Dementia Health Needs Assessment 2015/16
Executive Summary

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1. Executive Summary

Aims and objectives of the Needs Assessment:

- To provide an assessment of needs with regards to dementia in Merton and the extent of health inequalities or unmet needs
- To identify modifiable risk factors to dementia, and evidence-based public health interventions to reduce the burden of dementia
- To describe current health and social care provision and how this compares with best practice
- To identify gaps in service provision and make recommendations about how to address them particularly in relation to reducing health inequalities
- To consult with key stakeholders including carers to obtain a wide range of views on local needs
- To make recommendations for further action to improve care and outcomes for individuals with dementia and their carers.

Methodology

The methodology used was based on the traditional model of epidemiological, corporate and comparative healthcare needs assessment developed by Stevens and Rafferty[1]. Multiple methods were used including analysing quantitative data, from various sources namely:

- Health and Social Care Information Centre(HSCIC)
- Projecting Older People Population Information (POPPI)
- Public Health Outcomes Framework (PHOF)
- Secondary Users Services (SUS)
- Projecting Adults Needs and Services Information System (PANSI)
- Demographic census data on the Merton population.

Qualitative data was collected through focus groups, and a Commissioner and Provider stakeholder engagement event held at the Dementia Hub including representatives from statutory and voluntary service sectors. A systematic literature review was carried out on the topic of best practice around dementia care and risk factors of dementia. This needs assessment incorporated demographic data on Merton, projected population changes in the next fifteen years, prevalence and incidence of dementia and other risk factors. A population health perspective was used to provide an evidence base for the setting of priorities regarding good quality comprehensive dementia care. The needs assessment also looked at the extent of health inequalities.

Limitations

- Dementia Prevalence Calculator (DPC)[2] prevalence data does not give estimates of prevalence in different ethnic groups or early onset dementia therefore modelling was used to obtain indicative values for Merton.

[1] Stevens A. Rafferty J. Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Vol. 1. Oxford: Radcliffe Medical Press

[2] The Dementia Prevalence Calculator enables health and care communities to gain a better understanding of their local estimated prevalence of dementia in the community, and among people living in local care homes

- Only three of the 39 participants in the focus groups with carers of people with dementia and people with dementia were of Black, Asian and Minority Ethnic (BAME) background therefore the BAME voice was captured to a limited degree.
- There was limited data on hospital admissions for people with a primary or secondary diagnosis of dementia as the reason for admission is often not coded as dementia but the presenting symptoms of the patient for example urinary tract infection.

HIGHLIGHTS
1. **There is a forecast of growth in demand for all dementia care for people with dementia and their carers.** - The number of people (aged 65 and over) predicted to have dementia is forecast to grow by 51% from (1782) in 2015 to (2683) in 2030[3] - The numbers seen by the Community Mental Health Team (CMHT) for dementia ranged from 228 in (2011/12) to 325 in (2014/15)[4] and the number of patients seen by the CMHT over four years shows an upward trajectory showing a constant increase in demand on the service.
2. **Carers of people with dementia in Merton play a pivotal role in dementia care and need to be supported with advice and empowered to enable them to fulfil this role without detriment to their own quality of life.** - The Dementia Prevalence Calculator (DPC)[5] estimates that 1590 (83%) of people with dementia live in the community and 336 (17%) live in residential/nursing care. Due to the large proportion of people in the community, unpaid/informal carers play a substantial role in caring for people with dementia. - During focus groups, carers expressed a desire for better out of hour crisis support and respite care.
3. **The cohort of people with Early onset Dementia in Merton is small however, their needs are complex.** - The indicative number of people with early onset dementia in Merton in 2015 is 46 people. As a proportion of all cases of dementia in Merton in 2015, early onset dementia represents 2.38%. - There will be an estimated 28.2% growth (from 46-59 cases) in the total number of cases of early onset dementia in the next fifteen years (2015-2030)[6]. - As the number of people is small, it may be better to work on a sector level with other South West London boroughs to develop a pathway or service for this cohort as this would give the economies of scale necessary to develop a service of good quality.
4. **Considerable progress has been made in increasing diagnosis rates[7] but there is still variation between GP Practices and between localities within Merton in diagnosis rates.** - According to the DPC and Merton Clinical Commissioning Group (MCCG), the Merton diagnosis rate is 72% as at March 2015 meaning that 28% of people with dementia remain undetected or without a formal diagnosis; this is known as the dementia gap[8]

