**Greater Manchester Dementia Wellbeing Plan**

**Version 1.6**

**These notes** **are for the person completing the Dementia Wellbeing Plan**.

The focus of the Dementia Wellbeing Plan appointment will be on the person’s strengths and what motivates and matters to them. They should have been sent a leaflet before the appointment which introduces and explains the purpose of the plan, as well as a blank copy of the plan itself on which to record their initial thoughts. Remember to prompt for any notes which they may have made in advance which could help them lead the discussion.

Look at what Dementia Worker/Advisor/Support services are available in your locality when preparing to sit down and jointly write the Dementia Wellbeing Plan. The person with dementia and their family may need ongoing advice and support which such services can provide. Also consider looking at the resource pack for the Wellbeing Plan so you are aware of what resources you can signpost or refer to.

We advise taking at least 30 minutes to complete a Wellbeing Plan, and it may take more than one appointment to complete in full. This may mean booking a second appointment immediately afterward, agreeing with another practitioner to complete the rest, or reviewing it at a shorter interval to check what further information needs to be captured. As a single GM standard, the Wellbeing Plan is designed to be cumulative, capturing the outcome of successive appointments by different practitioners. Also, it may become apparent during the review that an appointment may be needed for a health check, medication review, or Advanced Care Planning. Make a referral to the appropriate person, or a separate appointment with you, if needed. This also applies to the carer as they may have their own needs that they wish to discuss.

The GM Dementia Wellbeing Plan is in a format that provides you with reasons for the questions and actions when writing the plan. Many of the questions are designed to elicit open and unstructured answers. You may find it useful to pull out key goals or actions when writing up the plan rather than record exactly what was said.

Make sure that you agree the timescale for the person to receive a paper copy of the completed plan. When sending the completed Wellbeing Plan out, please follow guidelines produced by the Alzheimer’s Society in terms of using double line spacing and larger font size. Please discuss the process of how the person can amend the plan, and when and how it will be reviewed.

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| **Reason** | **Questions (with examples)** | **Actions** |
| **Key information to be completed by the reviewer** | **Demographics**  Date of review  Name  Address  Date of Birth  NHS Number | Remember to introduce yourself and what you do. |
| **Many people living with dementia may be accompanied by a carer.** | **Other Person Present**  Name  Address  Contact details  Relationship |  |
| **The person with dementia should be capable of understanding why they are being asked the following questions and be able to provide answers upon which their support will be based.** | **Capacity**  *“Do you know why you’re here today? Are you aware of your diagnosis?”* | Check for understanding as consideration over mental capacity and consent in the moment. They should understand what the Wellbeing Plan and appointment is for. Ensure they have somebody with them if needed, and explain that they may answer questions on their behalf. Check for any lasting power of attorneys for health and welfare in place and if they want them to be present. |
| **The kind of dementia and time since diagnosis is important information to consider during the review. If person has a young onset or rare dementia this is a prompt too, to consider using specific resources that will help them to complete the care plan in a more meaningful way based on the more unique challenges associated with their age and diagnosis.** | **Diagnosis**  What is your diagnosis of dementia? Date of diagnosis and how did you get your diagnosis? | Accurate recording of diagnosis and when undertaken.  If the person has young onset dementia suggested documents to look at “Young Onset Dementia guide” and videos. Plus website links and videos for rarer forms of dementia provided with the resource pack. |
| **The person living with dementia should have the opportunity to “tell their story”. They are encouraged to explore what their dementia diagnosis means to them and their history.**  What matters to the person, They may not consider that the dementia has any bearing on this. | 1. **Personal Experience and History**   *“How have you been getting on since finding out you have dementia? What has been important to you? What does dementia mean to you?”* | Identify key issues they’ve faced or experienced.  What previous services were needed but not accessed or not sufficient. |
| **It is important that you use the appointment time to ensure that the person’s physical symptoms are known and managed. This includes cardiovascular disease, stroke, kidney disease and diabetes.** | 1. **Current Health**   *“How is your health at the moment? Areas you are managing well and areas you are not managing well”* | Check for pain, confusion, hearing and vision, and any other relevant medical issues.  Check for lifestyle factors and suggest prevention if appropriate.  If the reviewer is not clinical, refer for a health check with their GP. |
| **It will be important to consider the ability to safely take medication, including dementia-related medication if prescribed.** | 1. **Medication**   *“How do you find taking medication?”* “*How are you finding the medication you’ve been prescribed for dementia?”* – Only if prescribed medication for dementia. | Check for practical issues around handling and remembering to take medication as well as suitability of the medication.  Refer for review of dementia medication if appropriate. Consider referrals to the following as needed; Pharmacy, Memory Assessment Service and/or GP. |
| **Prompt for any new symptoms to ensure that changes are recorded, including the Single Question to Identify Delirium SQUID – “what have you noticed or someone close to you who may have noticed acute changes in the person’s level of confusion?”** | 1. **Changes and New Symptoms**   *“Has anything become more difficult or better for you recently? Have you experienced any changes? Anything you are worried about?”* | Check for new symptoms.  Check recent medical history which could affect condition, ask specifically if they have ever had a delirium. |

