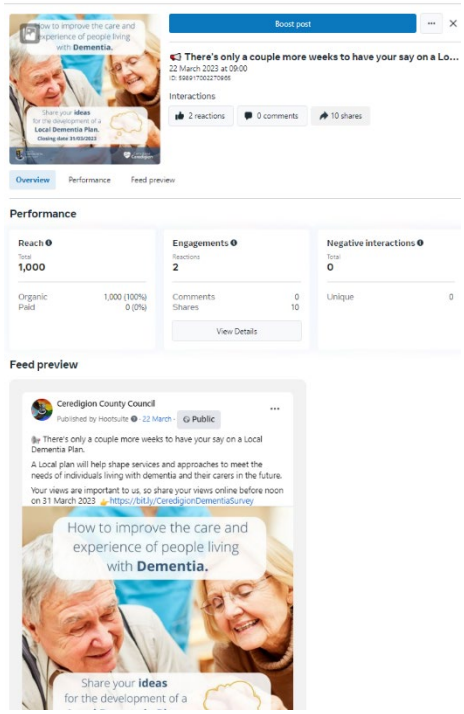
14 March



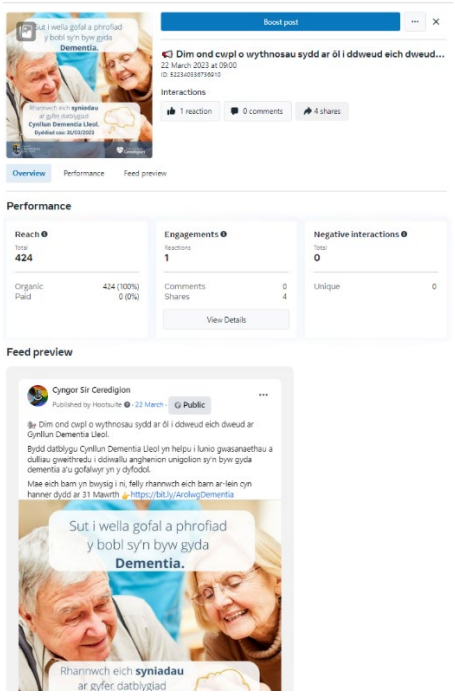
14 Mawrth



22 March

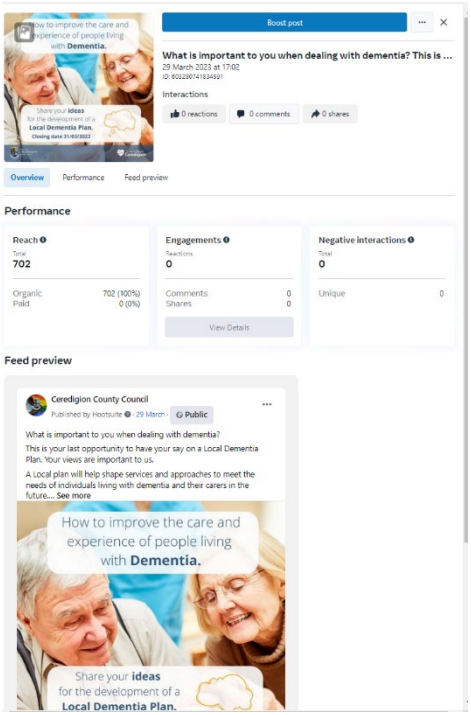


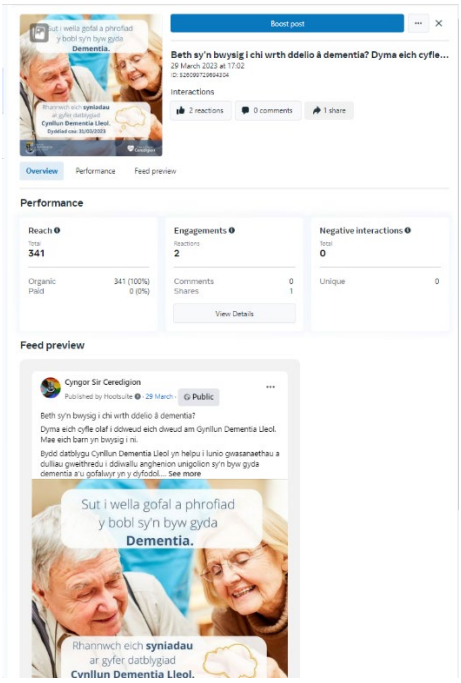
22 Mawrth



29 March

29 March





Twitter, English &Cymraeg

(Gan gynnwys argraffiadau, retweets, hoffwyr, cliciau i'r wefan / Includes impressions, retweets, likes, link clicks)

15 Chwefror - 80 impression
15 February – 318 impression, 1 retweet
28 Chwefror – 88 impression, 1 retweet, 1 like, 1 link click
28 February – 701 impression, 4 retweet, 3 likes, 1 link click
8 Mawrth – 200 impression, 1 retweet, 1 like
8 March – 408 impression, 2 retweet, 1 like, 1 link click
14 Mawrth – 103 impression, 2 retweet, 1 like
14 March – 653 impression, 4 retweet, 2 like, 1 link click
22 Mawrth – 286 impression, 2 retweet, 2 likes, 1 link click
22 March – 520 impression, 5 retweet, 3 like, 2 link click
29 Mawrth – 105 impression
29 March – 880 impression, 2 retweet, 3 like

Instagram

(Gan gynnwys ymweliadau, hoffwyr a sylwadau / Includes reach, likes and comments)

15 Chwefror / February – 122 reach

28 Chwefror / February – 142 reach, 2 likes
8 Mawrth / March – 95 reach, 2 likes
14 Mawrth / March – 2,908 reach, 3 likes
22 Mawrth / March – 154 reach, 2 likes
29 Mawrth / March – 168 likes, 1 comment

Ceredigion County Council – Dementia Engagement and Service Implementation Plan Project

Phase 2 Service Implementation Plan

May 2023

Cyngor Sir CEREDIGION County Council

Attain
Improving health and wellbeing

Document control

Owner	Ceredigion County Council
Document Title	Phase 2 Service Implementation Plan (Dementia Engagement and Service Implementation Plan Project)
Version	0.2 - Draft
Reference	1001073
Author	Joseph Middleton
Date	04/05/2023