[3] Projecting Older People Population Information (POPPI)
[4] Source: South West London and St George's Mental Health NHS Trust
[5] Source: South West London and St George's Mental Health NHS Trust
[6] PANSI Projecting Adults Needs and Services Information System
[7] **Diagnosis rates** are calculated as the number of people with a dementia diagnosis (QOF dementia register) compared to the number of people estimated to have dementia in the population (the ANDP% from the DPC)
[8] **The 'Dementia Gap'** is the percentage of patients on the practice list with dementia who are undiagnosed. This is calculated by subtracting the QOF dementia register from the ANDPR number, and expressing that figure as a percentage of the ANDPR. It is possible to have a negative dementia gap if the practice has more

- There is marked variation between GP Practices and Localities within in dementia diagnosis rates and this is suggestive of health inequalities in relation to dementias diagnosis, this is an area for further investigation locally
- The average diagnosis rate in East Merton is 57%, in Raynes Park is 78% and in West Merton the average is 68%.

Dementia Risk Factors

Modifiable

The key modifiable risk factors to dementia are:

- Vascular disease
- Obesity and Diabetes
- Depression
- Smoking
- Excessive alcohol consumption
- Physical inactivity[9]
- Cognitive inactivity or lower educational attainment and;
- Other risk factors i.e. sleep quality

Non-Modifiable

The key non-modifiable risk factors for dementia include age, having learning disabilities, genotype/genetics and brain damage and head injury

Dementia Best Practice

There is a plethora of best practice guidelines and policy documents that outline good quality services and principles of good dementia care. The guidance documents have been summarised in relation to the following primary themes for simplicity:

- Prevention
- Health and Social Care Deliver and Commissioning
- Identification, Assessment and Diagnosis
- Early Intervention and Treatments
- Living Well with Dementia, Supporting Carers and Dementia Friendly Communities
- Good Dementia Care in Hospital and Liaison Psychiatry
- Reablement and Dementia
- End of Life Care (EoLC)
- People with Learning Disabilities who develop Dementia

patients on the dementia register than would be expected from the ANDPR. The maximum Dementia Gap is 100%.

[9] Barnes DE, Yaffe K. The projected effect of risk factor reduction on Alzheimer's disease prevalence. *The Lancet Neurology,* Early Online Publication, July 19 2011

DEMENTIA BEST PRACTICE PRINCIPLES
1. Prevention - The biggest message in prevention of dementia is **what is good for your heart is good for your head.** The six pillars of Alzheimer's prevention[10] are regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life. The best practice principle for dementia prevention is strengthening each of the six pillars in daily life, this in turn contributes to a healthier brain
2. Health and Social Care Deliver and Commissioning - An integrated/ whole-systems approach to commissioning should be adopted meaning; developing integrated health and social care plans where possible as well as involving the public, people with dementia, their carers and families when commissioning services[11, 12].
3. Identification, Assessment And Diagnosis - Good-quality early diagnosis and intervention for all; if dementia is diagnosed early, more can be done to delay progression of the disease.
4. Early intervention and treatments - Commissioners should plan to increase access to behaviour and social interventions for people with dementia, which can reduce inappropriate use of antipsychotic drugs[13]. - Ensuring equitable access and no discrimination - Ensuring that people with dementia are fully involved in making important decisions and providing valid consent in all aspects of their investigation, diagnosis and treatment.
5. Living Well with Dementia, Supporting Carers and Dementia Friendly Communities - A dementia friendly community as one "in which people with dementia are empowered to have high aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them"[14]. - The implications of **The Care Act 2014[15]** are that commissioners and providers will have to be cognisant of new safeguarding duties, a duty to integrate, cooperate and work in partnership between partners and Local authorities. As of April 2015 there will be new rights for carers, more people with dementia should have access to an independent advocate to help navigate decisions about their care.