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| **People living with dementia often also have other conditions, such as high blood pressure, depression, frailty, heart disease, and diabetes, and may have other care plans or support plans for packages of care from an individual budget, personalised health budget** | 1. **Other Care Plans**   *“Have you had a care plan or support plan written before, for a condition other than dementia? Or a wellbeing plan?”* | Obtain a copy of the care plan. |
| **A second open question brings the conversation back to the individual and their needs. Asking about their current life lets you discover what’s important to them.**  Again, this gives you the chance to return to the discussion over support plans for packages of care from individual budgets and personalised health budgets.  **This also gives chance for a wider discussion over how the person connects with their community/relationships that are important (places and people that matter), hopes and goals, what they can currently do themselves and where they need help.** | 1. **Living Well**   *“What do you enjoy doing? What do you want to achieve or try in the next year? Do you need help with anything in your day-to-day life? Is there something which you feel you can no longer manage? If you could change something what would that be? What would you want to happen in your life – what are your priorities, hopes and goals? Things you like support with? Things you can do yourself?”* | Be alert to areas of vulnerability.  Evaluate for risks if struggling with key tasks, however balance uncertainty with freedom of choice  Identify support needed, such as around finance, functioning, maintaining independence, keeping driving, remaining in employment, welfare benefits to consider accessing and referring for, keeping active, physical exercise, eating and drinking, hobbies, isolation, mood, worries over loss of control. Signpost and provide information on personal budgets and on employment from Alzheimer’s Society which includes information on benefits. |

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| **Engaging in dementia research can empower people living with a diagnosis, offering them hope and the opportunity to contribute towards a dementia free future.** | 1. **Research**   *“Would you be interested in finding out about what dementia research is happening in and around Manchester?*  *There are many opportunities for you and your family to be part of the fight against dementia; you could help improve services by sharing your experiences, get involved in development of new technologies, help us better understand what happens in the brain during dementia or access new treatments.”* | If interested help patient to complete and post a JDR registration form. Explain that completing the form does not obligate them to take part in any studies it just means that they could be contacted about studies for which they are eligible – it will then be up to them whether or not they choose to take part in these. Mention that friends and family can sign up to, since there is still a lot we don’t know about how the brain’s memory systems work and JDR also has studies for people without a cognitive diagnosis. |

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| **Information about a person’s main carer is vitally important. They must also be supported.** | 1. **Carer Details**   *“Do you have somebody who helps with those things you find a struggle?”*  Name  Relationship  Contact | Ensure information is recorded in an easy to access place.  If not present arrange separate time for discussion with carer if appropriate. |
| **Think about offering the carer time to speak alone without the person with the lived experience present. Or offer the carer chance to send information to you, in advance of next appointment. This to enable them to express their concerns as a carer. Carers have the right to have support for them as a carers even if the person with the lived experience does not require support.** | 1. **Carer Support**   *“Do they have everything they need? They can get help if they need it to support you best.”* | Refer for Carer’s Assessment or signpost for other support as appropriate. Can register themselves as a carer with their own GP. |
| **Carer Advance Care Planning. Important information for if something happens to the carer.** | 1. **Carer Planning**   *“If your carer was ill do you know how you would be supported?”* | Record name of emergency carer/contact if possible.  Suggest discussion with dementia advisor if no planning has taken place. |

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| **Advance Care Planning can help people plan ahead for when things change. Allow the person to lead with what they think is important.**  **It may be difficult to discuss at a first appointment. This can be completed at a later stage when updating the plan.**  **If more advanced dementia/near end of life have they been considered for the palliative care register/Gold Standards Framework?** | 1. **Forward Planning**   *“If something in your life changed, such as taking a turn for the worse or needing to go into hospital, what would you like to happen? Would you need extra support? Who would take decisions for you?”* | Ensure information is recorded in an easy to access place.  Start the conversation about planning ahead and considering establishing Lasting Power of Attorneys  Suggest they complete “This is Me” booklet.  Refer to Advanced Care Planning template, such as “My Future Wishes”, if the person is ready to discuss and make arrangements to come back to discuss. Consider when and where these could be done. You may want to print off and send out the documents, for the person to complete, to help them plan for their future appointment to discuss their advanced care plan. |
| **The next review may not be for up to 12 months, but problems can arise suddenly. Allow them the name the route or resources they use when seeking information and support.** | 1. **Further Guidance**   *“We’re almost done now, but if you wanted more information or support is there somebody you normally ask?”* | Check this is an appropriate source.  Signpost to navigator or link worker where needed.  Provide with Post Diagnostic Support Care information |

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| **The Wellbeing Plan is a document that can be accessed and used by other services (statutory and in voluntary sector). It is intended that it is reviewed and updated as needs change, or what matters changes and/or support changes. It is intended to go alongside the person affected by dementia and their family following their journey and it will therefore also have Advanced Care Planning attached once this is completed, This is Me, Future Planning wishes if these are completed. This can be undertaken by any services and shared with the person’s consent.** | 1. **Information Sharing**   “*Are you happy for us to share the Wellbeing Plan with others involved in your care?”* | Check for consent to share and record this and note who with e.g. GP, social worker, voluntary sector advisor/worker, general hospital doctor, Memory Assessment Services. |
| **The next Wellbeing Plan review should be no more than 12 months away. It can be sooner if you or the person living with dementia prefers, or if there is a substantial change.** | **Date of next review** | Record this in a way that ensures the next review will be scheduled on time. Explain that they can make changes and review before that time if needed. |
|  | Date completed  Who completed – Name, role, and contact details  Date signed  Date paper copy of completed Wellbeing Plan sent out | Ensure the person living with dementia and carer understand that the plan will not be a verbatim record, but a summary of the discussion with key points highlighted for monitoring and action. |