Department of Health

health

Gippsland Dementia Plan 2011–2014

Department of Health (Gippsland)

State Government Victoria

Gippsland Dementia Plan 2011–2014

Department of Health (Gippsland)

Acknowledgement

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Contents

Executive summary

The *Gippsland Dementia Plan 2011–2014* has been developed to facilitate the provision of services that best meet the needs of people living with dementia, their families and carers in all settings. The specific objectives of the plan are:

- to provide direction to dementia policy and practice in Gippsland
- to improve coordination and access to services for people living with dementia and their carers
- to create client-focused services that go beyond program boundaries.

Dementia

Dementia is an umbrella term, used to describe a variety of symptoms that are associated with a progressive deterioration in a person's ability to think, learn and remember. Symptoms experienced vary, depending on the type of dementia and how far progressed the condition is, and will change over time as the condition worsens.

Dementia presents a complex and unique set of requirements for people with dementia and their carers. It is unique, as the condition affects carers of people with dementia as much as it affects those with the condition, with progressively greater demands placed on carers as the disease progresses.

To assist in maintaining quality of life for those with dementia and their carers, a complex service system has developed. Dementia-specific service networks are often complex and difficult to navigate. Further compounding this already difficult system is the changing need for different services at different stages of dementia.

Demand for dementia-related services

Within Gippsland, the prevalence of dementia is projected to increase, from 3837 in 2010 to 5944 in 2020, representing a 55 per cent increase. The increasing prevalence of dementia within the region is likely to result in increased demand for dementia-specific services. Combined with increasing life expectancy, this means that presentations of people with dementia will become increasingly complex, presenting a number of challenges to service providers within the region.

Considering the projected increase and complexity of dementia presentations, imposed over an already complicated service system, it is timely for the development of a Gippsland Dementia Plan to improve the provision of dementia-specific services within Gippsland.

Development of strategies for the Gippsland Dementia Plan

To develop the plan, an analysis of the strengths and weaknesses of the current dementia-specific service system was undertaken. The analysis involved an extensive consultation process within the Gippsland Region, revealing three key themes in relation to service limitations:

1. A lack of service coordination amongst dementia-specific service providers
2. A lack of access to dementia-specific services
3. A lack of knowledge and understanding of dementia as a condition, and how dementia services can assist people living with dementia and their carers.

To address these service limitations, and achieve the aims and objectives of the plan, the following strategies were developed. The strategies are grouped into two domains:

- **Building blocks:** Strategies within this domain are considered essential to the implementation of the remaining strategies, and will be implemented first.
- **Priority areas:** Strategies within this domain address the three key themes of service limitation (as outlined above), termed priority areas.

Domain one: Building blocks

- Service directory
- Education and training across the dementia-specific service continuum
- Pathway for dementia management
- GP pathway for dementia

Domain two: Priority areas

Priority area one: Service coordination

- Informal sessions between providers to support networking
- Dementia-specific complex care networks
- List servers/email lists for information distribution
- Central repository for available residential aged care services (RACS), respite beds and packages

Priority area two: Access and service provision

- Improved assessment processes (to reduce duplication)
- Flexible respite
- Development of resources/toolkits to support development of dementia-specific support groups
- Person-centred service delivery
- Indivdualised service plans driven by people with dementia and their carers
- Introduction of dementia-specific nurse practitioners

Priority area three: Knowledge and understanding

- Improve knowledge and understanding of the Dementia Behaviour Management Advisory Service (DBMAS) and Alzheimer's Australia Vic (AAV)
- Increased use and awareness of advance care planning (ACP)
- Increased knowledge and understanding of dementia within the Aboriginal community

1. Introduction

This section provides an introduction to the *Gippsland Dementia Plan 2011–2014* and the background to its development.

1.1 Background

Dementia describes a group of diseases that affect the brain and cause a progressive decline in the ability to think, remember and learn.1 In 2011, there are an estimated 69,000 people with dementia in Victoria. Of these people, approximately 47,000 live in Melbourne and 22,000 reside in the remainder of the state. It is predicted that by 2020, there will be some 98,000 Victorians with dementia, with about 67,295 in metropolitan areas, and 31,037 in regional and rural areas. In Gippsland, dementia is the second highest cause of disease burden,2 compared to Victoria as a whole, where dementia is ranked third for women and eighth for men as the cause of disease burden.

Dementia impacts both the person living with dementia and their families, carers and friends. In practice, people with dementia show a range of symptoms common to varying stages of dementia at any particular time. Along with timely assessment, knowledge of and access to the range of multidisciplinary, health, community and carer support and services, it is critical to ensure quality of life for people living with dementia and their carers and families.

Dementia care and support services are delivered via specialist dementia services, as well as mainstream services. Service provision is complex with a diverse range of providers including all levels of government, non-government organisations and private providers, and spanning multiple service sectors. Due to the unique nature of the experience of dementia, for example, the person's symptoms, their level of family and/or carer support, and quality of their living environment, not all services and/or care provided will be successful for all people. There are also specific challenges in regional areas, due to lack of service availability, limited access due to geographical location, waitlists and a reduced number of providers to deliver services. Understanding how to access the right services (navigating the service system) can be difficult and confusing. In order to address these issues in the Gippsland Region, the *Gippsland Dementia Plan 2011–2014* has been developed.

1.2 Objective of the Gippsland Dementia Plan

The objective of the Gippsland Dementia Plan is to provide overarching direction to dementia policy and practice in Gippsland to help create person-focused services that extend beyond program boundaries. The plan identifies gaps in service provision, and addresses these gaps with strategies to better meet the needs of people with dementia and their carers.

1 Australian Health Ministers Conference, *National Framework for Action on Dementia 2006-2010*, AHMAC, NSW 2006. <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-nfad-0610.htm, viewed February 2011>

2 Victorian Government, *Care In Your Community: Integrated Area Based Planning, Gippsland Trial*, Gippsland, 2006b.

1.3 Development of the Gippsland Dementia Plan

The Gippsland Dementia Plan was developed by KPMG on behalf of the Department of Health (Gippsland). The development process included the following stages:

- **Desktop review** incorporating:
  - a review of relevant policies and other documentation for Gippsland and Victoria in relation to dementia
  - a stakeholder survey in order to develop a high-level map of current services within Gippsland for people living with dementia and their carers
  - data review and analysis of existing epidemiological and activity data in relation to the changing population demographics and prevalence of dementia.
- **Service strengths and limitations** – an analysis of dementia-specific service strengths and limitations was undertaken based on individual stakeholder consultations, three stakeholder workshops held at Leongatha, Traralgon and Bairnsdale and consultations with people with dementia and their carers. Details of the consultations undertaken are outlined in Appendix B.
- **Strategy development** which incorporated the development of and validation of these strategies at a workshop with key stakeholders from across the Gippsland Region.

The process was overseen by the Project Steering Committee (outlined in Appendix C).

1.4 Outline of the Gippsland Dementia Plan

Section 1. Introduction provides an introduction to the development of the plan

Section 2: Summary of the *Gippsland Dementia Plan 2011–14* outlines the aims, objectives and summarises the strategies contained within the plan

Section 3: Dementia outlines the issues associated with dementia

Section 4: Strategies outlines the strategies that comprise the plan, including timelines for implementation

Section 5: Potential additional strategies and actions provides an overview of additional strategies and actions that do not fit within the plan, but may be explored if opportunities present for these strategies and actions to be implemented

Appendices

Appendix A: Development of the plan

Appendix B: Consultation schedule

Appendix C: Project Steering Committee members

Appendix D: Current services within Gippsland

2. Summary of the *Gippsland Dementia Plan 2011–2014*

This section provides an overview of the plan. Figure 1 outlines the plan's aims and objectives, identified gaps in services and the strategies developed to address them.

Figure 1: Summary of Gippsland Dementia Plan

Aim: To facilitate the provision of services that best meet the needs of people living with dementia, their families and carers in all setting

Objectives:

- To provide direction to dementia policy and practice in Gippsland
- To improve coordination and access to services for people living with dementia and their carers
- To create client-focused services that go beyond program boundaries

Priority area one: Service coordination	**Priority area two:** Access and service provision	**Priority area three:** Knowledge and understanding
Service gaps • Lack of awareness between service providers of what each service offers • Lack of understanding of how services fit together can best support people with dementia and their carers • Limited communication between service providers to support service coordination	**Service gaps** • Gaps between service provision/ providers • Challenges in the provision of individualised services to meet the needs of people with dementia and their carers • Lack of dementia-specific support groups for carers • Lack of flexibility in service provision for respite • Access issues for specialist services	**Service gaps** • Gaps in knowledge and understanding of diagnosis intervention and management by health professionals • Gaps in knowledge and management strategies of paid carers in the management of people with dementia • Lack of information for carers of people with dementia on what care is provided/what they are entitled to within packages • Significant amounts of information available – people not aware of where to locate it, receive too much information, information is not at the most appropriate time, or in a language that is not understandable for people • Limited use of coordinated information for the public
Strategies • Service directory • Dementia specific complex care networks • Informal sessions between providers to support networking • Central repository for RACS beds and packages • List servers/email lists for information distribution	**Strategies** • Individualised service plans driven by person with dementia and their carer • Person-centred service delivery • Flexible respite • Development of resources/toolkits to support the development of dementia specific carer support group • Improved assessment processes (to reduce duplication and repetition) • Introduction of dementia-specific nurse practioners	**Strategies** • Pathways for dementia management • Pathway for GP management of dementia • Education and training • Improve knowledge and understanding of DBMAS and AAV • Increased use of Advance Care Planning • Increased knowledge and understanding of dementia within the Aboriginal community