Document history

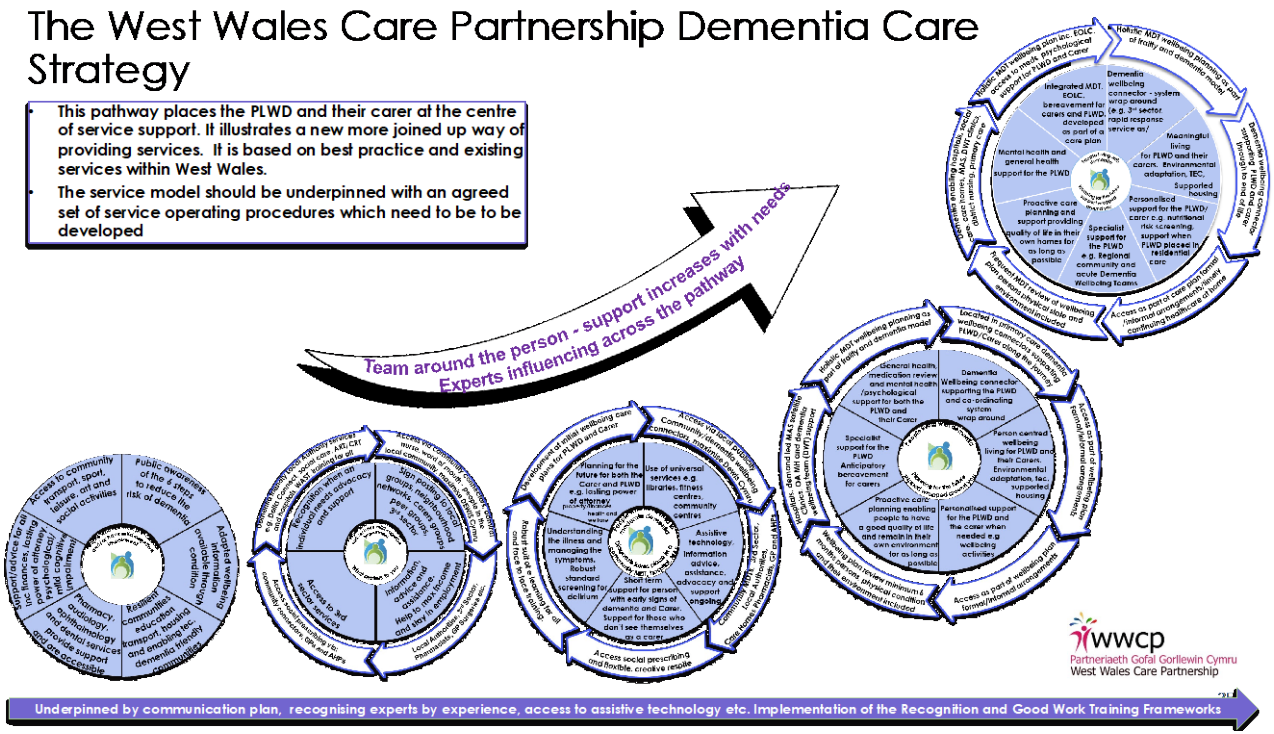
Version	Date	Author	Comments
0.1	04/05/23	Joseph Middleton	Initial Document Structure
0.2	30/05/23	Joseph Middleton	NL/JM Joint Review
0.3	02/06/23	Joseph Middleton	NL/EH Comments (Performance and Data Monitoring)
0.4	08/06/23	Joseph Middleton	Business Solutions and Early Intervention Comments
0.5	08/06/23	Martin Wilson	Review and edits
0.6	13/06/23	Joseph Middleton	NL/WC Comments
0.7	20/06/23	Joseph Middleton	Additional edits, introduction amends.
0.8	11/07/23	Joseph Middleton	Hafan y Waun Addition

Introduction

Following the analysis of extensive engagement across Ceredigion, delivered as the Phase 1 Report, the next step is to formulate an action plan to transform and improve dementia care in the county.

The foundation for this plan is the West Wales Regional Partnership Board Dementia Strategy, an evidence-based model of care that firmly places the individual at the centre. Our action plan has been structured around the core 'wheels' of the strategy where the right people are present to enact the actions in this document; that is not to say actions are exclusive to certain parts of the pathway, but where we believe the action will have the greatest impact.

In addition, we've included some overarching domains where everyone has a part to play in delivering these actions, and the benefits will be felt across the system, for people living with dementia, their unpaid carers, professionals, and the wider Ceredigion community.



How will the plan be delivered?

The plan will be executed with an integrated approach, together with or alongside other teams that reach far across both Ceredigion County Council but also health, the third sector and charitable groups. Similarly, some of these actions extend beyond the boundaries of the county and so collaborating with regional partners will be equally essential to avoid working in silo.

The actions specifically consider the existing landscape of services that care for people living with dementia (PLWD), where possible, actions should capitalise on existing resources and programmes and utilise connections to groups in the community that may be difficult to otherwise engage.

Leaders and Timelines

During engagement, we were able to identify key people that are well placed to drive actions forwards, trying to place the best people, closest to the issues as a suggested sponsor or action lead. In addition, where timeframes are concerned, these do not necessarily imply a

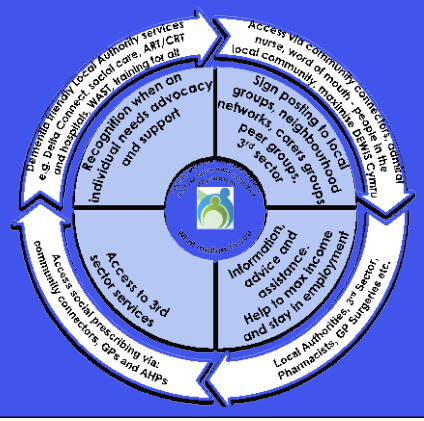
completion date, but an indication of the complexity and urgency with which each action should be addressed.

Pathway Point 1: **Wellbeing, risk reduction, delaying onset, raising awareness, and understanding.**

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
1.1 Incorporate and promote the Alzheimer's Society's Dementia Advice Line as part of ageing well offer	1, 2, 3, 4, 10, 12	General Public Primary Care	People are aware of an existing, trusted source of information, regardless of diagnosis to seek help and guidance for themselves or relatives. Relieves pressure from primary care.	Alzheimer's Society & CCC: Community Connectors	2 months
1.2 Build on the dementia-friendly towns initiative to offer support to any business or organisation wishing to better serve PLWD, aligned with Age Friendly Communities initiative.	2, 6, 13, 18	General Public Local businesses PLWD	Local shops, leisure centres, the Post Office and churches etc are knowledgeable and empowered to make changes to better welcome and support PLWD in their daily business.	CCC: Growth and Enterprise and Economic Community Development	6 months
1.3 Identify opportunities to work with organisations and groups that already have reach into under-represented groups (e.g agricultural workers, homeless, faith groups)	2, 3, 6, 10, 13, 15, 17	Under-represented groups possibly living with dementia	Existing, trusted relationships are leveraged with communities who may not as easily or regularly access dementia services. Tailored support for these vulnerable people is accessible, non-prejudiced and tackles pockets of entrenched stigma.	CCC: Through Age Wellbeing Team & Substance Misuse Team RABI, NFU	4 months

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
1.4 As part of the wider website development, improve CCC's content for dementia online to better meet the public's needs.	10, 11, 12, 15	General public PLWD Unpaid Carers	A dementia-friendly website with up to date and easy to understand information for residents of Ceredigion wishing to learn more about dementia, access services and navigate care, that includes support for those delivering unpaid care, relatives and those wishing to promote age friendly communities.	CCC: Communic-ations Programme Team	6-12 months
1.5 Continue to update and refine the DEWIS directory as a common source of available services	10, 11, 12, 15	General Public Community Connectors	A database of services, specific to Ceredigion, is available and updated regularly for professionals and the public to access to seek out services.	CCC: Community Connectors	3 months
1.6 Deepen joint working with Public Health Wales on preventative initiatives around dementia	13, 15, 17	General Public	Expertise and knowledge at national level from PHW is capitalised on for local action in preventing ill health (including dementia).	CCC: Through Age Wellbeing Team	2 months
1.7 Embed promotion and awareness of the Carer Information Service and Investors in Care Pathway at all possible touchpoints of health and social care.	3, 18, 15	Unpaid Carers	The CIS acts as a source of support and information for unpaid carers at the earliest stage possible and they are helped along the journey at each step; also encouraging registration as an unpaid carer unlocks support, assessment and registration. Unpaid carers are captured in Primary Care at every opportunity.	CCC: Carers and Community Support Manager HDdUHB / Primary Care: Dementia Leads	2 months
1.8 Ensure regular cognitive wellbeing checks are offered consistently and equitably to people with learning disabilities across the county.	17, 18	People with learning disabilities	People at greater risk of dementia are supported with the offer of regular follow up and early identification of symptoms that could indicate dementia.	HDdUHB / Primary Care: Dementia Leads	4 months

Pathway Point 2: **Recognition, identification, support and training.**



Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
2.1 Re-emphasise the importance of MDT working as the standard approach to managing dementia caseloads at every pathway point.	6	PLWD Whole system professionals	PLWD receive the full spectrum of professional input into their support and care as standard. Closer working relationships are established between health and social care specialists.	CCC and HDdUHB: Senior Leadership	2 months
2.2 Make End of Life care planning an open, proactive, and compassionate discussion at the start of the pathway.	5, 6, 14	PLWD Health and social care providers	PLWD and their carers feel confident and comfortable to discuss advanced care planning for EOL and understand the options open to them. PLWD and carers are given regular opportunities to make updates and amendments to plans, as desired.	CCC: Advanced Care Planning Team HDdUHB: Palliative Care	2 months
2.3 Identify a mechanism to allow partners to meet (preferably physically) in a forum to share best practice, tackle issues and give updates.	6, 9, 10, 12, 17	3rd Sector organisations Peripheral partners	Everyone working to support PLWD feel included and heard with a valued seat at the table. Duplication is reduced as a result of better communication across sectors and relationships are built between partners.	CCC: Through Age Wellbeing Team	6 months
2.4 Where possible, allocate named support staff to	4, 6, 10	PLWD Unpaid Carers	Single point of access remains consistent but provides a named contact, where appropriate,	CCC: Porth Gofal	6 months