[10] Alzheimer's: Six pillars of prevention http://www.cognitivehealthjh.org/perch/resources/pillars-of-brain-health.pdf

[11] NICE commissioning guidance (CMG48) Support for Commissioning Dementia Published April 2013 https://www.nice.org.uk/guidance/cmg48

[12] NICE and Social Care Institute for Excellence (SCIE) commissioning guides [CMG48] Published date: April 2013 https://www.nice.org.uk/guidance/cmg48/

[13] Support for commissioning dementia care NICE and Social Care Institute for Excellence (SCIE) commissioning guides [CMG48] Published date: April 2013 https://www.nice.org.uk/guidance/cmg48/

[14] Building dementia-friendly communities: A priority for everyone, The Alzheimer's society, August 2013 http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1916

[15] The Care Act 2014 is a significant piece of legislation in the social care sector and replaces numerous laws providing a coherent approach to adult social care in England http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

6. Good dementia care in Hospital (and Liaison Psychiatry)

- Hospitals have an important role to play in helping to identify patients with dementia, ensuring they are treated with compassion and discharged to an appropriate care setting
- People with suspected or known dementia using inpatient services should be assessed by a liaison service that specialises in the treatment of dementia and older people's mental health[16].
- National Institute of Clinical Excellence (NICE) also states that care should be planned jointly by the trust's hospital staff, liaison teams, relevant social care staff, the person with suspected or known dementia and carers.

7. Reablement and Dementia

- People should not be excluded from reablement based on a dementia diagnosis but should be assessed based on their needs and strengths without prejudice about their potential to be 'reabled'[17].

8. End of Life Care (EoLC)

- A key commissioning priority should be supporting primary care to identify people with dementia and add them to palliative care registers when they approach the end of their life[18].
- EoLC should be a key part of the dementia care plan[19.] However, this is a topic that needs to be broached sensitively to people with dementia and their carers and gradually after an individual has had an opportunity to come to terms with their diagnosis.

9. Best practice for people with learning disabilities who develop dementia

- The overarching principle of best practice for people with learning disabilities it the principal of "reasonable adjustments". These adjustments entail training staff about what people with learning disabilities are likely to need. This is in line with the disability Discrimination Act (DDA).

The Merton Dementia service user and stakeholder voice

KEY THEMES FROM STAKEHOLDER ENGAGEMENT

1. The overarching themes from the Commissioners and Provider stakeholder engagement event held on the 12th of March 2015 at the Dementia Hub were:

   Theme 1: The need for a change in strategic focus

   Significant progress had been made particularly around increasing diagnosis rates, closing the diagnosis gap and coping with the increase in service demand however, there is now a need to change the strategic focus to ensuring that the post –diagnostic support was of good quality. Areas for improvement given this proposed new direction of strategic focus are:

   - Ensuring sufficient capacity of the Community Mental Health Team (CMHT)

[16] NICE

[17] Maximising the potential for dementia reablement http://www.scie.org.uk/publications/guides/guide49/dementia.aspSocial

[18] NICE

[19] End of Life Care. The Alzheimer's society http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=428 Accessed 15 April 2015

- Increasing capacity in Improving Access to Psychological Therapies (IAPT)
- Increasing capacity in Occupational Therapy
- Developing stronger links between services

Theme 2: Service gaps in Merton

Dementia CQUIN[20]
Acute Trusts had the option of discontinuing the Dementia CQUIN

Older person's psychiatric liaison resource in hospital
There is no older person's psychiatric liaison resource at both St. Georges and at Epsom and St Helier for Merton residents. There is a Psychiatric liaison service that covers all age groups and the resource dedicated to older people at St Georges hospital is only for Wandsworth residents, the resource for older people at Epsom and St Helier is only for Sutton residents leaving a clear gap for Merton older residents

"Culturally appropriate" community activities for BAME
There are limited "culturally appropriate" community activities for BAME groups this was an expressed need by both commissioners and providers.

Theme 3: Considerations for the future Dementia Strategy 2015-2020

The Care Act 2014
A key future consideration is the Care Act 2014, which places a series of new duties and responsibilities on local authorities about care and support for adults. The personalisation agenda, which entails enabling individuals to have complete choice and control through receiving their own budget and deciding how they wish to spend it will have an impact on existing activities for people with dementia. Post-diagnostic supports needs to remain intact in light of influences from the personalisation agenda.