Source: KPMG

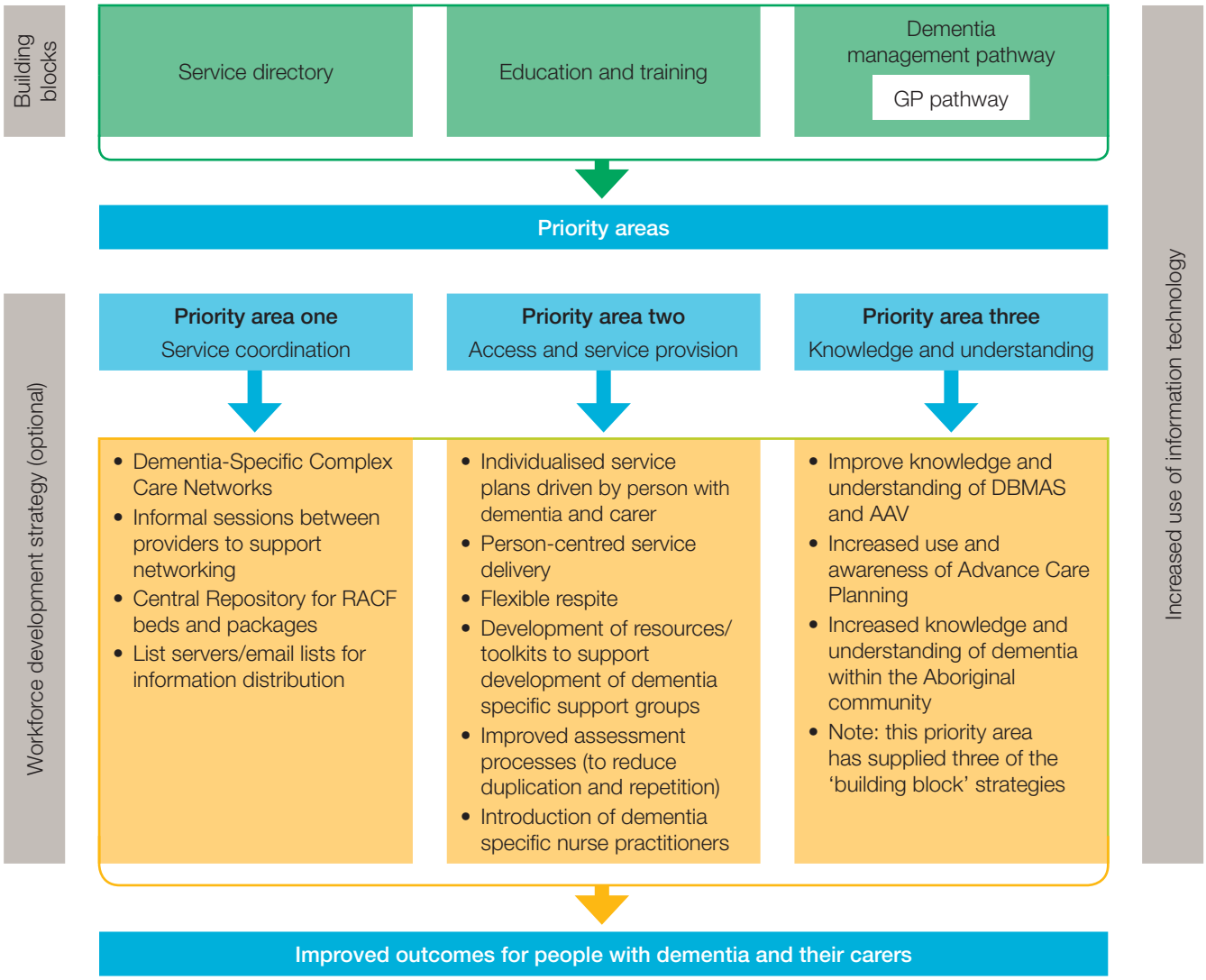
2.1 Strategy fit

During the consultation process, stakeholders provided input into how the strategies would best fit to effectively implement the Gippsland Dementia Plan. In response, the strategies have been arranged into two domains.

1. **Building blocks:** Each of the strategies within this domain were developed to address the service limitations as identified in Appendix A, and were originally included in one of the priority areas. However, during the consultation process, these strategies were identified as being essential to the development of the overall plan. Stakeholders stated that to effectively implement the remaining strategies, these strategies should be implemented first. These strategies have therefore been separated from the remaining strategies (outlined in the priority area domain), and grouped into this domain.
2. **Priority areas:** The remaining strategies (also developed to address the service limitations identified in Appendix A), continue to be grouped into the three priority areas identified during the gap analysis.

Figure 2 provides a high level graphical representation of the strategies and their position within the plan. The diagram also describes the use of a workforce development strategy and increased use of information technology. Information relating to these topics can be found in Section 5.

Figure 2: Gippsland Dementia Plan strategy fit



Source: KPMG

3. Dementia

This section provides an overview of dementia within Australia and its impact on people with dementia and their carers.

3.1 Dementia

Dementia is not considered to be a disease: it is an umbrella term used to encapsulate a variety of symptoms that either accompany or indicate the presence of certain diseases and conditions[3]. Dementia symptoms most commonly relate to a progressive deterioration in a person's ability to think, learn and remember[4]. The most common disease contributing to the symptoms of dementia is Alzheimer's disease, which accounts for more than half of all dementia cases[5]. Other conditions include vascular dementia, Parkinson's disease, Huntington's disease, Lewy Body disease, fronto-temporal dementia, alcohol-related dementia, and Down Syndrome[6].

Dementia can be characterised by four stages[7]:

1. Early stage - early difficulties, such as short term memory loss and word finding difficulties
2. Moderate stage – a reduced capacity for independence
3. Advanced stage – significant difficulties with activities of daily living
4. End stage – terminal phase and a high dependence on care

Dementia has a number of contributing risk factors.

Non-modifiable risk factors:

- Age is the most important risk factor for dementia with prevalence increasing exponentially after age 65 as outlined in Table 1.
- Autosomal dominant gene mutations have been identified for some rare causes of dementia. These account for only a small percentage of dementia cases, and usually result in younger onset dementia (diagnosed before 65 years of age).
- People with Down syndrome are at very high risk of developing Alzheimer's disease.
- A family history of dementia is associated with an increased risk. Those with a first degree relative with Alzheimer's disease have a two to three-fold increased risk of developing the disease themselves[8].

3 Dementia Care Australia, *What is dementia?* available from http://www.dementiacareaustralia.com/index.php/what-is-dementia.html

4 Australian Health Ministers Conference, National Framework for Action on Dementia 2006-2010, AHMAC, NSW 2006.

5 Access Economics, Keeping dementia front of mind: incidence and prevalence 2009-2050, Access Economics, Canberra 2009.

6 Ibid.

7 Australian General Practice Network, *Stages of Dementia*, available from http://www.agpn.com.au

8 Jarvik LF & Blazer D, 'Children of Alzheimer patients: an overview', *J Geriatric Psychiatry Neurology*, 2005, 18: 181-186

Table 1: Prevalence rates of dementia with increasing age

Age bracket	Prevalence rates	
	Male	Female
60–64	1.2	0.6
70–74	3.5	3.3
80–84	12.1	12.9
90–94	37.2	47.3

Source: Access Economics (2010): Projections of dementia prevalence and incidence in Victoria 2010-2050: Department of Health regions and statistical local areas

Increasing health and wellbeing

Due to the influence of non-modifiable risk factors, especially age and genetics, dementia cannot be definitely prevented, but there is growing evidence that addressing modifiable risk factors can reduce the risk or delay the onset of dementia. Epidemiological research shows that certain medical and lifestyle factors are consistently associated with a higher or lower risk of developing dementia. Regular physical, mental and social activity is associated with reduced dementia risk, while vascular risk factors are associated with increased dementia risk[9].

Modifiable risk factors associated with dementia risk include:

- Alcohol consumption
- Blood pressure
- Body weight
- Cholesterol
- Depression
- Diabetes
- Diet
- Head injury
- Mental activity
- Physical activity
- Smoking.

Encouraging active lifestyles and effective treatment of vascular risk factors therefore has the potential to reduce the risk of dementia among the population.

While there is no cure for dementia, addressing modifiable risk factors remains an important strategy for reducing the incidence of dementia.

9 Woodward M, et al. *Dementia risk reduction: the evidence*, Alzheimer's Australia, Canberra, 2007.

3.2 Prevalence of dementia

Dementia is considered to be the leading cause of disability in older Australians aged 65 years and over. It is one of the fastest growing sources of major disease burden, and is projected to overtake coronary heart disease in relation to total wellbeing costs by 2023[10]. Within two decades, dementia is expected to become the third greatest source of health and residential aged care spending, representing around one per cent of gross domestic product.

In Australia the incidence and prevalence of dementia is expected to rise significantly in the next 20 years. The total number of individuals presenting with dementia is projected to rise to approximately 590,000 by 2030, from around 257,000 in 2010[11]. Of note, a more rapid increase in prevalence rates is projected in regional Australia compared to capital cities, due to the faster ageing of regional Australia. It is important to note that 2010 is the first year that 'baby boomers' start turning 65, and will now begin working their way through age brackets with a greater risk of dementia (old age being the greatest risk factor associated with dementia). This is considered to be the main driving factor behind the increase in prevalence and incidence rates of dementia into the future.

More vulnerable communities, such as those from culturally and linguistically diverse (CALD) backgrounds and Aboriginal groups are also projected to experience increases in dementia prevalence. Specifically, CALD communities are projected to increase dementia prevalence significantly from 2010 (over 35,000) to 2030 (almost 62,000)[12]. This has substantial implications for the number of CALD-specific services required into the future. Amongst Aboriginal cultures, information in relation to prevalence of dementia is limited. Information that is available indicates the prevalence of dementia amongst Aboriginal communities is approximately 5.2 per cent, which is higher than the overall Australian population dementia prevalence rate (2.4 per cent).[13] An increased presence of risk factors amongst Aboriginal populations has been suggested as a contributing factor to the higher prevalence rates.

Within Victoria, the prevalence of dementia is projected to increase by around 86 per cent by 2030, from approximately 66,000 people in 2010 to in excess of 123,000 in 2030.[14] The Department of Health regions in Victoria with the highest number of cases of dementia in 2010 are the North and West and Southern Metropolitan Regions, with both regions having around 16,000 cases. In 2030, the North and West Metropolitan Region is projected to have the highest number (approximately 37,000) of dementia cases. For non-metropolitan regions, the Barwon-South Western Region has the highest number of people with dementia (5,500 cases), and is projected to remain the non-metropolitan region with the highest prevalence in 2030 (approximately 12,000 cases).[15]

10 Access Economics, *Keeping dementia front of mind: incidence and prevalence 2009-2050*, Access Economics, Canberra,2009.

11 Ibid

12 Ibid

13 Access Economics, *Keeping dementia front of mind: incidence and prevalence 2009-2050*, Access Economics, Canberra, 2009.

14 Access Economics, *Projections of dementia prevalence and incidence in Victoria 2010-2050*: Department of Health regions and statistical local areas, Access Economics, Canberra, 2010.

15 Ibid.

3.3 Needs of people living with dementia and their carers

Dementia not only affects the person living with the condition, but also their family and carers. Dementia is one of the main reasons why people seek community care or residential aged care and support.

Dementia presents a complex and unique set of requirements for people with dementia and their carers. People with dementia will have a range of different symptoms depending on the individual, the type of dementia, and the progression of the condition. This means that timely assessment and the knowledge of and access to the range of multidisciplinary, health, community and carer support and services are critical to ensuring quality of life for the person with dementia, their carers and families.

Many people with dementia continue to live within the community, with the support of family and friends. This creates challenges to those providing care and support to people with dementia. As dementia progresses, individuals providing care to people with dementia are required to provide increasing amounts of care and resources. Moreover, surrogate decision making may be required by carers on behalf of people with dementia. To ensure adequate support for the carer, respite and other carer support services are important parts of the overall dementia service offering.