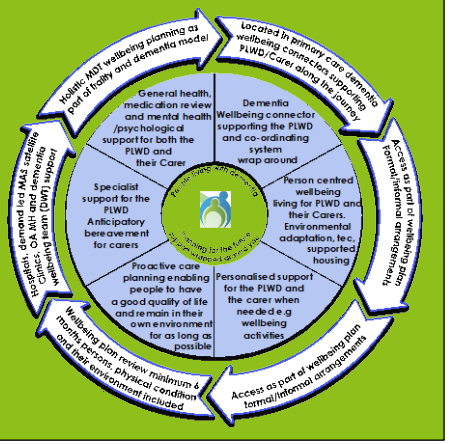
Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
cases.		& Relatives	to avoid repetition and frustration.	SPA Team	
2.5 Work with WWRPB in the progression of the framework for skills and development for dementia care.	16, 17, 18	Carer Workers	Training provision is collated across the county and region to provide a unified programme of learning and development, both formal and informal for those in the care profession.	WWRPB: Dementia Lead	4 months
2.6 Enhance the education offer for members of the public to better their knowledge and understanding of dementia.	18	Unpaid Carers General Public	An engaging and broad variety of education and training is available for lay persons that supports their understanding and care for PWLD.	WWRPB: Dementia Lead Alzheimer's Society Regional Lead	6-12 months
2.7 Continue to circulate and promote the West Wales Dementia Strategy as a pathway that drives person-centred care.	4, 17, 18	Health and care professionals Unpaid carers	A wider understanding of the collective aims of the strategy generates cohesion and a shared purpose amongst teams and also helps direct specific resources where required.	WWRPB: Dementia Lead CCC: Through Age Wellbeing Team	6 months

Pathway Point 3: **Assessment and diagnosis.**

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
3.1 Ensure the needs of local people are incorporated in the provision of WWRPB Dementia Wellbeing Connectors.	1, 4, 3, 10, 13, 15	PLWD	In an uncertain and anxiety-provoking time, people will have access to high-quality information and support with a named connector. CCC holds WWRPB to account in the success of this programme in Ceredigion.	WWRPB: Dementia Lead CCC: Through Age Wellbeing Team	3-4 Months
3.2 Explore future models to empower more GPs to diagnose and initiate therapies for dementia in primary care.	17, 18	PLWD Primary Care Memory Clinic	PLWD wait a shorter amount of time to receive a diagnosis and start treatments. Memory clinic compliments primary care diagnosis and owns complex cases as a more specialist service.	HDdUHB: Memory Assessment Service Senior Leadership	12-24 months
3.3 Maximise uptake of the Alzheimer's Society pathfinding service offered as part of MAS pathway ahead of redesign into wellbeing connectors.	1, 3	PLWD undergoing diagnosis	The commissioned service as part of a memory assessment is utilised by a far greater number of people to benefit from their care navigation and support ahead of the service's incorporation into wellbeing connector programme (see 3.1).	HDdUHB: All MAS Staff MDT staff referring to MAS	2 months
3.4 Recalibrate people's	4, 12	PLWD	Memory assessment is seen as a component	HDdUHB /	2 months

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
understanding of Memory Assessment as a diagnostic part of the pathway		Primary Care MAS	part of a wider pathway for dementia care instead of a 'one stop shop' for health and social care issues.	Primary Care: Dementia Leads	
3.5 Enhance the screening and early identification of possible dementia in primary care.	1, 2, 15	People with Pre-clinical dementia	Better capture rates of those with early signs of dementia and screening for memory impairment is part of routine practice, particularly for care of the elderly.	HDdUHB: Dementia Leads	4 months
3.6 Investigate how existing peripheral services such as Community Connectors and Carers service will integrate, interface and compliment the new Dementia Connector role.	1, 4, 3, 10, 13, 15	PLWD Unpaid Carers General Public	Existing services have well defined roles supporting PLWD. They will use their strengths as a compliment rather than overlap for new roles like the Dementia Connector.	CCC: Through Age Wellbeing And Commuinity Connector Lead WWRPB: Dementia Lead	6 months

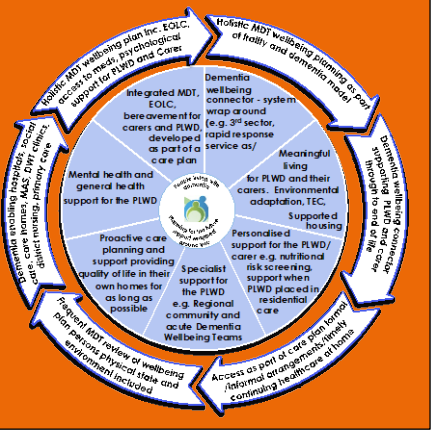
Pathway Point 4: **Living well with dementia**



Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
4.1 Ensure Dementia is part of the explorative work for virtual solutions for health and care professionals to monitor remotely to enable PLWD to maintain independence and to support their carers.	5, 9, 13, 14, 19	PLWD living independently or with little support	An understanding of the current landscape of virtual and digital solutions for care of PLWD and their carers both locally and internationally with a view to what could benefit those in Ceredigion. Technology innovation in this field is supported by the CCC TEC team.	CCC: Technology Enabled Care Team	6 months
4.2 Create tailored opportunities for those that would like to take part in activities.	7	PLWD	PLWD seeking opportunities for entertainment and socialisation have a range of activities on offer that are tailored to their interests, particularly those that appeal to men LWD and that integrate PLWD into existing societal activity, particularly seizing opportunities for intergenerational experiences and those with or without carers, as appropriate.	CCC: PSL Team	6 months
4.3 Ensure medication reviews are undertaken in timely fashion and proactively.	6, 10	PLWD	PLWD have their medications reviewed without requiring a catalyst event to prompt change. Polypharmacy and overprescribing are reduced.	HDdUHB / Primary Care: Dementia Leads	4-6 months

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
				& MAS Clinical Leads	
4.4 Establish the role of Dementia Link Worker as part of the WWRPB programme.	1, 2, 3, 4	PLWD Unpaid Carers	PLWD have a trained professional as their named first point of contact relating to issues with dementia who can provide knowledgeable and local information and support.	WWRPB: Dementia Lead	6 months
4.5 Address issues with access and capacity for respite care, possibly at a regional level.	19	PLWD Unpaid Carers	Respite care is accessible and abundant across the county that supports unpaid carers in their care of PLWD, particularly those with complex or additional needs requiring specialist skills and environments.	CCC: Porth Gofal WWRPB at regional level	12 months

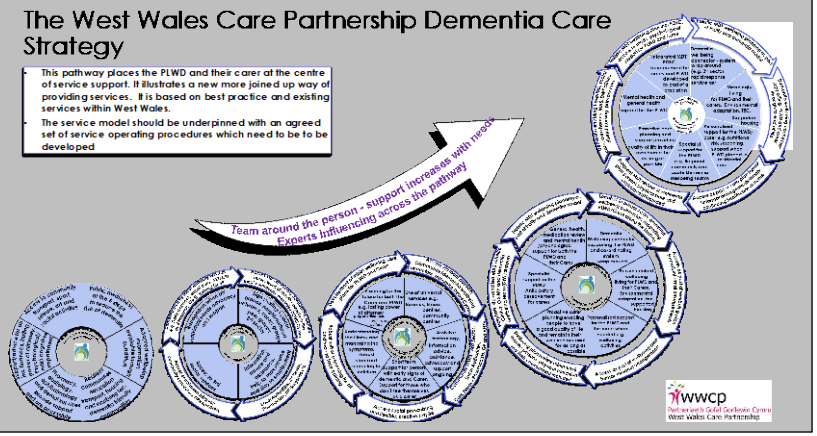
Pathway Point 5: **Increased support when you need it**



Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
5.1 Develop enhanced training packages and roles for care workers to build a specialised care workforce that meet complex needs	16, 17, 18	PLWD in care Care workers	PLWD with complex needs are cared for by staff with additional training, knowledge and experience and can champion the wellbeing of PLWD in care. Increased recruitment, retention and job satisfaction for care workers who feel well equipped to meet complex dementia needs. *NB Building on success of Dementia Bus training*	CCC: Through Age Wellbeing Team WWRPB Dementia Lead	12 months
5.2 Establish a working group to identify the key issues surrounding lack of specialist care and nursing beds within the county.	14, 16, 17, 19	PLWD with complex needs in care	PLWD can remain in their locality despite additional care needs. Relatives can more easily visit loved ones. Complex needs are met by staff with enhanced training and expertise. Explore opportunities that Hafan y Waun presents.	CCC: Through Age Wellbeing	6 months
5.3 Formulate a common 'escalation plan' for care staff to work through to get help with issues more effectively	10, 13, 20	Complainants Care staff	A unified structure to escalate concerns by frontline care staff supports both people wishing to raise concerns but also empowers care staff to share problems and know they will be dealt with by the right people.	CCC: Corporate Manager, Residential Care	4 months

Action Point	Phase 1 Theme #	Key Beneficiaries	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
5.4 Investigate options for an 'in-reach' team to provide enhanced care and support, particularly in twilight hours to prevent admission and crisis	5	PLWD in health or social crisis	A responsive, round the clock team of specialists able to support existing care arrangements, including for unpaid carers in times of challenge to prevent hospital admission or care breakdown.	CCC: Through Age Wellbeing Team and input from MDT/HDdUHB Team	12 months
5.5 Develop a phased communication and transition programme when entering domiciliary care services.	14, 15, 17	PLWD	Devised with alignment to best practice, PLWD are gradually introduced to new living arrangements in a manageable and gradual fashion and relatives are supported with difficult conversations about transition to increased support.	CCC: Corporate Manager, Care Providers HDdUHB: Discharge Team	3 months

Cross Cutting Themes



Action Point	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
Shared Care Records Work towards further integration and record sharing and reduce the divide between health and social care information access. This must include care plans, ideally with an even wider scope of access for supporting providers.	Partners have the full picture of support and care around PLWD. PLWD don't have to repeat themselves and information flows easily between hospital, community, social care and health.	CCC & HDdUHB Data Governance & EPR Teams	12-24 months
Workforce Ensure the WWRPB regional strategy for workforce addresses pinch points in Ceredigion and reflects unique challenges to the county.	Collective action from the wider region enables a cohesive strategy to address workforce gaps across health and social care, specifically relating to dementia care. Ceredigion is viewed as an attractive place to undertake a career in caring for PLWD.	WWRPB: Dementia Lead	6-12 months
Covid Recovery Continue, at pace, the recovery of all services and relax restrictions for all services.	Reduced isolation and unfettered access to the full range of care and health services for PLWD.	All partners	2 months
Transport Establish a working group to tackle transport issues affecting equity of access to health and social care, risk of isolation and adaptation for people living with dementia in Ceredigion.	Groups and areas most at risk of transport 'blackspots' are supported and mitigated through a multi-disciplinary team that works with public, private and charitable organisations to increase transport provision with additional reference to solutions that are particularly suitable for PLWD.	CCC: Through Age Wellbeing & Transport Dept. WAST Country Cars	6 months

Action Point	Impact	Lead Partner & Possible Sponsors	Estimated Timeframe
Data and Performance Measuring Across health and social care, formulate a suite of metrics to measure performance and quality across the county and align at regional level with WWRPB to benchmark against regional measures.	Ceredigion has quantitative, objective measures of performance for delivering excellent dementia care. Key performance indicators will allow teams to direct focus into areas that need attention.	CCC: Through Age Wellbeing with support from Performance Team and HDdUHB and WWRPB	4 months

Cyngor Sir Ceredigion County Council - Integrated Impact Assessment (IIA)

An integrated tool to inform effective decision making

This **Integrated Impact Assessment tool** incorporates the principles of the Well-being of Future Generations (Wales) Act 2015 and the Sustainable Development Principles, the Equality Act 2010 and the Welsh Language Measure 2011 (Welsh Language Standards requirements) and Risk Management in order to inform effective decision making and ensuring compliance with respective legislation.

1. PROPOSAL DETAILS: (Policy/Change Objective/Budget saving)	
Proposal Title	**Endorsement of the Ceredigion Dementia Development Plan**

Service Area	**Direct Services**	Corporate Lead Officer	**Donna Pritchard**	Strategic Director	**James Starbuck**

Name of Officer completing the IIA	**Nerys Lewis**	E-mail	**Nerys.lewis2@ceredigion.gov.uk**	Phone no	**01545 574293**

Please give a brief description of the purpose of the proposal
Following the development and approval of the West Wales Region Dementia Strategy it was agreed that a local development plan would be required to ensure that the strategy vision and aims can be delivered within the County. The development plan has been created following engagement and consultation with key partners and stakeholders in Ceredigion including people living with dementia and their families and carers. It is proposed that Cabinet endorse the Ceredigion Development Implementation Plan, so that the Plan can be delivered.
Who will be directly affected by this proposal? (e.g. The general public, specific sections of the public such as youth groups, carers, road users, people using country parks, people on benefits, staff members or those who fall under the protected characteristics groups as defined by the Equality Act and for whom the authority must have due regard).
People living with dementia Carers of people living with dementia

VERSION CONTROL: The IIA should be used at the earliest stages of decision making, and then honed and refined throughout the decision making process. It is important to keep a record of this process so that we can demonstrate how we have considered and built in sustainable development, Welsh language and equality considerations wherever possible.

Author	Decision making stage	Version number	Date considered	Brief description of any amendments made following consideration
Donna Pritchard	*Cabinet*	1		

COUNCIL STRATEGIC OBJECTIVES: Which of the Council's Strategic Objectives does the proposal address and how?	
Boosting the Economy	The plan will support local communities and services to deliver dementia friendly services, improving access to local services which will encourage economic growth. The plan will Support new and growing businesses in the County, create new job opportunities for skilled young people, promote equal opportunities in employment, achieve sustainable economic growth, enhance the provision of skills and learning opportunities for people aged 16+ and further develop apprenticeships in the County
Investing in People's Future	Dementia, whilst traditionally considered to be a condition of old age affects everyone associated with the disease. Supporting the person living with dementia (PLWD) in local communities will enable carers and family members to also live well. Individuals with Young onset dementia can be supported to live as independently as possible with the right access to support and services.
Enabling Individual and Family Resilience	The Council's Through Age and Wellbeing Strategy states that the health and social care partnership in conjunction with third sector partners will provide strategic direction to develop early intervention strategies for those in need to help them to live independently for longer with the aid of family and community support. The Ceredigion Dementia Development Plan, with its focus on enabling people affected by dementia to live well and independently for as long as possible, will directly contribute to this. The Plan's endorsement will enable us to develop and deliver services in line with the needs of our communities, and to improve the wellbeing and experiences of those affected by dementia. The Ceredigion Dementia Development Plan will contribute to the following outcomes under this strategic objective: • Citizens of all ages will have an improved quality of life • Improved support networks for families and those in need across the County. • Improved well-being and health by adopting effective interventions. • There will be well established networks of community and voluntary groups throughout the County providing strategic preventative support thus increasing community resilience and sustainable social care.
Promoting Environmental and Community Resilience	Dementia friendly communities are a key feature within the local plan and will support community resilience.