Building and developing effective links with new service developments
Ensuring effective links with new service developments such as the Community Dementia Nurse Specialists (DNSs), Better Care Fund (BCF), Holistic Assessment and Rapid Intervention(HARI).

2. The overarching themes from engagement with the carers of people with dementia and people with dementia were:
   i. A need for more respite care and crisis response options
   ii. Misinformation on options for those who are self-funding
   iii. A perception of limited availability of General Practitioners
   iv. Carer Privacy
   v. Improved post diagnostic support, sources, and methods of communication
   vi. The difficulty of conversations about End of Life Care (EoLC)

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3. The overarching themes from engagement with People with dementia were :
   i. Stigma around Dementia is still a real concern
   ii. EoLC remains a sensitive, contentions and challenging area
   iii. Improved shared care monitoring arrangements with Primary Care
   iv. Having no single individual to ring with concerns of dementia

[20] The dementia CQUIN aims to help identify patients with dementia and other causes of cognitive impairment, alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

Gaps and Recommendations

TABLE 1: GAPS AND RECOMMENDATIONS

	THE PICTURE IN MERTON & GAPS	RECOMMENDATIONS
PREVENTION	- The biggest cohort is those with Alzheimer's disease (62%) then vascular dementia (17%), which is modifiable by improving vascular health - The prevalence of dementia in BAME people aged 65 and over is 5.5%. This is a higher prevalence to the dementia (all ages, all ethnicities) in Merton of 0.9%. Targeted interventions towards BAME groups was a gap identified in the baseline review of the 2010 Local Dementia Strategy but little progress has been reported in this area	1. Consider implementing prevention of vascular risk factors with a focus on atrial fibrillation a. Consider targeted interventions at the BAME population as they have a higher prevalence of vascular disease and are more at risk of vascular risk factors b. Interventions could align with physical health services such as diet and nutritional advice and consider joint working practices between stroke services and dementia services
HEALTH AND SOCIAL CARE DELIVER AND COMMISSIONING	- More people are being identified in primary care ,the diagnosis rate is was 72% as at March 2015 and exceeded the national target of 67% - From 2011-2015 there has been a 49.3% growth in the number of referrals for dementia to the CMHT and a 42.5% growth in number of patients seen by the CMHT	2. Consider ensuring that there is sufficient capacity to meet with the increase in demand particularly in the Memory Assessment re-design that is underway in Merton, and all post-diagnostic support services. Also ensure that any service developments (in the Memory clinics) are in line with Memory Services National Accreditation Programme (MSNAP)[21] recommendations
	- People with Dementia and carers are not always aware of the different services and sources of information in Merton - The proportion of referral from GPs and Social Workers to the Dementia Adviser and Dementia Support Worker at the Dementia Hub is smaller than 4% in both services. - The provider landscape is changing due to the Better Care Fund (BCF), new MDT Locality teams, the Holistic Assessment Rapid Investigation (HARI) service, the Adult Social Care (ASC) Redesign and the new Community Dementia Nurses	3. Consider effectively promoting the services at the Dementia Hub, raising the profile and developing strong links between existing services i.e. a. The Dementia Hub and GPs and the Hub and social workers b. The Dementia Hub and other Voluntary Sector organisations in Merton c. The Holistic Assessment Rapid Investigation (HARI) service and the New Community Dementia Nurses
	- Sufficient data capture on size and caseload in relation to dementia While ASCOF has a placeholder for the dementia indicator, local solutions will be required to ensure efficient data collection - The data on dementia admissions with a primary or secondary admission of dementia was insufficient to compare the average length of stay (ALOS) between those with dementia and those without - A key theme from the Commissioner and	4. Consider improving information sharing across organisational boundaries and improving data collection on the size, protected characteristics[22], caseload and the costs in relation to people with dementia and their carers to inform planning and enable the assessment of equitable access. The specific areas in Merton include: a. Acute care data on people with a primary or a secondary diagnosis of dementia and ensuring that people discharged from hospital have their dementia diagnosis in

[21] Memory Services National Accreditation Programme (MSNAP), Standards for Memory Services http://www.rcpsych.ac.uk/quality/qualityandaccreditation/memoryservices/memoryservicesaccreditation/msnapstandards.aspx