It is also important to recognise the needs of people from more vulnerable backgrounds, such as those from CALD and Aboriginal communities. For people with dementia from these communities, services will need to be tailored across the dementia service continuum to ensure that cultural sensitivities are respected and that appropriate communication strategies and resources are in place and available. People in rural and remote areas, as well as younger people with dementia, also pose unique challenges to dementia services.

3.4 Complexity of service provision and supports

People with dementia and their carers have, in many cases, a multitude of services, programs and supports available to them. Services are provided by a range of different organisations, which include private providers, non-government organisations and governments at all levels. This contributes to a complex service environment, whereby services are delivered by mainstream and specialist providers, and across sectors including aged care, health, disability, housing and community services.

The unique nature of dementia; whereby a person's symptoms, type, and progression of their condition create differing needs; means that individuals will require a set of services that best meets their needs at a specified point in time. Certain service provision approaches will therefore not be suitable for certain individuals, increasing the complexity of decision making required to obtain an appropriate service. The living environment of the person with dementia and the level of support received from carers also dictate what level of services will be required. In addition, the services required to support people with dementia and their carers may change markedly over time, depending on the types of symptoms exhibited by the person with dementia.

Within regional services, a number of factors impact on dementia service provision. Some services are simply not available in certain areas, whilst in other areas, long waiting lists, a lack of service providers and geographical inaccessibility can all contribute to a service environment that does not meet the demands of people with dementia and their carers. A similar lack of availability of services can also affect those from CALD and Aboriginal backgrounds.

The complex nature of service provision for those with dementia can therefore lead to difficulty accessing and navigating the dementia service system. A more effective and efficient service system is required to ensure that service pathways are clear and more accessible to people with dementia and their carers.

3.5 Relevance for the Gippsland Dementia Plan

The following key findings from the above information are relevant to the Gippsland Dementia Plan.

- The prevalence of dementia is increasing in Australia
- Prevalence of dementia is increasing at a faster rate in regional Australia compared to metropolitan areas.
- People living with dementia present with specific care needs that change over time depending on the type and stage of dementia.
- The dementia service provision environment can be complex and difficult to navigate.
- Dementia-specific services must also address the needs of carers of people with dementia, due to the unique role they play as the condition progresses.

The Gippsland Dementia Plan includes appropriate actions and strategies to address these key findings.

4. Strategies

The Gippsland Dementia Plan has been developed to facilitate the provision of services that best meet the needs of people living with dementia, their families and carers in all settings. The strategies presented in this section outline the actions that if executed successfully, should achieve this aim.

The strategies have been arranged under two domain headings:

1. Building blocks

Strategies included in this domain are considered to be essential to the implementation of the overall plan. Without implementation of these strategies, priority area strategies are unlikely to be implemented effectively. Building block strategies provide the foundation which priority area strategies will use to build upon.

Priority areas

Strategies within this domain have been included to address the service gaps identified by stakeholders, grouped into the priority areas as outlined in the gap analysis (Section 6). The priority areas are:

- Priority area one: Service coordination
- Priority area two: Access and service provision
- Priority area three: Knowledge and understanding.

4.1 Building blocks

Stakeholders identified the strategies outlined below as requiring priority implementation. Strategies included in the priority area domain are unlikely to be successful without the foundation that a building block strategy provides. For example, to implement the dementia-specific complex care networks (strategy 1.1), participants would need a strong understanding of what services exist in the region, what stage of dementia the service is most relevant to, and a strong understanding of the needs of people with dementia at the various stages of dementia. Implementation of the service directory (strategy B1), pathway for dementia management (strategy B3) and the education and training strategy (strategy B3) would address each of these gaps in understanding respectively.

The following strategies are included within this domain:

B1 Service directory: a document, in online and paper format, that lists all dementia-specific and related services in the Gippsland Region.

B2 Education and training: a region- wide, comprehensive education and training program that addresses educational and training needs across dementia stages and the service continuum.

B3 Pathway for dementia management: will consist of a standardised pathway for referral and progression of people with dementia and their carers along the dementia service continuum within the Gippsland Region.

B4 GP pathway for dementia management: will consist of a standardised pathway for the referral and management of dementia patients by GPs.

Implementation of the service directory (strategy B1) should address the current lack of awareness of other dementia-specific services amongst service providers.

Both pathways for dementia management (strategies B3 and B4) should result in improved referral processes, more timely receipt of dementia-specific services and improved assessment processes for people with dementia and their carers.

The implementation of a region-wide education and training strategy (strategy B4) should lead to a more highly skilled (in relation to dementia) workforce, increased effectiveness and efficiencies amongst dementia-specific services, and improved outcomes for people with dementia and their carers.

It should be noted that the strategies in this section were originally developed to address the service gaps in priority area one (service directory) and priority area three (education and training, pathway for dementia management and GP pathway for dementia management).

Strategy B1: Service directory	
Considerations: Incorporating dementia pathways into the directory system **Enhancing existing directory and pathways systems, such as the Human Services Directory and Bendigo Health dementia management strategy, to be considered in developing this strategy.** **The service directory should be in an online and paper format** **There needs to be two service directories – one for the general population, one for service providers**	
Actions:	• Design of the directory must be user friendly. A paper form should be in a generic, easy to understand layout. • An appropriately targeted marketing strategy will be required to create awareness of the directory within the Gippsland Region • The directory should be regularly updated to ensure it remains relevant and accessible to the target audience • The directory must be relevant to regional needs
Anticipated outcomes	• Improved awareness amongst service providers and the public in relation to what dementia services currently exist • Greater numbers of, and more appropriate, referrals • An improved service continuum amongst dementia-specific services
Risks	• The service directory is inaccessible to its target audience • A lack of an appointed driver could result in the service directory becoming obsolete, due to an ongoing requirement for maintenance
Roles and responsibilities	• Requires a dedicated position to update the directory – this may be best sourced from Department of Health Gippsland • Designated roles will be required for initial set up
Timeline	• < 12 months
Performance monitoring	• Online hits (if service directory is in online form) • Referral traffic analysis • Reduced number of inappropriate referrals • Increased awareness of dementia-specific service options amongst service providers
Related strategies	• All strategies within the Gippsland Dementia Plan

Strategy B2: Education and training across the dementia-specific service continuum	
Actions:	• For optimal strategy execution, the service directory and pathway for dementia management should be embedded prior to consideration of this strategy • An appropriate and comprehensive region-wide education program should be considered that addresses all dementia-specific services, and the different stages of dementia • The mode of training delivery should be considered (such as online or group-based) • Provision of education should be matched to identified need within the Gippsland Region (use training survey results) • Different learning styles of individuals and groups must be taken account of in education delivery • Introduce a consistent competency framework • Depending on the implementation model, mandatory components of training may be introduced
Anticipated outcomes	• Increased understanding of dementia (such as recognition of symptoms, dementia stages, types, appropriate interventions and identification of complex needs) • Improved client care, with an associated decrease in stress and anxiety amongst people with dementia and service providers • Increased appropriateness of referrals • Targeted education/training within a variety of settings and disciplines • Staged approach to training • Improved staff retention • Improved professional recognition across disciplines
Risks	• Lack of buy in from management amongst various service providers • The targeting of education does not meet participants needs • Denial amongst service providers of training and educational needs • Successful execution may require a concurrent workforce strategy • Lack of funds to enable successful implementation
Roles and responsibilities	• It is likely that a working group will be required for successful implementation of this strategy. Key dementia training stakeholders should be included
Timeline	• < 12 months
Performance monitoring	• Feedback/evaluation forms related to individual sessions • Workforce survey annually • Annual competency mapping
Related strategies	• All strategies

Strategy B3: Pathway for dementia management	
Actions:	• Develop a sequence guide for referral and management of dementia, which specifies where each dementia-specific service fits along the dementia service continuum, providing an appropriate referral pathway. The pathway should articulate the levels of care and need at each stage. Entry points will vary along the continuum depending on individual circumstance • Determine clear boundaries for each dementia-specific service • Determine clear boundaries around who does the initial assessment for the person with dementia • Successful execution may require a patient-held history or record • Develop risk tools for people with dementia/carers/workers, either in an online and/or hard copy format, to facilitate decision making in relation to referring along the pathway • Development of the pathway must include an appropriate information dissemination/marketing plan
Anticipated outcomes	• Creation of an integrated dementia-related service pathway • People with dementia and their carers receive appropriate care at the appropriate time • Services recognise there are 'no wrong doors, but better doors' in relation to referral
Risks	• Services and individual providers do not relinquish ownership to enable referral • Lack of marketing/information dissemination leads to lack of awareness amongst services • Lack of buy in from service providers
Roles and responsibilities	• It is likely that a working group will be required, with members from a range of service providers, to develop the pathway and manage its implementation • The service directory will play an important role in informing the development of the pathway
Timeline	• < 12 months
Performance monitoring	• Online hits (assuming pathway is maintained online) • Referral traffic analysis • Agency data analysis (could include staff usage survey)
Related strategies	• All strategies

Strategy B4: GP pathway for dementia	
Actions:	• Develop a GP dementia pathway for the management and referral of people with dementia • Provide an education program for GPs to enable appropriate use of the pathway • Medicare locals to be utilised (when implemented) to reinforce the GP dementia pathway
Anticipated outcomes	• Increased understanding of dementia amongst GPs • More appropriate referrals for dementia assessment and other dementia-related services • Timely contact and assessment of clients, resulting in earlier diagnosis, and linkages to dementia-specific services • Improved client and carer outcomes, and a reduction in crisis admissions to acute facilities
Risks	• GP practices may be unwilling to use the pathway due to the associated time and opportunity cost • Ability of GPs to attend education sessions in relation to dementia and the use of the pathway may be limited • GPs do not fully recognise the longer-term benefits associated with use of the pathway
Roles and responsibilities	• Geriatrician to draft GP referral pathway • Input from Division of GPs within the Gippsland Region and other relevant stakeholders
Timeline	• < 12 months
Performance monitoring	• Funded evaluation of the developed pathway • Referral traffic analysis (including metrics related to timeliness) • Reduction in crisis dementia-related admissions to acute facilities
Related strategies	• Service directory • Pathway for dementia management • Education and training

4.2 Priority area one: Service coordination

Strategies included in this priority area have been developed to address the specific gaps outlined by stakeholders related to service coordination, including: a lack of awareness amongst service providers of what each service offers; a lack of understanding of where services fit along the dementia service continuum; and a lack of communication between services resulting in poor service coordination.

The following strategies are included in this priority area.

1.1 Informal sessions between providers to support networking – to consist of sessions between dementia-specific service providers to facilitate the transfer of information and updates on the progress of patient caseloads (consisting of people with dementia and their carers).