NOTE: As you complete this tool you will be asked for **evidence to support your views**. These need to include your baseline position, measures and studies that have informed your thinking and the judgement you are making. It should allow you to identify whether any changes resulting from the implementation of the recommendation will have a positive or negative effect. Data sources include for example:

- *Quantitative data - data that provides numerical information, e.g. population figures, number of users/non-users*
- *Qualitative data – data that furnishes evidence of people's perception/views of the service/policy, e.g. analysis of complaints, outcomes of focus groups, surveys*
- *Local population data from the census figures (such as Ceredigion Welsh language Profile and Ceredigion Demographic Equality data)*
- *National Household survey data*
- *Service User data*
- *Feedback from consultation and engagement campaigns*
- *Recommendations from Scrutiny*
- *Comparisons with similar policies in other authorities*
- *Academic publications, research reports, consultants' reports, and reports on any consultation with e.g. trade unions or the voluntary and community sectors, 'Is Wales Fairer' document.*
- *Welsh Language skills data for Council staff*

2. SUSTAINABLE DEVELOPMENT PRINCIPLES: How has your proposal embedded and prioritised the five sustainable development principles, as outlined in the Well-being of Future Generations (Wales) Act 2015, in its development?

Sustainable Development Principle	Does the proposal demonstrate you have met this principle? If yes, describe how. If not, explain why.	What evidence do you have to support this view?	What action (s) can you take to mitigate any negative impacts or better contribute to the principle?
Long Term Balancing short term need with long term and planning for the future.	Yes, this principle has been met. The Plan is based on the anticipated need for dementia care and support, using population projections through 2040 (see evidence column). It focuses on early diagnosis and support in order to increase the number of people having their needs met, along with improving existing services and filling identified gaps in support in order to improve quality of care and support and overall quality of life for people affected by dementia. Much of this will be future-proofing health and social care services for the projected increasing levels of dementia over the coming 20 years.	Attain completed a West Wales population analysis, using data from the Office for National Statistics (ONS) for general population demographics, and data from the GP Quality and Outcomes Framework dementia register for specific data on dementia diagnosis and prevalence rates. This enabled them to make population predictions through 2040, which demonstrate that: – 1 in 10 people over 85 in West Wales currently have dementia	

	Many of the specific service models and interventions identified as part of the draft dementia wellbeing pathway are still in development but are being developed with a long-term view in mind. For example, the Dementia Wellbeing Connector role service specification is in development. The staffing model for this role, also developed by Attain, is based on future population predictions, with staffing models gradually increase year-on-year in order for the service to keep up with increasing need. We will ensure that long-term need and sustainability is a key consideration of any service re-design or new service development.	– Over 10% of the population across Hywel Dda will be over 85 by 2040. – Ceredigion has the highest proportion of over-65s at 26%; this will see a 4% increase over the next 20 years. – Ceredigion is projected to see nearly a 50% increase in dementia prevalence by 2040. – Across the region, an estimated 47% of people are believed to be living with dementia and undiagnosed. If nothing changes to improve diagnosis rates, data suggests that by 2040, 760 people in Ceredigion will be living with dementia undiagnosed, and therefore likely living with unmet needs. The long-term population analysis outlined here has shaped the Ceredigion Dementia development Plan, demonstrating how this principle has been met.	
Collaboration Working together with other partners to deliver.	Yes, this principle has been met. Partnership working across the local authorities, health board, and third sector is ongoing and will be key to the delivery of the Plan. Input from key partners is evidenced within the Plan. The Ceredigion Dementia development Plan will be overseen by a local Dementia Steering Group, which will be established and includes representation at senior level from both Hywel	Existence of the Dementia Steering Group (DSG) Historic and ongoing collaboration through the organisations represented at the DSG	

	Dda Health Board and the local authority, as well as third sector representation. The Health Board, Local Authorities, and third sector partners already deliver a number of services which support the Plan's objectives, and the local Dementia Steering Group will continue to identify opportunities for partnerships in service delivery and development to ensure that services are delivered efficiently, effectively, and by those who are best-equipped and best-placed within relevant communities and wider systems.		
Involvement Involving those with an interest and seeking their views.	Yes, this principle has been met. Independent consultants 'Attain', were commissioned to develop the Ceredigion Dementia Implementation Plan, ran a series of focus groups and 1:1 interview with relevant stakeholders. These included staff from relevant Local Authority services, Healthcare services, and the third sector, as well as people living with dementia and their carer's. The goal of these was to understand the perspectives, experiences, and priorities of people affected by dementia across the region to ensure that these shaped the development of the Plan and the draft dementia wellbeing pathway within the Plan. The primary groups of people with protected characteristics who were engaged in the development of this Plan were older people and people with disabilities (dementia). Other protected characteristic groups were not directly engaged as part of the Plan development. While views were not deliberately sought specifically from these	The themes and outcomes of the engagement of both professional stakeholders and those with lived experience directly shaped the wellbeing pathway proposed in the Regional Dementia strategy and the subsequent local Implementation Plan.	Agree a plan for continuous engagement of people with lived experience with the Plan, the Dementia Steering Group, and related work. Develop a regional communication and engagement plan for promotion of the Ceredigion Dementia development Plan, once endorsed locally

	groups, members of these groups may have been a part of broader engagement, as there will be people affected by dementia across the region who are members of these groups. For example, feedback from professional stakeholders highlighted issues for several of these groups which shaped the Plan: – Feedback from frontline staff on the challenges of identifying and assessing dementia in people who are blind or deaf and Welsh speakers led to a specific commitment within the Plan around training staff to recognise the signs of dementia and how to best support people living with dementia in these groups.		
Prevention Putting resources into preventing problems occurring or getting worse.	Yes, this principle has been met. The thematic areas within the Plan's wellbeing pathway are linked to many of the root causes of current challenges in dementia care, for example: – *Wellbeing, risk reduction, delaying onset, raising awareness and understanding:* this theme focuses on prevention and delaying onset of dementia, as well as supporting communities to be better prepared to support people affected by dementia, which has the potential to delay/reduce demand on statutory care services. – *Recognition, Identification, Support and Training:* limited training, support, and knowledge surrounding dementia is one of the root causes of poor experiences of care and support, or challenges in the workplace and the community for people living with	The contents of the Ceredigion Dementia Implementation Plan	

	dementia and their carer's. This thematic area would seek to address this to improve experiences and enable people to stay active in their communities for longer. – *Assessment and diagnosis:* delayed or lack of diagnosis is one of the biggest issues facing people with dementia across the UK, and this is a key root cause. Getting diagnosis processes and post-diagnosis support right, has the potential to significantly improve people's experiences and also to delay/reduce the demand on services.		
Integration Positively impacting on people, economy, environment and culture and trying to benefit all three.	Yes, this principle has been met. Dementia is 'everybody's business'—people affected by dementia will come into contact with any number of adult health and social care services, as well as sectors such as housing, transportation, community groups, and local businesses. This is one of the reasons that widespread dementia education and awareness is a priority.		Local Dementia Steering Group to consider developing a prioritisation framework aligned to the Plan, to support decision-making in line with the Plan's goals and ambitions.

3. WELL-BEING GOALS: Does your proposal deliver any of the seven National Well-being Goals for Wales as outlined on the Well-being of Future Generations (Wales) Act 2015? Please explain the impact (positive and negative) you expect, together with suggestions of how to mitigate negative impacts or better contribute to the goal. We need to ensure that the steps we take to meet one of the goals aren't detrimental to meeting another.