[22] The protected characteristics in the Equality Act 2010 are Age, Gender/sex, Gender Reassignment, Disability, Marriage and civil partnership, Race, and Religion / belief

	THE PICTURE IN MERTON & GAPS	RECOMMENDATIONS
	Provider stakeholder engagement event was the need for improved information sharing across organisational boundaries	the discharge summary b. Dementia Hub data capture on service user ethnicity in both the Dementia Advisor (DAS) and Dementia Support Worker (DSW) and age of carers who use the DSW service. c. Adult Social Care service user data in the absence of ASCOF indicators d. Regarding information sharing consider developing systems locally for sharing information across different information capture systems particularly considering those who do not have access to RIO [23]
ASSESSMENT AND DIAGNOSIS, EARLY INTERVENTION AND TREATMENTS	- There is variation in relation to dementia diagnosis. The average diagnosis rate in East Merton is 57%, in Raynes Park is 78% and in West Merton the average is 68%. - The proportion of people with dementia (of all age groups) whose care plan has been reviewed in a face-to-face review with their GP in Merton is 83.6%[24] - There is a perceived limited availability of GPs as sources of information expressed through the qualitative research by both carers and people with dementia - According to analysis of Primary Care data on indicators relating to dementia and key dementia risk factors there are some Merton GP practices with relatively[25] ▪ Lower diagnosis rates ▪ Lower Face- to-face reviews of dementia patients ▪ Higher proportions of GP registered older people (people aged 65 and over) ▪ Higher hypertension and smoking prevalence (QOF) ▪ In addition, higher levels of deprivation. (See Table 7) - These practices have been deemed to be requiring more targeted support with improving dementia care and prevention and they are located in Cricket Green, Lavender Fields, Wimbledon Village and Ravensbury.	5. Consider: a. Reducing variation in dementia diagnosis rates between GP practices and localities as this could lead to health inequalities b. Improving the face-to-face reviews of people with dementia carried out in Primary care. c. Strengthening the role of primary care to ensure robust shared care monitoring arrangements for people with dementia and tackling the perceived limited availability of GPs d. Consider a plan of action for more targeted support to the areas identified through the Primary Care mapping, these are located in Cricket Green, Lavender Fields, Wimbledon Village and Ravensbury.

[23] An electronic service user Record system
[24] (QOF ID: DEM002) 2013/14
[25] In relation to other Merton GP Practices

	THE PICTURE IN MERTON & GAPS	RECOMMENDATIONS
EARLY INTERVENTION AND TREATMENTS	- The indicative number of people with early onset dementia in Merton in 2015 is 46 people[26]. While the cohort is small their needs are complex - There are more men than women with early onset dementia in Merton (i.e. people aged 30-64). In the younger age bands i.e. people aged 65 to 74, the dementia prevalence is higher in men than women	6. Consider developing a programme for the identification and early intervention of dementia in people of working age. a. To achieve economies of scale, consider developing pathways at a South West London sector level b. Bearing in mind that in early onset dementia the rate is higher in men, consider developing programmes around encouraging men to come forward with their symptoms and not attributing them to stress. The programme could incorporate help to sustain employment and be linked with NHS Health Checks[27]
LIVING WELL WITH DEMENTIA, AND DEMENTIA FRIENDLY COMMUNITIES	- The dementia prevalence is higher in BAME populations in Merton. It is estimated that 332 people (aged 65 and over) from BAME groups have dementia in Merton in 2015 - There is substantial anticipated growth of 56% in people aged 65 and over from BAME groups from 2015-2025 - There are limited "culturally appropriate" community activities for BAME groups	7. Consider sharing learning and good practice around dementia care for BAME populations. Also consider: a. Develop "culturally appropriate" community activities for BAME groups b. Consider developing South West London Partnerships for BAME service developments
	- There was an expressed need for out of hours crisis support (particularly around challenging behaviour).	8. Consider improving the availability, flexibility and responsiveness of respite care for carers of people with dementia to enable people to stay in the community longer. As residential care represents the largest segment of the dementia care budget, better provision of community support both for people with dementia and carers is a cost-effective way to enable people to live at home for longer, thus reducing the significant costs of residential care
	- Stigma remains an issue for people with dementia as expressed in the focus group	9. Consider tackling dementia stigma through increased education to all stakeholders (i.e. Health and Social Care, Commissioners and Providers and the Voluntary Sector). Also consider developing a joint work force development and training strategy
	- An overarching theme in the Dementia Commissioner and Provider Stakeholder engagement event was the need for a strategic shift from identification and diagnosis to ensuring good quality post-diagnostic support	10. Developing a strategic shift from the emphasis of increasing identification and diagnosis rates to improving post-diagnostic support and enabling people to live well with dementia