1.2 Dementia-specific complex care networks – consisting of networks at an LGA level that include service providers across the spectrum of dementia-specific service providers. These networks are proposed to link into a higher level region-wide network, potentially comprising members from the Department of Health and other relevant organisations. The existing Gippsland Dementia Reference Group may fulfill this role. The network would therefore act to disseminate dementia-specific information; both up to a regional level and down to the local level.

1.3 List servers/email lists – creation of lists for electronic distribution of dementia-specific information, such as training and education and meetings.

1.4 Central repository for available RACS, respite beds and packages – an online repository containing an up-to-date list of currently available RACS beds and care packages, specifically for people with dementia and their carers.

Strategies 1.1 and 1.2 both seek to improve awareness amongst service providers about what dementia-specific services are provided within the region, how they can best work together to improve outcomes for people with dementia and their carers, and provide a forum to encourage communication between service providers.

Strategy 1.3 aims to inform service providers throughout the region of upcoming events and dementia-related information. In doing so, it should provide a common communication channel for service providers, increase awareness in relation to the availability of dementia-specific services, and create opportunities for service providers to improve their understanding of how services fit together. Strategy 1.4 seeks to improve coordination amongst services in relation to the allocation of packages and RACS beds. Both strategies should ultimately improve outcomes for people with dementia and their carers.

Strategy 1.1: Informal sessions between providers to support networking	
Actions	• Map current networks and utilise/develop where appropriate to avoid duplication • Define an appropriate framework for networking sessions, including how to gain support within the dementia services sector. Formalisation may be required to ensure appropriate function of the networks • Identify stakeholders required for participation • Successful execution will likely require an appropriate communication/ marketing strategy
Anticipated outcomes	• Reduced duplication of services • Improving and building relationships amongst dementia-specific service providers • Peer support/debriefing • Identify training and educational needs • Improved service coordination
Risks	• Developed networks may fail to meet their intended purpose • Lack of engagement by stakeholders • Lack of awareness of networks leading to poor participation rates
Roles and responsibilities	• A driver will be required to lead, coordinate and maintain the networks and any associated marketing strategy
Timeline	• 12–24 months
Performance monitoring	• Attendance at network meetings • Outcome measures • Referral traffic analysis
Related strategies	• Education and training • Service directory

Strategy 1.2: Dementia-specific complex care networks	
Actions	• Existing networks should be mapped, to avoid duplication when developing new networks • Current examples of good practice should be built upon (example of complex care network in South Gippsland) • The developed network must be accessible. The use of technology aides should be harnessed to assist (for example videoconferencing such as skype, or teleconferencing facilities) • Determine required stakeholders for network participation • Consider utilisation of the Gippsland Dementia Reference Group • Develop terms of reference for the network, to determine the value proposition • The network will need a driver to maintain
Anticipated outcomes	• Service gaps experienced by people with dementia and their carers reduced • Reduced duplication of service provision and assessment • Maximise service outcomes for clients and carers • Positive workforce outcomes – professionals should feel more supported. This may also lead to improved workforce retention • Network may create a catalyst for local research
Risks	• Duplication of existing networks • Loss of interest in the network, associated with a decline in participation and effectiveness. To mitigate this risk, a 'team of champions' – with clear roles and responsibilities could be created • The network is ineffective • The network is not allocated sufficient attention/time by stakeholders. Lack of resources within organisations may be a contributor
Roles and responsibilities	• A person will be required to coordinate and maintain the network. This role could be filled from a variety of service providers. Dependent on the nature of the network, a number of drivers may be required to coordinate the various feeder networks • Stakeholders to be identified for participation in the network
Timeline	• 12–24 months
Performance monitoring	• Attendance at networks • Frequency of meetings • Improved client outcomes (measured through feedback or outcome measures) • Evidence-based research opportunities are realised
Related strategies	• Improved assessment processes (to limit duplication) • Education and training • Pathway for dementia management • Individualised service plans driven by the person with dementia and their carer

Strategy 1.3: List servers/email lists distributing information relating to dementia within the Gippsland Region (including education and training opportunities/service information/meetings)	
Actions	• Review the existing list (Infoxchange) to identify current stakeholder participation • Ensure key stakeholders are included and/or added to the lists • Determine what information will be disseminated via the lists • Ensure all appropriate dementia-related education and training information is received from all relevant organisations, to be distributed through the list server/email list. The list/s should aim to be the primary source of information for upcoming training and education courses, meetings and service information, and will act as a central repository for all dementia-related information within the Gippsland Region • The list will require ongoing maintenance, coordination and updating
Anticipated outcomes	• Increased education and knowledge amongst service providers should result in improved care and service provision to people with dementia and their carers, as well as the general public • Improved knowledge of what training and education courses are available, updated service information and meeting times/alterations • The list should improve equity of access to training, service information and education • Improved service coordination as a result of improved, up-to-date information about alterations to services and greater awareness of relevant meeting dates/times • Improved workforce retention due to greater engagement with the dementia-specific services sector
Risks	• The list is not updated, loses relevance and becomes obsolete • Organisations do not commit to using the list as their primary source of information for upcoming courses • Information received from multiple sources results in confusion (that is the list server/email list is not treated as the sole primary source of information) • Duplication of information
Roles and responsibilities	• A driver or central coordinator will be required to monitor and update the list server/email list
Timeline	• 12–24 months
Performance monitoring	• Repeat use of the workforce training survey • Attendance at advertised events • Feedback at training events specifically measuring how participants found out about the event • Number of participants on list, including number of read receipts from participants receiving emails
Related strategies	• Education and training • Service directory • Informal sessions between providers to support networking

Strategy 1.4: Central repository for available RACS, respite beds and packages	
Actions	• A process will be required to receive information from package and RACS providers to ensure real time information is received to enter into the repository • Consider utilisations of existing systems, such as infoxchange-packages and 'respite seeker' • Develop a platform/system to display information • Platform/system must be user friendly and easy to use • Service providers must be aware of the availability of the repository. A marketing strategy may be required to ensure stakeholder buy-in/usage.
Anticipated outcomes	• Improved transition processes between services and packages • Reduced time associated with searching for available beds and packages • Decreased stress for client and carer • Improved bed utilisation and more efficient sourcing of clients
Risks	• Private facilities may choose not to participate (commercial interests) • The repository is not updated
Roles and responsibilities	• A coordinator role will be required to update and maintain the repository
Timeline	• 12–24 months
Performance monitoring	• Person with dementia and carer feedback • Increased throughput and utilisation of services • Reduced waiting times • RACS data
Related strategies	• Pathway for management of dementia • Service directory • Person-centred service delivery • Identifying and supporting alternative strategies for respite to improve flexibility

4.3 Priority area two: Access and service provision

The strategies outlined in this section have been developed to address the identified deficiencies related to the accessibility of dementia-specific services, and the nature of dementia-specific service provision within the Gippsland Region. Specifically, strategies within this priority area aim to improve access to services for people with dementia and their carers, and improve service responsiveness to need.

The following strategies are included in this priority area.

2.1 Improved assessment processes (to limit duplication) – assessment processes are to be streamlined between organisations to ensure that the number of assessments performed on people with dementia are minimised

2.2 Identifying and supporting alternative strategies for respite to improve flexibility – respite services offered within the Gippsland Region are to be altered so as to match the person with dementia and carer need

2.3 Development of resources and or toolkit to support the development of dementia-specific carer support groups (includes formal and informal groups) – educational resources, toolkits and systems/platforms (amongst others) are to be developed to improve the quality and number of dementia-specific support groups

2.4 Person-centred service delivery: personal care services to meet individual need, developed in consultation with the person with dementia and their carer – services providing packages of care are to be encouraged to increasingly match care to need, with input from the person with dementia and their carer

2.5 Individualised service plans driven by the person with dementia and their carer – service plans are to be introduced that specifically identify the needs of the person with dementia and their carer

2.6 Introduction of dementia-specific nurse practitioners – dementia-specific nurse practitioners are to be introduced within the Gippsland Region, subject to funding and departmental guidelines

Strategy 2.1 should result in an improved and more streamlined process for assessing people with dementia. This should in turn lead to quicker and more appropriate referrals to dementia-specific services.

Strategies 2.2, 2.4 and 2.5 should result in services that are more tailored to the needs of people with dementia and their carers, that respond quicker to changes in need, and improve access to respite services for people with dementia and their carers.

Strategy 2.3 should provide carers with a platform to assist understanding of the dementia-specific service system, resulting in better access to services. The strategy should also improve a carers ability to match services to need. This should reduce gaps in services received by people with dementia and their carers, and ultimately improve outcomes.

Strategy 2.6 should result in a reduction of the time burden on GPs for the assessment and treatment of people with dementia, improve the quality and timeliness of delivery of information to the person with dementia and their carer, improve service coordination and better match dementia-specific services to need.

It is noted that many of the strategies included in this priority area require significant amounts of planning work, potential changes to funding guidelines and/or program regulations. These strategies have been allocated longer timelines for implementation to reflect this.

Strategy 2.1: Improved assessment processes (to limit duplication)	
Actions	• Dementia pathways and referral processes to be clearly defined • Determine the impact of guidelines for streamlining pathways between ACAS and HACC assessment services (HAS). This is already underway with the development of a memorandum of understanding for each LGA in Gippsland between ACAS and HAS. • Increase information sharing between service providers. Privacy and consent issues to be considered • Use of common screening tools, such as service coordination tool templates. • Use of common assessment tools to be considered, including appropriate tools for CALD and Aboriginal assessments • Information record to be held by client. This could be in paper or electronic (USB) form
Anticipated outcomes	• Reduced number and duplication of assessments • Improved service efficiency and effectiveness • People with dementia and their carer's stress and anxiety is reduced as a result of decreased assessment processes • People with dementia receive appropriate services at the appropriate time
Risks	• Lack of available and appropriate resources to drive the strategy • Lack of engagement by stakeholders • Lack of professional recognition and awareness amongst stakeholders of the developed assessment process • Reluctance of people with dementia to seek assessment • Problems with obtaining consent from the person with dementia for sharing of assessment information
Roles and responsibilities	• A working group will be required to implement the strategy
Timeline	• 24–42 months
Performance monitoring	• Reduced number of assessments performed on people with dementia • Increased use of S2S referral system • Feedback received from people with dementia and carer
Related strategies	• Individualised service plans driven by the person with dementia and their carer • Pathway for dementia management • Informal sessions between providers to support networking • Dementia-specific complex care networks

