**INTRODUCTION**

There is a proposed exponential rise of people being diagnosed with dementia. Frontline care mainly provided by general practice. How can the primary care deliver a high quality service to meet the needs of patients in a sustainable way?

**METHODS**

Patients, their families and other stakeholders were engaged to identify problems and solutions within the current pathway. PSQA cycles, confidence interval and benchmarking were applied to measure outcome.

**RESULTS**

Helping patients come to terms with the diagnosis and support them to live the lives they choose within the boundaries of their diagnosis promotes independence and leads to fewer emergency consultations.

**DISCUSSION**

Working collaboratively, with secondary care and the voluntary agencies results in better outcome for patients and clinicians. Linking the surgery to memory care keeps patients on the radar. Effective signposting and early intervention help reduce crisis and keeping patients out of the surgery.

**CONCLUSION**

Dementia care delivered by general practice needs to be standardised. A robust pathway prevents gap in patient care. Additional training and support is required to ensure the right care, is provided to the right patient, at the right time for the best outcome.

**OBJECTIVE**

To embed dementia care into general practice from pre diagnosis, to the end of life with support provided in a familiar and local setting.

- Explore the disconnects in the current pathway
- Identify areas for improvement
- Implement and measure those changes
- Share our learning

**HOW?**

Dementia Advisor
- Employed by the surgery
- To identify patients
- Explore solutions
- Engage with both local and wider organisation

**RESULTS**

- Increase the recognition of dementia and the prevalence in the registered patient list
- Support patients and families once diagnosed by linking with the voluntary agencies. Older Peoples Mental Health, Adults Services and the wider community.
- Work with patients to find out what doesn’t happen or work for them and where we could improve to support them
- Identify a pathway of care within the general practice that supports patients
- Work with the wider community to support a dementia friendly environment
- Share knowledge within the practice

**DIAGNOSIS**

- Clearer pathway to diagnosis
- More awareness
- Early identification
- GP involvement

**PATIENT**

- Well informed patients understand what is to come, hence more likely to take the responsibility to conduct their own journey through the stages of the disease.
- To reduce emergency consultations and prevent the need for premature residential care.
- Patient can feel safe, supported and valued, which promotes independent, keeping active socially and physically.

**CONCLUSIONS**

Short term actions
- Maintain an active memory cafe with more to be set up soon.
- Improved communication across the services
- Setting up a social befriender service is underway with The Living Well Centre
- Missing person policy is being rolled out
- Working with other surgeons to improve practice on the basis of this dementia care pathway

Medium term actions
- Standardising care pathway as it is currently missing
- Raising it to the wider community
- Measure outcome in 12 months