Well-being Goal	Does the proposal contribute to this goal? Describe the positive or negative impacts.	What evidence do you have to support this view?	What action (s) can you take to mitigate any negative impacts or better contribute to the goal?
3.1. A prosperous Wales Efficient use of resources, skilled, educated people, generates wealth, provides jobs.	Not applicable		

3.2. A resilient Wales Maintain and enhance biodiversity and ecosystems that support resilience and can adapt to change (e.g. climate change).	The Development Plan will likely have an environmental impact; at this stage no assessment has been made of whether this will be positive or negative. The Development Plan's focus on keeping people in their homes and communities as long as possible is tied to ambitions for more effective utilisation of health and social care resources. This could have an environmental impact through, for example, reducing reliance on emergency transportation and therefore reducing emissions. Keeping care in the community will require professionals to travel to individuals in their homes, so this is not an automatically an environmentally better solution. However, aligned to keeping people in their homes is the ambition to provide care as close to home as possible, another way to reduce/limit emissions. Existing models of dementia care across the region, including both the Memory Assessment Service and the Admiral Nursing Service, have taken learnings from the last few years of COVID to enable greater use of virtual working both between professionals and to support service users where appropriate, which can reduce both cost and environmental impacts through reduction of travel. With video, telephone, and email support having become more common throughout the pandemic, the use of virtual service provision will need to be carefully considered to balance environmental benefits against the appropriateness and effectiveness for each service, as well as for individual service users.	No detailed assessment has been completed of the Plan's potential environmental impact.	The Local Dementia Steering Group will need to consider potential environmental impacts of any changes made to services as part of the Plan's implementation.

3.3. A healthier Wales People's physical and mental wellbeing is maximised and health impacts are understood.	The Ceredigion Dementia Development Plan will contribute positively to meeting the goals of 'A healthier Wales'. The Plan focuses on enabling people affected by dementia to live well and independently for as long as possible, starting from a position of prevention, early diagnosis, and proactive management of dementia and the health and wellbeing of people affected by dementia and their carer's. The Plan aims to reduce unmet health and wellbeing needs amongst people affected by dementia, and to ensure that 'what matters to you' is at the centre of all care and support pathways. Delivery of the Plan will encourage collaboration across the health and social care sectors, including the third sector.	The Ceredigion Dementia Development Plan outlines the Plan's vision, the draft dementia wellbeing pathway, and priority initiatives to support this.	
3.4. A Wales of cohesive communities Communities are attractive, viable, safe and well connected.	The Ceredigion Dementia Development Plan will contribute positively to meeting the goals of 'A Wales of cohesive communities. Creating dementia-friendly communities is a key theme within the Plan, and the local Dementia Steering Group will look to identify and support existing Dementia Friendly Communities initiatives across the region, as well as identifying opportunities to expand and grow this work locally	The Plan outlines the Plan's vision, the draft dementia wellbeing pathway, and priority initiatives to support this.	Complete comprehensive mapping of Dementia Friendly communities and related initiatives across the region, in order to identify good practice and opportunities for further development which the work of the Plan could support.
3.5. A globally responsible Wales Taking account of impact on global well-being when considering local social, economic and environmental well-being.	Not applicable		

<table>
<tr>
<td>3.6. A more equal Wales
People can fulfil their potential no matter what their background or circumstances.

In this section you need to consider the impact on equality groups, the evidence and any action you are taking for improvement.
You need to consider how might the proposal impact on equality protected groups in accordance with the Equality Act 2010?
These include the protected characteristics of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, gender, sexual orientation.
Please also consider the following guide:
Equality Human Rights - Assessing Impact & Equality Duty</td>
<td>Describe why it will have a positive/negative or negligible impact.

Using your evidence consider the impact for each of the protected groups. You will need to consider do these groups have equal access to the service, or do they need to receive the service in a different way from other people because of their protected characteristics. It is not acceptable to state simply that a proposal will universally benefit/disadvantage everyone. You should demonstrate that you have considered all the available evidence and address any gaps or disparities revealed.</td>
<td>What evidence do you have to support this view?

Gathering Equality data and evidence is vital for an IIA. You should consider who uses or is likely to use the service. Failure to use data or engage where change is planned can leave decisions open to legal challenge. Please link to involvement box within this template. Please also consider the general guidance.</td>
<td>What action (s) can you take to mitigate any negative impacts or better contribute to positive impacts?

These actions can include a range of positive actions which allows the organisation to treat individuals according to their needs, even when that might mean treating some more favourably than others, in order for them to have a good outcome. You may also have actions to identify any gaps in data or an action to engage with those who will/likely to be effected by the proposal. These actions need to link to Section 4 of this template.</td>
</tr>
<tr>
<td>Age
Do you think this proposal will have a positive or a negative impact on people because of their age? (Please tick ✓)
<table>
<tr><td>Children and Young People up to 18</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>People 18-50</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td>✓</td><td></td><td></td></tr>
<tr><td>Older People 50+</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td>✓</td><td></td><td></td></tr>
</table>
</td>
<td>The Ceredigion Plan is intended to have a positive impact on adults. This impact will primarily be seen for people over 50, due to the increasing prevalence of dementia with age. The Plan is also intended to increase support for and improve the experience of carers, some of whom will fall within the 18-50 age group.

As highlighted throughout this document, the Plan has the potential to significantly increase the quality of life of people living with dementia and their carers, by support them to live independently</td>
<td>The Plan has been shaped by feedback from people with lived experience, and professionals who support them.</td>
<td>The Regional Dementia Steering Group will need to ensure appropriate evidence of the impact that the Local Plan is having on individuals across the region as well as Ceredigion is gathered. This will include quantitative measures (a need to improve our impact and outcome measures of Welsh Government funded work has already been identified and is a priority), but importantly should also consider the lived experiences of people affected by dementia.</td>
</tr>
</table>

				in their communities for as long as possible/desired.		

Disability Do you think this proposal will have a positive or a negative impact on people because of their disability? (Please tick ✓)						
Hearing Impartment	Positive	Negative	None/ Negligible	*Hearing impairment, physical impairment, visual impairment:* Input from professionals during the strategy development process highlighted the need to improve dementia assessment and support for those with hearing and visual impairments, and this has been included in the Ceredigion Plan. These groups, as well as those with physical impairments, will also benefit from the Plan and wellbeing pathway's focus on holistic care planning and ensuring that what matters to individuals is prioritised. This will support better accessibility of services for those with disabilities. *Learning disability:* There is a specific action within the Ceredigion Plan, linked to the 'All Wales Dementia Care Pathway' of Standards, to ensure cognitive wellbeing checks for people with learning disabilities, due to the increased risk of dementia within this population. As part of ongoing work the Memory Assessment Service has also been working with the learning disabilities service to ensure clear pathways are in place for people with learning disabilities who are being assessed for potential dementia diagnoses. Therefore, the Plan's delivery has the potential to increase dementia diagnosis rates in	The Plan has been shaped by feedback from people with lived experience, and professionals who support them	As above
	✓					
Physical Impairment	Positive	Negative	None/ Negligible			
	✓					
Visual Impairment	Positive	Negative	None/ Negligible			
	✓					
Learning Disability	Positive	Negative	None/ Negligible			
	✓					
Long Standing Illness	Positive	Negative	None/ Negligible			
	✓					
Mental Health	Positive	Negative	None/ Negligible			
	✓					
Other	Positive	Negative	None/ Negligible			
	✓					

				people with learning disabilities and increase their access to dementia-related support. *Long-standing illness, mental illness, and other:* These three groups have been placed together for the purposes of this assessment due to their overlaps. Dementia would fall under the category of long-standing illness or other. Although dementia services are often placed within NHS mental health teams and services, dementia is not a mental illness. However, people with dementia can experience mental illness, such as depression and anxiety, as can carers. This may be linked to the impact of the dementia, particularly where there is minimal support available and high levels of isolation, stress, and carer burden. With its focus on improving the experiences of both people with dementia and carers, the Plan is therefore expected to have a positive impact on people within these three groups.		

Transgender Do you think this proposal will have a positive or a negative impact on transgender people? (Please tick ✓)				It is anticipated that the Ceredigion Plan will have no/negligible impacts on transgender people.	There is a lack of regional and national statistics on the transgender population in Wales and the UK, and estimates vary widely. Transgender people living with dementia or caring for people with dementia living in West Wales may benefit from the Plan through improvements to their access to care and quality of life, but no	The Regional Dementia Steering Group should consider how the needs of transgender people affected by dementia can be better understood, and based on this, what specific initiatives might be needed e.g. specific support groups, reasonable adjustments in services, training and education of
Transgender	Positive	Negative	None/ Negligible			
			✓			

					specific assessment has been performed in this area. There are known barriers to healthcare access for transgender people, and a high proportion of transgender people report discrimination and unequal treatment in healthcare[1]; these will need to be considered as part of the Plan's delivery. There has been no specific engagement with this group as part of the Plan development.	health and social care staff to reduce barriers in access to care.