Strategy 2.2: Identifying and supporting alternative strategies for the provision of respite to improve flexibility (community and residential)	
Actions	• Determine an efficient and effective process to gather feedback from carers to determine need • Develop a process to coordinate available dementia residential respite services – this could be included in the Central RACS repository (Strategy 1.4) • Reorient respite service provision to respond to the carer and the person with dementia's need. Remove 'one size fits all' approach • Review current funding guidelines relating to the provision of respite • Increase flexibility for ACAS assessments for respite • Further explore opportunities with the Support for Carers Program and National Respite for Carers Program • Evaluate selected Gippsland respite facilities for effectiveness of respite service and client use by type
Anticipated outcomes	• Decreased carer stress and increased health and wellbeing • Increased social inclusion for carer • Improved understanding of dementia amongst service providers • Possible delayed entry into residential care • Improved transition process from the community into RACS
Risks	• Providers of respite resist change • Funding models do not allow changes to the current provision of respite services • Lack of clarity amongst service providers concerning the authority responsible for authorising changes to provision of respite
Roles and responsibilities	• A working group will be required that is likely to include members from RACS and higher level care packages
Timeline	• 24–42 months
Performance monitoring	• Feedback from carers • Improved client outcomes • Flexible respite offering
Related strategies	• Central RACS repository • Education and training • Service directory • Individualised service plans driven by the person with dementia and their carer • Flexible packages of care

Strategy 2.3: Development of resources and/or toolkit to support the development of dementia-specific support groups for carers (includes formal and informal groups)	
Actions	• Develop a booklet of services available to carers (link with service directory, strategy B1) • Provide a dementia guide for carers outlining the steps required for ongoing care • Develop and provide a variety of dementia-specific support group options for carers (such as email or online forums) • Provide regional opportunities for carers related to training/education
Anticipated outcomes	• Reduced carer stress and time wasting • Increased number and type of carer support groups • Improved carer linkages with services • Improved socialisation for carers
Risks	• Lack of updated information • Carer support groups do not respond to individual need • Lack of driver to support and coordinate the strategy • Carers are not aware of groups and are missed
Roles and responsibilities	• A driver will be required to ensure coordination of the strategy and updating of resources occurs • The driver may also involve key stakeholders such as AAV, Latrobe Community Health Service Carer Services and carer representatives
Timeline	• 12–24 months
Performance monitoring	• Increased group participation numbers • Increased number of groups • Improved carer engagement with services
Related strategies	• Service directory • Education and training • Pathway for dementia management

Strategy 2.4: Person-centred service delivery: care services to be developed to meet individual need, through individual consultation with the person with dementia and their carer	
Actions	• Service providers (including HACC) should be reviewed on an ongoing basis to ensure they continue to address identified need • Increase education for service providers to improve understanding of the needs of people with dementia at the different stages of dementia. Service providers will then have an increased ability to tailor packages to individual need • Improve advocacy for service providers to change regulatory requirements surrounding packages, to allow improved flexibility • Education of HACC providers to deliver services to people with dementia using an active service model approach
Anticipated outcomes	• Care services meet more needs of people with dementia and their carers • Improved outcomes for people with dementia and their carers • Decreased stress on people with dementia and their carers
Risks	• Inadequate funding leading to providers being unable to alter/increase packages, resulting in lack of flexible options • Package providers may not wish to participate in the process • Regulations may limit the ability to increase the flexibility of packages
Roles and responsibilities	• Service providers will have to drive person-centred care • A central coordinator from Department of Health Gippsland may be required to provide a driving and coordinating role to the strategy
Timeline	• 24–42 months
Performance monitoring	• Client and carer feedback
Related priority areas and actions	• Individualised service plans driven by the person with dementia and their carer • Pathway for dementia management • Central repository for RACS/packages • Education and training • Identifying and supporting alternative strategies for the provision of respite, to improve flexibility

Strategy 2.5: Individualised service plans driven by the person with dementia and their carer (held by the person with dementia and their carer)	
Actions	• The individual support packages model used by disability services could be considered as an example for strategy implementation • Increase education for people with dementia and their carers to improve the understanding of their needs at the different stages of dementia. This will assist people with dementia and their carers in determining what services they will require • Produce a standardised document across the Gippsland Region to document the service plan, to be kept with the person with dementia and/or carer
Anticipated outcomes	• Increased flexibility and responsiveness of care to the individual • Reduction in current package costs, due to a reduction in administration • Carer empowerment • Reduced need for communication with case manager
Risks	• Currently, approximately 15 per cent of package funds are used to administer packages. A reduction in this rate may reduce provider viability, especially within rural settings. • Level of carer capacity, relating to their cognitive and educational level
Roles and responsibilities	• It is likely that a significant amount of planning will be required for this strategy, and as such, a working group will be required with members from community service providers and the Department of Health
Timeline	• 24–42 months. A pilot may be required.
Performance monitoring	• Efficiency gains with current funding • People with dementia are able to stay at home longer • Improved usage of individual funding options
Related strategies	• Person-centred service delivery • Improved assessment processes • Education and training • Service directory

Strategy 2.6: Introduction of dementia-specific nurse practitioners	
Actions	• Roles and responsibilities of the nurse practitioner will need to be outlined at a departmental level, including funding arrangements • Location of nurse practitioners should be matched to demand for dementia services within the region • The nurse practitioner should be linked into relevant dementia networks to improve service coordination • The nurse practitioner should work closely with GPs to improve the timeliness and accuracy of dementia assessment, and provide an alternative for access/referral to dementia-specific services
Anticipated outcomes	• Increased access to dementia-specific services • Improved and more timely dementia assessment processes • Improved referrals and linkages to dementia-specific services • Decreased dementia-related workload on GPs • Improved client outcomes
Risks	• Demand for services provided may result in extensive waiting lists if there are insufficient nurse resources and availability • Lack of awareness of the service within the region may lead to underutilisation • Availability of suitable geriatrician supervision for nurse practitioners/candidates • Workforce constraints may hinder recruitment for the positions • Unsuccessful for Commonwealth funding grants
Roles and responsibilities	• A working group may be required to develop the appropriate implementation steps • Latrobe Regional Hospital is to take a leading role in implementing the strategy • It is likely that significant direction around guidelines and responsibilities for the role will be required from the Department of Health
Timeline	• 12–24 months
Performance monitoring	• Number of contacts with the dementia-specific nurse practitioner • Referral traffic analysis • An evaluation of the role may be required
Related strategies	• Education and training • Pathway for dementia management

4.4 Priority area three: Knowledge and understanding

The strategies included in this priority area have been developed to address the gaps within the Gippsland Region related to knowledge and understanding of dementia. As mentioned in section 8 and 9.1, strategies that were originally within this priority area have been included in the building block domain, as they were deemed by stakeholders as being essential to the implementation of the overall plan.

The strategies for this priority area are:

3.1 Increased use and awareness of ACP

3.2 Improved knowledge and understanding of DBMAS and AAV by service providers

3.3 Increased knowledge and understanding of dementia in the Aboriginal community

Strategy 3.1 has been developed to address the specific gaps identified by stakeholders in relation to the use of ACPs. The implementation of this strategy should result in increased understanding of ACPs, greater usage of ACPs amongst relevant service providers, and a better outcome for the person with dementia at end of life.

Strategy 3.2 specifically aims to address the lack of understanding of the services both DBMAS and AAV provide within the Gippsland Region. Both of these services were identified as examples of good practice, and are seen as important sources of dementia-specific information for people with dementia, carers and service providers. An increased understanding of these services by other service providers should therefore improve the knowledge and information of dementia within the Gippsland dementia-specific service environment, which in turn should improve outcomes for people with dementia and their carers.

Strategy 3.3 aims to improve the knowledge and understanding of dementia amongst Aboriginal communities. The strategy should result in improved access and use of dementia-specific services by the Aboriginal community, improved outcomes for Aboriginal people with dementia and improved awareness of dementia amongst Aboriginal communities.

Strategy 3.1: Increased use and awareness of ACP	
Actions	• Encourage a standardisation model to ACP in the region • Professional development opportunities to be introduced for ACP, targeting all key stakeholders. Education to be included in relation to dementia and end-of-life processes, with an emphasis that dementia leads to death • ACP (including enduring power of attorney issues) to be introduced at earlier stages of dementia • Link ACP information into a relevant network for appropriate information dissemination
Anticipated outcomes	• The wishes of the person with dementia are met • Carers/families have an opportunity to understand the wishes of the person with dementia • Staff are able to advocate for the person with dementia about end-of-life care decisions • Stress and anxiety associated with end-of-life processes are reduced • Improved understanding of carers/staff and people with dementia about the nature of dementia and it's end stage
Risks	• Family/staff/carers not comfortable with the clients decision • Lack of knowledge/understanding of the disease, resulting in underutilisation of ACP • Denial on the part of the client of dementia diagnosis
Roles and responsibilities	• May require a working group to ensure all actions are implemented
Timeline	• 24–42 months
Performance monitoring	• Reduced unnecessary admissions to acute care facilities for end-of-life patients
Related strategies	• Education and training • Pathway for dementia management • Dementia-specific complex care networks • Informal sessions to support networking

Strategy 3.2: Improve knowledge and understanding of DBMAS and AAV by service providers	
Actions	• Institute an intensive advertising program to raise awareness of DBMAS and AAV • Advertising strategies should focus on increasing community/public awareness of DBMAS and AAV • DBMAS/AAV to form strategic partnerships to increase effective use of resources and reduce duplication • Utilise the networks/agencies currently in place, and those implemented in previous strategies
Anticipated outcomes	• Increased knowledge, information and uptake of the services • Improved service coordination between the two services • Improved outcomes for people with dementia and their carers (especially concerning dementia assessment and early stage dementia needs)
Risks	• AAV and DBMAS may not be able to meet increased demand associated with successful implementation • Wait times may increase • Duplication of existing and newly implemented strategies
Roles and responsibilities	• DBMAS and AAV would be expected to lead the strategy
Timeline	• 12–24 months
Performance monitoring	• DBMAS and AAV should report on: • Increased referrals and source • Outcomes for people with dementia and their carers, including client satisfaction • Audit professional knowledge amongst service providers in relation to DBMAS and AAV
Related strategies	• Education and training • Pathway for management of dementia • Service directory • Informal networks • Dementia-specific complex care networks

Strategy 3.3: Increased knowledge and understanding of dementia within the Aboriginal community	
Actions	• Development of dementia-related education and training opportunities tailored specifically for Aboriginal communities/organisations • Development of dementia-specific information tailored to Aboriginal communities • Where relevant, dementia-specific services will be tailored to take account of cultural issues within Aboriginal communities • An awareness campaign to be instituted amongst Aboriginal communities to improve understanding of dementia, and the services available • Participation of members from Aboriginal organisations in dementia-related networks • The strategy may utilise aspects of the Gippsland HACC Aboriginal Plan 2011–2013
Anticipated outcomes	• Improved knowledge of dementia within the Aboriginal community • Increased awareness of dementia-specific services within the Aboriginal community • Improved culturally-specific dementia resources and services • Decreased stigma of dementia amongst the Aboriginal community
Risks	• Lack of a dedicated resource could result in the initiative losing momentum
Roles and responsibilities	• A coordinator, Aboriginal HACC regional development officer, may be required to coordinate and drive the information gathering and dissemination process • Gippsland Network for Aboriginal Disability and Aged Care is likely to take a leading role in the development of this strategy
Timeline	• 12–24 months
Performance monitoring	• Increased use of, and access to, dementia services by the aboriginal community • Improved outcomes of Aboriginal people with dementia
Related strategies	• Education and training • Pathway for dementia management • Informal sessions to support networking