[26] POPPI

[27] The NHS Health Checks programme is for adults in England aged 40-74 and checks circulatory and vascular health as well as assesses the risk of getting a disabling vascular disease.

	THE PICTURE IN MERTON & GAPS	RECOMMENDATIONS
LIVING WELL WITH DEMENTIA, SUPPORTING CARERS AND DEMENTIA FRIENDLY COMMUNITIES	**Adult Social Care users with Dementia** - A crude direct comparison of the ethnic distribution of Merton borough in 2014 the ethnic distribution of all ASC service users with dementia in 2013/14 resident in Merton suggests that the Black and Asian ethnic groups with dementia are under represented in terms of ASC service access. In specific services: ▪ In Nursing Care- the data is suggestive that the white ethnic group is considerably over represented, the black ethnic group is marginally under represented and the Asian ethnic group is considerably under represented ▪ In Direct Payments- the data is suggestive that the white ethnic group is markedly under-represented, and Black and Asian people are marginally over-represented ▪ In Residential Care and Home Care - the data is suggestive that the white ethnic group is markedly over represented the black ethnic group is marginally under represented and the Asian ethnic group is markedly under represented. The data is suggests that there may be an issue regarding equitable access to ASC services for people with Dementia. **The Dementia Hub DAS and DSW users** - The Dementia Advisor Service (DAS) user data is suggestive that the 85 and over age group is under-represented and males aged between 65-74 are under-represented	11. Consider: a. Investigating further if there are access issues to Adult Social Care Services for the under-represented ethnic groups. b. Regarding the Dementia Hub consider increasing the reach on the Dementia Advisor Service (DAS) to people aged 85 and over and males aged between 65-74 and improving data capture on protected characteristics particularly ethnicity.
GOOD DEMENTIA CARE IN HOSPITAL AND LIAISON PSYCHIATRY	- There is no dedicated psychiatric liaison resource for older residents of Merton - There is a Psychiatric Liaison Service that covers all age groups but the resource dedicated to older people at St Georges Hospital is only for Wandsworth residents; the resource for older people at Epsom and St Helier Hospital is only for Sutton residents leaving a gap of an older person's resource for Merton residents	12. Consider a service development of a dedicated psychiatric liaison resource for older residents of Merton in the main acute trusts for Merton residents
	- Acute Trusts had the option of discontinuing the Dementia CQUIN and St. Georges reported that it would be discontinuing the Dementia CQUIN. It is however redesigning older people's	13. Consider ensuring the momentum in the main acute trusts for Merton residents in identifying assessing and referring people with dementia in light of changes to the CQUIN scheme

	THE PICTURE IN MERTON & GAPS	RECOMMENDATIONS
	services and incorporating a Frailty Model and Acute Senior User's Unit (ASHU)	
GOOD DEMENTIA CARE IN HOSPITAL	- There is a need to further investigate discharge processes for those with Dementia admitted into hospital to ensure seamless care i.e. ensuring discharge letters include the dementia diagnosis and social service re-set up after brief hospitalisation (less than 72hours) to ensure this is in line with best practice (at the time of the research the latter point was raised as a theme)	14. Consider investigating further the discharge processes for those admitted into hospital with dementia. In order to ensure that they are in line with best practice and that people with dementia receive seamless care.
END OF LIFE CARE (EoLC)	- None of the participants (n=39) in the focus groups reported having had a conversation with health and social care professional on the subject of their preferred place of care at the end of their life - There are misconceptions on how much advance care planning in End of Life Care (EoLC) a person with dementia can do particularly if they are self-funding	15. Consider improving advanced care planning, conversations around preferred place of care and End of Life Care (EoLC) discussions between clinicians (Particularly in Primary Care) and dementia patients and their carers