## Bristol Dementia Wellbeing Service Doing Things Differently

Established in 2014, Bristol Dementia Wellbeing Service is an innovative primary care service delivered in partnership between Devon Partnership NHS Trust and Alzheimer's Society, working with GPs, professionals and partners across Bristol to support people with help when and where they want, and in a way that suits them.



People living with dementia, their carers and statutory community specialists told us that dementia should be considered as a long-term condition separate from mental health pathways. The service therefore includes all aspects of living well with dementia, including:

Access to early diagnosis. Previously Bristol had a diagnosis rate of 50% limiting access to treatment, advice and support. This is now over 75%.

**Supporting GP confidence** with complex diagnoses. Each GP practice has a named practitioner and navigator who meet regularly to provide support in diagnosis and the management of ongoing care.

Each person with dementia is allocated their own navigator who remains their main point of contact for them and their family and carers. Practitioners work closely with navigators to provide intensive support and interventions as required.



**Everyone receives a personalised wellbeing plan**, reviewed at east every 6 months which reflects what is important to them, their plans, wishes and support needs. This helps to build a structure of support to ensure people living with dementia are able to remain well and active in their communities.

We have an Enhanced Support Function who provide additional support and interventions at times of need with the aim of reducing hospital admission or re-admission and ensuring a safe and timely discharge when people are in hospital.

Our Care Home Liaison team works into Bristol's Care Homes, including Residential Homes operating a person-centred 'whole home' approach to care, including end of life.

Our aim is for Bristol to become a dementia-friendly city, with improved awareness and service provision. Initiatives led by our Community Development Coordinators across the city and in schools aim to raise awareness and access to services, particularly in communities with historically low rates of engagement.

## positive outcomes

We have maintained low psychiatric admissions to hospital despite a caseload that has increased from 300 at the start of the service to over 2,900 today.

- We do not discharge. As long as someone wants to receive the service, they will remain with us throughout their journey from diagnosis to end of life. Our service users and carers tell us that this consistency of care is really important to them.
- We actively promote access to research opportunities and have developed effective partnerships with other mental health services (crisis, inpatient and liaison psychiatry), social services (care direct, integrated carers team) and community organisations.
- ✓ The service is part of Bristol's community, normalising dementia care at a community level, addressing stigma and ensuring that dementia is everyone's business.

"We have been lovingly treated and supported - we could not have got through our journey without your caring support and tremendous help. Thank you all so very much" (carer)

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