4.5 Timeline for implementation

Proposed timeframe							
Strategy	**2011–H2**	**2012–H1**	**2012–H2**	**2013–H1**	**2013–H2**	**2014–H1**	**2014–H2**
B1 – Service directory							
B2 – Education and training							
B3 – Pathway for Dementia Management							
B4 – GP Pathway							
1.2 – Dementia-specific complex care networks							
1.1 – Informal sessions between providers to support networking							
1.3 – List servers/email lists							
1.4 – Central repository for RACS beds and packages							
2.1 – Improved assessment processes							
2.2 – Improved strategies to improve respite flexibility							
2.3 – Development of resources and toolkit for dementia-specific carer support groups							
2.4 – Person-centred service delivery							
2.5 – Individualised service plans							
2.6 – Introduction of dementia-specific nurse practitioners							
3.1 – Increased use and awareness of ACP							
3.2 – Knowledge and understanding of and DBMAS and AAV by service providers							
3.3 – Increased knowledge and understanding of dementia within the Aboriginal community							

H1= First half of calendar year H2= Second half of calendar year

5. Potential additional strategies and actions

5.1 Workforce development strategy

Throughout the consultation process, stakeholders repeatedly identified retention and recruitment of the workforce within dementia-specific services as a significant problem. As highlighted in section 6, workforce issues result in decreased quality and availability of services. To address this, many stakeholders suggested that a workforce development strategy should be considered. It was felt that the strategy would assist in the successful implementation of the overall Gippsland Dementia Plan. For example, the education and training strategy (strategy B2) would benefit from increased retention, as lower workforce turnover would result in more high level education opportunities. Those staff with greater knowledge of dementia could then be harnessed to impart their knowledge to others, creating a 'virtual cycle'.

The workforce development strategy would also complement the strategies in priority area one and two. Through improved retention of staff the workforce would maintain a greater level of service awareness and understanding of individualised need. This should lead to greater effectiveness and efficiency in service provision, improving the ability to successfully implement many of the strategies contained within this plan.

It is noted however that the formal development of this strategy will likely require significant investment, and is currently beyond the scope of this plan.

5.2 Information technology

Stakeholders identified that information technology should be used to increase the chances of successful implementation of many of the outlined strategies. Stakeholders outlined 'easy wins', which included the use of Skype and teleconferencing to increase participation in networks and other forums requiring stakeholder participation. It was noted that the use of these technologies is particularly relevant in the Gippsland Region, due to the travel distances, which in many cases is an impediment to participation.

5.3 Evaluation process

A number of stakeholders outlined the need to evaluate the implementation of the Gippsland Dementia Plan to determine whether the strategies were achieving their aims. The evaluation process would also seek to assess the success of individual strategies and create opportunities to address shortcomings experienced to date.

Stakeholders suggested that a yearly forum, comprising participants similar to those present at the validation workshop, may convene on a yearly basis to discuss the progress of the implementation of the plan.

The description of an evaluation process is out of scope in the development of the Gippsland Dementia Plan. The Department of Health Gippsland Region may wish to consider development of an evaluation process.

Appendix A: Development of the plan

This appendix provides the background and context to the development of the *Gippsland Dementia Plan 2011–14*. Current government policy initiatives and directions are outlined, including the relevance for the Gippsland Region. Gippsland-specific demographic information, including aging populations and prevalence of dementia, (both current and future projections) are included. Finally, region-specific plans and policies relevant to dementia services within Gippsland are examined.

A.1 Government policy and directions

A.1.1 Commonwealth policy and direction

In 2005 the Australian Government announced dementia as a national priority. At the same time, Australian health ministers jointly agreed to the development of the National Framework for Action on Dementia 2006–2010. The framework was developed in consultation with numerous stakeholders including people with dementia and their carers, peak bodies and service providers. A number of related government policies, strategies and programs were also used to inform the framework. These included:

- The National Action Plan for Dementia Care 1992-1997
- A New Strategy for Community Care – The Way Forward
- National Palliative Care Strategy
- National Plan for Improving the Care of Older People across the Acute Care Continuum
- National Health Workforce Strategic Framework
- The National Mental Health Plan
- Beyondblue, National Depression Initiative
- National strategy for an Ageing Australia.

The National Framework for Action on Dementia seeks to build on some of these established policy initiatives. It provides an overarching vision for Australia's dementia care and support system, including clear objectives and principles. It is supported by all Australian governments. The vision, objectives, principles and priorities for action of the framework are outlined below.

Vision

A better quality of life for people living with dementia and their carers and families.

Objectives

Australians working together to make a positive difference to the lives of people with dementia, their carers and families.

Australian governments, along with service providers and the broader community, working together to create an accessible, seamless pathway for people with dementia, their carers and families.

Principles

1. People with dementia are valued and respected. Their right to dignity and quality of life is supported.
2. Carers and families are valued and supported and their efforts are recognised and encouraged.
3. People with dementia, their carers and families are central to making choices about care.
4. Service responses recognise peoples' individual journeys.
5. All people with dementia, their carers and families receive appropriate services that respond to their social, cultural or economic background, location and needs.

6. A well-trained supported workforce delivers quality care.
7. Communities play an important role in the quality of life of people with dementia, their carers and families.

Priorities for action

Priority area 1: Care and support services that are flexible and can respond to the changing needs of people with dementia, their carers and families.

Priority area 2: Access and equity to dementia information, support and care for all people with dementia, their carers and families regardless of their location or cultural background.

Priority area 3: Information and education that is evidence-based, accurate and provided in a timely and meaningful way.

Priority area 4: Research into prevention, risk reduction and delaying the onset of dementia as well as into the needs of people with dementia, their carers and families.

Priority area 5: Workforce and training strategies that deliver skilled, high quality dementia care.

As part of this process, the Australian Government allocated more than $320 million over the period 2005–2009 to the initiative Dementia – A National Health Priority. A broad range of projects were funded under the initiative including:16

- programs, services and resources that provided direct assistance to people with dementia, and their families and carers
- training programs and resources for care workers and health professionals working with people with dementia
- dementia related research, including supporting collaborative approaches to research
- promoting prevention and screening, early diagnosis and early intervention for people at risk of, or in early stages of dementia.

Funding through the National Framework for Action on Dementia is also being used for the development of new assessment tools for those at risk and living with dementia. Additionally, the Australian Government continues to provide services and referral points for people with dementia and their carers through a number of programs, which include (but are not limited to):

- DBMAS
- HACC
- ACAS.

A.1.2 Victorian policy and directions

The Victorian Government's approach to supporting people living with dementia, their carers and their families is reflected in several policy documents. Guiding policies include:

- *Health Priorities Framework 2012-2022: Metropolitan Health Plan, Rural Regional Health Plan, Health Capital and Resource Plan*
- *Pathways to the future, 2006 and beyond: Dementia Framework for Victoria*

16 Government policy, viewed May 2011, at <http://www.health.gov.au/internet/main/publishing.nsf/Content/5F1EBB498DEC1E29CA25745B00829E38/$File/13.%20Government%20policy.pdf>

The *Health Priorities Framework 2012–2022* establishes the key outcomes, attributes and improvement priorities for the health care system. It provides a framework for planning and delivering an innovative, informed and effective health care system that is responsive to people's needs, now and in the future. Seven priorities are proposed to create a health system where people can live healthy and productive lives. The first four of these priorities target specific changes and improvements to our health system and the other three are essential underlying changes to allow the health system to work more effectively. The health services are to become more responsive to people's needs, better coordinated, more efficient, and more informed. In addition, the system needs greater capacity to deliver prevention, primary care and early intervention.

The framework's first application is through the Metropolitan Health Plan. The framework will next be applied in the Rural and Regional Health Plan and the Health Capital and Resources Plan, due for release later this year.

Pathways to the future, 2006 and beyond: Dementia Framework for Victoria, together with its implementation plan, sets out the priorities for policy and practice for the subsequent five to ten years. It seeks to promote the rights of people with dementia, support active living in the community, improve access to quality services, encourage creativity and innovation in flexible service delivery, and focus on the diverse needs and preferences of people with dementia.

The pathways framework builds on Victorian Government directions to better meet the needs of Victorians with dementia, and their families and unpaid carers. It seeks to:

- promote and protect the rights of older people with dementia
- support older people with dementia to live active and independent lives in their communities where possible and desired
- facilitate high quality accessible health and aged care services to support people with dementia, and their families and unpaid carers
- encourage creativity and innovation in flexible service delivery. This may involve the reconfiguring of service delivery models, and developing and refining service design
- focus on social connectedness, diversity and equity, including being responsive to the diverse needs and preferences of individuals in delivery of dementia services.

The strategies identified in the pathways framework centre around each of the four levels of dementia. These are outlined below.

A. Healthy and active living, which may assist in preventing or reducing the risk of dementia

- Promoting positive ageing and social connectedness.
- Meeting diverse needs such as those of Aboriginal and Torres Strait Islander (ATSI) communities, people who are homeless, people living in rural and remote areas, and people from culturally and linguistically diverse backgrounds.

B. Early stages on the dementia pathway

- Life planning
- Education and information
- Service development and enhancement
- Support for people with dementia and their carers

C. Middle stages on the dementia pathway

- Service development and enhancement
- Support for people with dementia and their carers
- Respite and residential accommodation
- Meeting diverse needs.

D. Late stages on the dementia pathway

- Transitions from living at home to residential care
- Service development and enhancement
- Support and counselling for families and carers
- Respite and residential accommodation.

The pathways framework also identifies common themes and individual needs that are evident along the pathway of dementia. Some of the needs and themes identified that relate to the Gippsland Dementia Plan include:

- support for people with dementia and their families and unpaid carers, including flexible respite and counselling information and resource materials
- participation of people with dementia and their families and unpaid carers in decisions about diagnosis, treatment and care
- training and education for all people involved in the care of people with dementia, including families and unpaid carers, service organisation staff, and volunteers
- research on risk reduction, prevention, treatment and care practices education of the general public and responsiveness, including community awareness and de-stigmatisation, community support and social connectedness
- appropriate care and management in hospitals of older people with complex needs and of people with cognitive impairment, including reducing the use of physical or chemical patient restraints which increase the risk of adverse events
- system interfaces/design, including:
  - awareness of a whole-of-government approach
  - improved screening and assessment processes
  - entry to a continuum of care system, which in the early stages offers an opportunity to build confidence in the system, and can reduce, at the middle and late stages, crisis management and premature admission to residential aged care
  - access to case managers to promote consistency of information, continuity of care and a smooth transition to residential care
  - fostering partnerships
  - implementation of collaborative models across all health sectors, including GPs.
- development of best practice evidence-based guidelines
- removing restrictions in the service system that can work against innovative practices, for example, Commonwealth Government guidelines
- protection of rights and interests
- providing consistency and equity of services across Victoria, including to rural and remote regions, for example, support, education and training.