Marriage or Civil Partnership Do you think this proposal will have a positive or a negative impact on marriage or Civil partnership? (Please tick ✓)				There are no anticipated impacts this area.		
Marriage	Positive	Negative	None/ Negligible			
			✓			
Civil partnership	Positive	Negative	None/ Negligible			
			✓			

Pregnancy or Maternity Do you think this proposal will have a positive or a negative impact on pregnancy or maternity? (Please tick ✓)				There are no anticipated impacts this area.		
Pregnancy	Positive	Negative	None/ Negligible			
			✓			

[1] Stonewall. 2018. *LGBT in Britain Health Report.* https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

Maternity	Positive	Negative	None/ Negligible			
			✓			

Race Do you think this proposal will have a positive or a negative impact on race? (Please tick ✓)				It is anticipated that the Ceredigion Plan will have no/negligible impacts on race equality.	The estimated population percentages who identify as Black, Asian, or minority ethnic backgrounds across the region are[2]: – Ceredigion 2.1% – Pembrokeshire 1.3% – Carmarthenshire 4.1% People from minority ethnic backgrounds in West Wales who are living with dementia or caring for people with dementia may benefit from the Plan through improvements to their access to care and quality of life, but no specific assessment has been performed in this area. There has been no specific engagement with this group as part of the Plan development. Language and cultural barriers can impact access to and experiences of healthcare for people from minority ethnic backgrounds, and this will need to be considered as part of the Plan's delivery.	The Regional Dementia Steering Group should consider how the needs of people from minority ethnic backgrounds affected by dementia can be better understood and based on this, what specific initiatives might be needed e.g., specific support groups, reasonable adjustments in services, training and education of health and social care staff to reduce barriers in access to care.
White	Positive	Negative	None/ Negligible			
			✓			
Mixed/Multiple Ethnic Groups	Positive	Negative	None/ Negligible			
			✓			
Asian / Asian British	Positive	Negative	None/ Negligible			
			✓			
Black / African / Caribbean / Black British	Positive	Negative	None/ Negligible			
			✓			
Other Ethnic Groups	Positive	Negative	None/ Negligible			
			✓			

[2] Stats Wales. 31 December 2021. https://statswales.gov.wales/Catalogue/Equality-and-Diversity/Ethnicity/ethnicity-by-area-ethnicgroup

<table>
<tr>
<td colspan="4">Religion or non-beliefs
Do you think this proposal will have a positive or a negative impact on people with different religions, beliefs or non-beliefs? (Please tick ✓)</td>
<td rowspan="20">It is anticipated that the Plan will have no/negligible impacts on people on the basis of their religion, beliefs, or non-belief.</td>
<td rowspan="20">People from different religious and non-religious backgrounds in West Wales who are living with dementia or caring for people with dementia may benefit from the Plan through improvements to their access to care and quality of life, but no specific assessment has been performed in this area.</td>
<td rowspan="20">The Regional Dementia Steering Group should consider how the needs of people from different religious and non-religious backgrounds affected by dementia can be better understood and based on this, what specific initiatives might be needed e.g., specific support groups, reasonable adjustments in services, training and education of health and social care staff to reduce barriers in access to care.</td>
</tr>
<tr><td>Christian</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Buddhist</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Hindu</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Humanist</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Jewish</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Muslim</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Sikh</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Non-belief</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td>Other</td><td>Positive</td><td>Negative</td><td>None/ Negligible</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
</table>

Sex Do you think this proposal will have a positive or a negative impact on men and/or women? (Please tick ✓)				The Dementia Plan is intended to have a positive impact on all people living with or caring for someone with dementia, regardless of sex. There may be a greater level of positive impact on women, as women make up a greater proportion of those diagnosed with dementia in West Wales, (see next column). Women also make up the majority of carers across the UK[3] (although specific figures on this for West Wales are not available).	According to Attain's population assessment, women make up 62% of dementia diagnoses in West Wales. Women make up an even larger proportion of dementia diagnoses amongst the over 85s. While this has not directly shaped the Plan, it highlights the need to remain aware of these differences and how they may impact/be impacted by changes to services. While the difference in the proportion of men versus women diagnosed with dementia may be in part due to life expectancy between the sexes, it also highlights the need to explore what other factors may affect this, for example, differing diagnosis rates between men and women.	The Regional Dementia Steering Group will need to ensure we are gathering appropriate evidence of the impact that the Plan is having on individuals across the region. This will include quantitative measures (a need to improve our impact and outcome measures of Welsh Government funded work has already been identified and is a priority), but importantly should also consider the lived experiences of people affected by dementia. The continuous engagement approach which is currently being developed (described in section 2 under Involvement) will support this. This work may support further exploration of the different experiences of people living for/caring with people affected by dementia based on sex.
Men	Positive	Negative	None/ Negligible			
	✓					
Women	Positive	Negative	None/ Negligible			
	✓					

Sexual Orientation Do you think this proposal will have a positive or a negative impact on people with different sexual orientation? (Please tick ✓)				It is anticipated that the Ceredigion Plan will have no/negligible impacts on people on the basis of their sexual orientation.	Everyone in West Wales who is intended to benefit from this Plan has a sexual orientation. However, no specific assessment has been performed looking at potential impacts broken down by different sexual orientation groups.	A significant proportion of lesbian, gay, and bisexual (LGB) people report having experienced or witnessed discriminatory treatment in healthcare settings[4]. The Regional Dementia Steering Group should consider how the needs of LGB people affected by dementia across the region can be better understood and based on this, what specific initiatives might
Bisexual	Positive	Negative	None/ Negligible			
			✓			
Gay Men	Positive	Negative	None/ Negligible			
			✓			

[3] Carers UK. 2019. *Facts and Figures.* https://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures
[4] Stonewall. 2018. *LGBT in Britain Health Report.* https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

Gay Women / Lesbian	Positive	Negative	None/ Negligible			be needed e.g. specific support groups, reasonable adjustments in services, training and education of health and social care staff to reduce barriers in access to care.
			✓			
Heterosexual / Straight	Positive	Negative	None/ Negligible			
			✓			

Having due regards in relation to the three aims of the Equality Duty - determine whether the proposal will assist or inhibit your ability to eliminate discrimination; advance equality and foster good relations.

3.6.2. How could/does the proposal help advance/promote equality of opportunity?

You should consider whether the proposal will help you to: ● Remove or minimise disadvantage ● To meet the needs of people with certain characteristics ● Encourage increased participation of people with particular characteristics

The Ceredigion Dementia Development Plan will support health and social care services across the County to better meet the needs of people affected by dementia and their carer's, and support better community integration of these same groups. It will promote human rights-based approaches to dementia care and reduce the isolation that people affected by dementia can face, therefore supporting equality of opportunity for people affected by dementia.

3.6.3. How could/does the proposal/decision help to eliminate unlawful discrimination, harassment, or victimisation?

You should consider whether there is evidence to indicate that: ● The proposal may result in less favourable treatment for people with certain characteristics ● The proposal may give rise to indirect discrimination ● The proposal is more likely to assist or imped you in making reasonable adjustments

Not applicable

3.6.4. How could/does the proposal impact on advancing/promoting good relations and wider community cohesion?

You should consider whether the proposal with help you to: ● Tackle prejudice ● Promote understanding

Creating dementia-friendly communities is a key theme of the dementia Plan. This includes increasing public awareness and understanding of dementia, decreasing stigma, and ensuring people with dementia are accepted and included within their communities, therefore supporting community cohesion and inclusion.

Having due regard of the Socio-Economic Duty of the Equality Act 2010.

Socio-Economic Disadvantage is living in less favourable social and economic circumstances than others in the same society.