People have diverse needs to be addressed, with particular strategies required to support them and their families and unpaid carers. People who may not find the service system particularly user friendly include:

- other diverse needs groups such as: people with Down syndrome and dementia; people with frontotemporal dementia; and people with younger onset dementia
- people living in rural and remote areas
- people from CALD backgrounds.

There are a number of other policies and programs that influence dementia care in Victoria.

- **Victorian Government's role in residential aged care – public sector policy directions**
  The Victorian Government has a significant role in the provision of public residential aged care in Victoria, particularly in rural areas. These are known as public sector residential aged care services (PSRACS). The Victorian Government is taking opportunities to foster and support this industry, while recognising the Commonwealth Government's responsibility for funding, regulating and planning residential aged care places.
- **Recognising and supporting care relationships for older persons policy** and **A Victorian charter supporting people in care relationships** promote recognition, respect and support for those in care relationships and their application in care planning, management and service delivery where appropriate. A carers recognition bill is being developed in Victoria.
- **2011 Victorian Families Statement – starting the discussion on what matters to families**
  This government statement refers to various factors shaping the lives of Victorian families including: how Victorians can stay healthy or manage an illness or disability, and how much time Victorians get to spend with friends, partners, parents and children.
- **Victorian Well for Life**
  Since 2003 this program, using health promotion principles, has focused on improving physical activity, nutrition and emotional wellbeing of older people who participate in HACC services, live in PSRACS, and live in public housing.
- **The Victorian HACC Active Service Model**
  This model is based on the premise that all clients have the potential to make gains in their wellbeing and that HACC services can improve their capacity to make gains. The approach is to strengthen good practice and build capability among service providers. The goal of the active service model is to assist people in the HACC target group to live in the community as independently and autonomously as possible. This initiative is to ensure that clients are able to gain the greatest level of independence they can possibly achieve, and equally, that they can be as actively involved in making decisions about their life as they can be – such as the type of services they receive and the goals they wish to achieve. This includes people with dementia.
- **Demonstration projects to produce dementia-friendly, physical, social and green environments in rural public sector residential aged care services (PSRACS)**
  It is widely recognised that the physical and social environment can have a significant effect on a person with dementia. These demonstration projects funded by the Department of Health are about bridging the gap between what is known and already practised by some providers regarding dementia-friendly environments, while also giving providers opportunities to create, or enhance, existing environments. The Dementia-friendly environments website (www.health.vic.gov.au/dementia) provides a guide to creating dementia-friendly environments in residential care.

A.1.3 Learnings from other regions in Victoria

There are a number of Victorian regions that have implemented dementia-specific plans from which the Gippsland Dementia Plan can learn from.

Loddon Mallee Regional Dementia Management Strategy

The Loddon Mallee Regional Dementia Management Strategy (RDMS) was first developed and published online in 2001 in response to local research, anecdotal evidence and dementia literature which highlighted that both people with dementia, their carers and service providers were not fully aware of information, supports and services available to them. It was identified that the lack of a comprehensive package of information for carers made the dementia pathway often disjointed and stressful. The RDMS is an online tool which contains resources for health professionals and carers of people with dementia to assist in the transition through the dementia-specific service continuum.

Content has since been updated to reflect evidence-based practice and includes resources developed through the Improving the Dementia Care Journey project which was funded centrally by the Department of Human Services. The main purpose of the RDMS website is to share evidence-based tools and resources with health professionals and to provide carers of people with dementia access to a comprehensive information resource that may assist their transition through the dementia journey.

Barwon-South Western Region Dementia Strategy

The Barwon-South Western Region Dementia Strategy was developed with regional health professionals in response to the regional, state and national priority to improve services for people affected by dementia. The aim of the strategy is to provide people with dementia a continuity of care throughout their journey of the dementia illness, creating appropriate transition from inpatient settings and to optimise community integration. The strategy is guided by key themes that were identified through regional consultation. These include: dementia education, service system development and coordination, dementia pathway planning and gaps in service.

The creation of a region-wide approach enables the coordination of services, programs and activities, education and treatment to be most effective. Flexibility of care will allow increased opportunities for people with dementia and their carers to access best practice models of care across the region, particularly for people who live in rural and remote areas.

A.1.4 Relevance for the Gippsland Dementia Plan

The above policy directions and jurisdictional dementia strategies provide an important basis for the development of the Gippsland Dementia Plan. It is timely for Gippsland to develop a dementia plan given the emphasis placed on dementia at a national level through NFAD and other Australian Government programs. Similarly at a state level the Victorian Health Priorities Framework 2012–22 and Pathways documents have set out priorities to better meet the needs of people with dementia and their carers with priorities including better supporting people with dementia to live active and independent lives, facilitating high quality accessible health and aged care services and encouraging creativity and innovation in flexible service delivery. These policy directions are highly relevant to the Gippsland Dementia Plan as they provide a clear understanding of the pathway for the person with dementia and supports that are required to improve this pathway.

A number of regions across Victoria have already started to tackle state and national priorities through the development of their own dementia plans and strategies. The regions of Loddon Mallee and Barwon-South Western have developed their own dementia plans in response to the state and national dementia priorities and the needs that were identified within their local communities. The dementia strategies within both these regions include evidence-based tools and resources to improve the continuity of care provided to people with dementia. The experiences of other Victorian regions in their dementia journey are important for the Gippsland Dementia Plan as they can provide shared learnings and reduce duplication.

A.2 Gippsland Region

This section provides an overview of the Gippsland Region and its demographics. The prevalence of dementia within Gippsland and relevant policies and plans identified for the development of the Gippsland Dementia Plan are also outlined.

Figure 3: Location of Gippsland within Victoria

Source: Victorian Government, Department of Primary Industries[17]

The Gippsland Region is located in eastern Victoria (Figure 3) and covers 41,538 kms,[18] representing over 18 per cent of Victoria's total landmass.[19] Geographically, Gippsland is diverse, with alpine regions, lake districts and significant tourist areas, such as Phillip Island and Wilson's Promontory. It contains areas of regional isolation, such as the towns of Omeo and Dargo, as well as the heavily industrialised Latrobe Valley.

Gippsland is comprised of six local government areas (LGAs) as outlined in Figure 4, including:

- Bass Coast Shire
- Baw Baw Shire
- East Gippsland Shire
- Latrobe City
- South Gippsland Shire
- Wellington Shire.

17 Victorian Government, Department of Primary Industries, viewed April 2011 at <http://new.dpi.vic.gov.au/agriculture/investment-trade/region-overviews/gippsland>

18 Victorian Department of Human Services, Gippsland region, viewed April 2011 at: <http://www.dhs.vic.gov.au/operations/regional/gippsland/regional-information>

19 Victorian Department of Health, Health Status of Victorians, Gippsland Health Online, viewed April 2011 at <http://www.health.vic.gov.au/healthstatus/gippsland/index.htm>

The main regional centres within Gippsland are Traralgon, Morwell, Moe, Sale, Bairnsdale and Warragul.

Figure 4: Map of Gippsland Region divided by LGAs

Source: Victorian Department of Planning and Community Development, Victoria in future, 2008: Gippsland Region

A.2.1 The population of Gippsland

The population of the Gippsland Region was estimated to be 265,990 in 2010.[20] The projected population in 2020 for the region is 294,997, representing a 10.91 per cent increase over 10 years.[21] Population growth is not uniform across the region. The highest growth in population is within the Bass Coast and Baw Baw LGAs, which may reflect their proximity to Melbourne, whilst Latrobe City represents the lowest growth within the region, at 4.1 per cent over ten years. Table 2 outlines the current and projected Gippsland regional population, broken down by LGA.

20 Australian Bureau of Statistics, Estimated Resident Population, viewed April 2011 at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02009?OpenDocument>

21 Victorian Department of Planning and Community Development, Victoria in future 2008: Gippsland Region, viewed April 2011 at <http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/victoria-in-future-2008>

Table 2: Population within the Gippsland Region (all ages)

LGA	2010	2015	2020	Percentage change (2020 vs 2010)
Bass Coast	30,974	33,949	37,620	21.5
Baw Baw	42,921	46,883	50,957	18.7
East Gippsland Shire	44,262	47,424	50,652	14.4
Latrobe City	76,144	77,732	79,281	4.1
South Gippsland Shire	28,079	29,207	30,369	8.2
Wellington Shire	43,610	45,363	46,118	5.8
Gippsland Region total	265,990	280,125	294,997	10.9

Source: Australian Bureau of Statistics, Estimated resident population, and Victoria in future, 2008, Gippsland Region[22]

Ageing population

The Gippsland Region's demographics are changing, including the ageing of the population. In 2009, the estimated percentage of the population within Gippsland aged over 65 was 17.4 per cent, 23 whilst in 2021 this percentage is expected to increase to 25 per cent.24 Table 3 reveals that the percentage of the population over 65 within the Gippsland Region is substantially higher than that of Victoria, both currently and estimated in the future. Considering that the incidence of dementia increases with age, this suggests that demand for dementia services within the Gippsland Region will be higher on a per capita basis than in other parts of Victoria.

22 Note: 2010 estimated population data taken from the ABS was used as the base year, on which the Victoria in future projected population percentage growth was then applied over a five and ten-year period.