As a listed public body, Ceredigion County Council is required to have due regard to the Socio-Economic Duty of the Equality Act 2010. Effectively this means carrying out a poverty impact assessment. The duty covers all people who suffer socio-economic disadvantage, including people with protected characteristics.

3.6.5 What evidence do you have about socio-economic disadvantage and inequalities of outcome in relation to the proposal?

Describe why it will have a positive/negative or negligible impact.
The Ceredigion Dementia Development Plan is not anticipated to have either a positive or negative impact on people on the basis of socio-economic disadvantage or income inequality.
What evidence do you have to support this view?
No specific assessment has been completed regarding the potential impact of the Ceredigion Dementia development Plan on socio-economic disadvantage or income inequality.
What action(s) can you take to mitigate any negative impacts or better contribute to positive impacts?
The Regional and local Dementia Steering Groups should consider how socio-economic disadvantage and income inequality may impact the needs of people affected by dementia across the region, and/or their ability to access services and support (e.g. transportation costs), and, based on this, what specific initiatives might be needed to ensure equality of access for those from lower income backgrounds.

3.7. A Wales of vibrant culture and thriving Welsh language Culture, heritage and Welsh Language are promoted and protected. *In this section you need to consider the impact, the evidence and any action you are taking for improvement. This in order to ensure that the opportunities for people who choose to live their lives and access services through the medium of Welsh are not inferior to what is afforded to those choosing to do so in English, in accordance with the requirement of the Welsh Language Measure 2011.*				Describe why it will have a positive/negative or negligible impact.	What evidence do you have to support this view?	What action (s) can you take to mitigate any negative impacts or better contribute to positive impacts?
Will the proposal be delivered bilingually (Welsh & English)?	Positive	Negative	None/ Negligible	Information provided as part of the Plan's delivery, for example, promotion and communication of the Plan, will be delivered in both Welsh and English, as will any public meetings or events associated with the Plan.		Ensure that opportunities to support the Plan's development through community engagement are promoted to Welsh speakers and that arrangements are in place to enable Welsh speakers to contribute in Welsh.
	✓					

Will the proposal have an effect on opportunities for persons to use the Welsh language?	Positive	Negative	None/ Negligible	There are no anticipated impacts this area.		
			✓			
Will the proposal increase or reduce the opportunity for persons to access services through the medium of Welsh?	Positive	Negative	None/ Negligible	Improving staff training and awareness around supporting Welsh speakers with dementia is a part of the action plan, resulting from engagement during the plan's development. The Ceredigion Dementia Development Plan supports ongoing work in line with the Dementia Action Plan and the 'All Wales Dementia Care Pathway of Standards'. There are several national actions linked to Welsh language and dementia including: – Utilise the Welsh language and drive forward recommendations from the Alzheimer's Society and Welsh language commissioners report on Welsh Language and dementia, and – Commission research to further identify good quality normative data on Welsh language	The Ceredigion Dementia Development Plan	
	✓					

				versions of cognitive assessment scales that are commonly used in Wales, allowing the confident interpretation of assessments carried out in a clinical context. The overall aim of the project is to collate information on the dementia assessment tools/scales available in Welsh, how they are currently used and identify the most robust Welsh language clinically validated tool(s). The region will engage with and support this work and consider implementing any changes and best practice identified (e.g., if a specific Welsh language dementia assessment tool is assessed as the most robust and effective, look at consistency of use across the region).		
How will the proposal treat the Welsh language no less favourably than the English language?	Positive ✓	Negative	None/ Negligible	Any service changes or developments will be delivered in line with existing Welsh Language Standards, which all partners (NHS, local authorities, and third sector) are required to adhere to.	Existing commitment of all partners to deliver services in this way.	

Will it preserve promote and enhance local culture and heritage?	Positive	Negative	None/ Negligible	There are no anticipated impacts this area.		
			✓			

4. STRENGTHENING THE PROPOSAL: If the proposal is likely to have a negative impact on any of the above (including any of the protected characteristics), what practical changes/actions could help reduce or remove any negative impacts as identified in sections 2 and 3?			
4.1 Actions.			
What are you going to do?	When are you going to do it?	Who is responsible?	Progress
4.2. If no action is to be taken to remove or mitigate negative impacts please justify why. *(Please remember that if you have identified unlawful discrimination, immediate and potential, as a result of this proposal, the proposal must be changed or revised).*			
4.3. Monitoring, evaluating and reviewing. *How will you monitor the impact and effectiveness of the proposal?*			
Implementation of the Ceredigion Dementia Implementation Plan will be led by a Ceredigion Implementation/steering group which will report to the TAW Board. The local group will also feed information through the Regional Dementia Programme and Change Manager/Regional Steering Group.			

5. RISK: What is the risk associated with this proposal?					
Impact Criteria	1 - Very low	2 - Low	3 - Medium	4 - High	5 - Very High
Likelihood Criteria	1 - Unlikely to occur	2 - Lower than average chance of occurrence	3 - Even chance of occurrence	4 - Higher than average chance of occurrence	5 - Expected to occur

Risk Description	Impact (severity)	Probability (deliverability)	Risk Score
Lack of progress with the local plan due to the need for working across partners both locally and regionally.	2	2	4

Does your proposal have a potential impact on another Service area?
As highlighted throughout this document, the Plan will require collaboration across key partners and stakeholders.

6. SIGN OFF			
Position	Name	Signature	Date
Service Manager	Nerys Lewis	N.G. Lewis	27th September 2023
Corporate Lead Officer	Donna Pritchard	Dpritchard	27th September 2023
Strategic Director			
Portfolio Holder			

CYNGOR SIR CEREDIGION COUNTY COUNCIL

Report to: **Cabinet**

Date of meeting: **3 October 2023**

Title: **Feedback from the Healthier Communities Overview and Scrutiny Committee on the outcome of the Ceredigion Dementia Implementation Plan**

Purpose of the report: **To provide feedback from the Healthier Communities Overview and Scrutiny Committee meeting held on 18th September 2023**

Background:

Officers attended to present feedback on the outcome of the Dementia Implementation plan following Attains' appointment to undertake and facilitate engagement sessions to explore what actions were needed to support people living with dementia in Ceredigion. The engagement period took place over a 6-week period from 13.02.2023 to the 31.03.2023. Over the engagement period, Attain spoke with a wide remit of stakeholders, from individuals living with dementia, their careers, and professional from across Health and Social Care, including support networks in the 3rd sector. As part of this work Attain have developed a report and an Implementation Plan that will support Ceredigion County Council and Hywel Dda University Health Board to address some of the challenges and gaps identified.

The key findings were reported as follows:

- The current number of People living with Dementia (PLWD) in Ceredigion is approximately 1,260,
- By 2040 the predicted growth of PLWD ranges from 600 to 2000, so there will be a significant increase.

Analysis of the engagement phase activities resulted in the identification of 20 key themes which represents "pinch points" in current service provision and opportunities to provide improved experiences:

- Referral process / route
- Pre-clinical diagnosis
- No appropriate sign-posting
- Fragmented pathway
- Lack of crisis support
- Multi-Disciplinary Team (MDT) approach
- Day Services
- Transport
- Patient recording systems
- Access and information sharing
- Funding
- Misinformation around 3rd sector providers
- Silo working

- Lack of nursing-based beds
- Communication
- Recruitment and staffing
- Skills mix and training and development
- Education
- Respite Care
- Confidentiality

Following discussion, Members agreed to recommend that Cabinet:

1. Approve the Dementia Implementation Plan for Ceredigion, subject to:

    - present the report to the Healthier Ceredigion Strategic Group and create an integrated Health, Social Care and 3rd Sector Development Group to oversee the delivery of the implementation plan.
    - To communicate the initial findings of the engagement with the public, and to develop a Communication and Engagement Plan ensuring that the public are aware of the on-going progress relating to the delivery of the implementation plan.
    - To return to the Healthier Communities Overview and Scrutiny Committee with an Annual Progress report.

Councillor Caryl Roberts
Chair of the Healthier Communities Overview and Scrutiny Committee