23 Australian Bureau of Statistics, Population by Age and Sex, Regions of Australia, 2009, viewed April 2011 at <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02009?OpenDocument>

24 Victoria in future, 2008, Gippsland Region, viewed April 2011 at: <http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/victoria-in-future-2008>

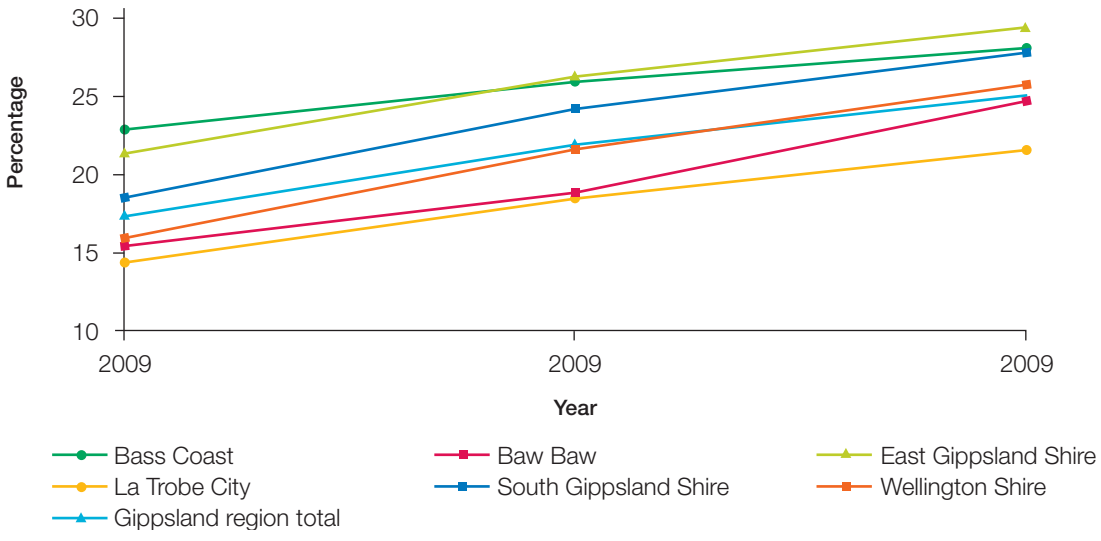
Table 3: Population over 65 in Gippsland

LGA	2009		2016		2021	
	Total number of people over 65	Percentage of population over 65	Total number of people over 65	Percentage of population over 65	Total number of people over 65	Percentage of population over 65
Bass Coast	6,752	22.8	8,958	25.9	10,721	28.1
Baw Baw	6,410	15.5	8,651	18.9	10,547	21.2
East Gippsland Shire	9,363	21.5	12,557	26.3	14,984	29.4
Latrobe City	10,856	14.4	13,887	18.6	16,465	21.6
South Gippsland Shire	5,148	18.5	6,941	24.2	8,302	27.8
Wellington Shire	6,896	16	9,599	21.7	11,775	25.7
Gippsland Region total	45,425	17.4	60,593	22	72,793	25
Victoria	738,131	13.6	945921	15.9	1,106,645	17.5

Source: Australian Bureau of Statistics, and Victoria in future, 2008: Gippsland Region

There are four LGA regions within the Gippsland Region projected to have more than a quarter of their residents aged over 65 by 2021, with the East Gippsland Shire LGA projected to have the highest proportion of residents aged over 65, at 29.4 per cent (Table 3). The high number of residents over 65 within this region should be considered in the context of overall demand for aged care services, noting that aged care service provision may suffer from resource constraints, placing extra pressure on resource allocation for dementia-specific services. Figure 5 displays graphically the increases in those aged over 65 in each region from 2009 to 2021.

Figure 5: Percentage of persons aged over 65 in the Gippsland Region, 2009-2021



Source: Australian Bureau of Statistics, and Victoria in future, 2008, Gippsland Region

Figure 5 demonstrates that two LGA regions, Baw Baw and Latrobe city, have lower proportions of their population aged over 65 than the Gippsland Region total. Baw Baw LGA's proximity to expanding populations within Melbourne and the location of the main population centres within the Latrobe City LGA (where younger populations would be more likely to reside) may explain this finding. Allocation of resources for dementia services may need to take into account the differences in potential demand, as associated with age, in different LGAs.

Vulnerable and disadvantaged populations

Socioeconomic status

Socioeconomic index for areas (SEIFA) scores measure different aspects of an area's socioeconomic status. There are four different categories of SEIFA score: this report utilises the index of relative socioeconomic disadvantage (IRSED) scores, which focus on levels of disadvantage, combining variables such as low income, low educational attainment and unemployment.[25] The average score across Australia is 1000: scores below 1000 indicate relative disadvantage, while scores above indicate relative socioeconomic advantage.[26] Decile scores give a rating of IRSED within Victoria, with one representing the lowest ten per cent, two the next highest ten per cent and so on. IRSED scores within Gippsland are outlined in Table 4.

Table 4: IRSED scores within Gippsland Region by LGA

LGA	SEIFA (IRSED) score	Decile (within Victoria)
Bass Coast	979	4
Baw Baw	1001	6
East Gippsland Shire	963	2
Latrobe City	951	1
South Gippsland Shire	1001	6
Wellington Shire	978	4
Gippsland Region (average)	979	3.8

Source: Australian Bureau of Statistics

IRSED scores demonstrate that the Gippsland Region is disadvantaged, with an average score for the region of 979. LGA's within Gippsland are more disadvantaged than others. For example, Latrobe City is the most disadvantaged LGA within the region, being in the lowest decile within Victoria, whilst Baw Baw and South Gippsland Shire have IRSED scores very close to the average. Socioeconomic disadvantage is associated with poorer health outcomes[27], which in turn are associated with risk factors for dementia. This may indicate that Gippsland's level of relative disadvantage may contribute to higher incidence and prevalence rates of dementia in the region.

25 Australian Bureau of Statistics, SEIFA: Socio-Economic Indexes for Areas, viewed April 2011 at <http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Seifa_entry_page>

26 Ibid.

27 NSW Health Socioeconomic status viewed July2011 at <http://www.health.nsw.gov.au/publichealth/chorep/ses/ses_intro.asp>

Aboriginal and CALD population

The Aboriginal population within Gippsland was 3076, (as measured by the 2006 census), comprising 1.2 per cent of the total 2006 Gippsland regional population.[28] This is higher than the overall Aboriginal population (as a percentage of the population) within Victoria, measured in 2006 at 0.6 per cent.[29] Of note, the East Gippsland Shire LGA has the highest proportion of Aboriginal persons as a percentage of the population, at 2.8 per cent, which is significantly higher than any of the other LGAs within the Gippsland Region. This suggests that demand for dementia-specific services for Aboriginal people may be higher in the region's east, due to the higher populations of Aboriginal people. Table 5 outlines the total Aboriginal population in 2006 by LGA in Gippsland.

Table 5: Aboriginal population in the Gippsland Region (2006)

LGA	Total number of Aboriginal persons	Percentage of population
Bass Coast	160	0.6
Baw Baw	354	0.9
East Gippsland Shire	1143	2.8
Latrobe City	871	1.2
South Gippsland Shire	123	0.5
Wellington Shire	431	1.0
Gippsland Region	3076	1.2

Source: Gippsland Aboriginal Services Plan, 2010-2011

Within the Gippsland Region, CALD populations comprised 5.9 and 6.2 of the total Gippsland population in 2001 and 2006 respectively[30] (Table 6). The highest percentage of CALD populations was recorded in the Latrobe City LGA (8.1 per cent in 2001 and 8.0 per cent in 2006). Of note, a significant proportion of CALD populations in the Gippsland Region are aged 65 and over (33.3 per cent in 2006), significantly higher than the overall Gippsland Region population aged over 65 (17.4 per cent in 2009). This is especially so in the Bass Coast LGA, where in 2006, almost 40 per cent of the CALD population are aged over 65[31]. As the prevalence of dementia increases with age (as shown in Table 7), it is reasonable to conclude that the CALD population within Gippsland will demonstrate a higher prevalence rate of dementia than non-CALD populations. This has implications for dementia services within the region, as services provided to CALD communities may require different resources (such as interpreters and culturally appropriate services).

28 Victorian Department of Human Services, *Gippsland Aboriginal Services Plan (2010-2011),* viewed April 2011 at <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/431591/Gippsland-Aboriginal-Services-Plan-2010-2011.pdf>

29 Department of Human Services Gippsland Region, 2008, Aboriginal Statistical profiles

30 Gippsland Multicultural Services *CALD communities in Gippsland* Viewed April 2011 at <http://culturaldiversity.com.au/component/content/article/12-content/80-seminarconference-presentations>

31 Ibid.

Table 6: CALD populations in the Gippsland Region 2001-2006.

LGA	CALD population		Percentage of total LGA population		Over 65		Percentage of over 65 in CALD population	
	2001	2006	2001	2006	2001	2006	2001	2006
Bass Coast	1428	1813	5.6	6.6	529	714	37	39.4
Baw Baw	1697	1973	4.7	5.1	440	572	25.9	29
East Gippsland Shire	1802	2054	4.6	5.0	511	734	28.4	35.7
Latrobe City	5724	5784	8.1	8.0	1706	2016	29.8	34.9
South Gippsland Shire	1336	1497	5.1	5.6	399	513	29.9	34.3
Wellington Shire	2178	2352	5.3	5.7	461	604	21.2	25.7
Gippsland Region	14165	15473	5.9	6.2	4046	5153	28.6	33.3

Source: Gippsland Multicultural Services

A.2.2 Prevalence of dementia in Gippsland

The prevalence of dementia in Gippsland is increasing. Table 7 outlines the prevalence and projected prevalence of dementia by LGA within Gippsland

Table 7: Prevalence of Dementia within Gippsland Regio

LGA	2010		2015		2020		Percentage increase in dementia prevalence (as a percentage of the population) 2010 to 2020
	Total number of people with dementia	Percentage of population	Total number of people with dementia	Percentage of population	Total number of people with dementia	Percentage of population	
Bass Coast	567	1.8	715	2.1	860	2.3	25.1
Baw Baw	560	1.3	736	1.6	933	1.8	40.8
East Gippsland Shire	772	1.7	985	2.1	1232	2.4	39.7
Latrobe City	922	1.2	1155	1.5	1391	1.8	44.6
South Gippsland Shire	424	1.5	524	1.8	622	2.1	35.8
Wellington Shire	592	1.4	749	1.7	906	2.0	44.1
Gippsland Region	3837	1.4	4864	1.7	5944	2.0	39.6
Victoria	65,669	1.2	81,393	1.4	98,332	1.6	31.4

Source: Access Economics: Projections of dementia prevalence and incidence in Victoria 2010-2050, and Victoria in future 2008

Table 7 indicates that the increase in prevalence of dementia within the Gippsland Region between 2010 and 2020 to be almost 40 per cent. The Bass Coast LGA is projected to have the lowest percentage increase (25.1 per cent) in dementia prevalence as a percentage of the population over the examined time frame, which is significantly below the total Gippsland Region increase. All other LGAs have percentage increases of dementia prevalence, as a percentage of the population, within range of the Gippsland Region's total increase. The East Gippsland Shire LGA is projected to have the highest prevalence of dementia as a percentage of the population (2.4 per cent) in 2020[32].

When compared to the percentage of the population with dementia in the state of Victoria, Gippsland has a higher percentage of people with dementia (at a regional and LGA level), at each of the years used for comparison (Table 7). It is also noted that the rate of increase of dementia (as a proportion of the population) is higher in the Gippsland Region (39.6 per cent) compared to Victoria (31.4 per cent). Only the Bass Coast LGA displayed a rate of increase of dementia as a proportion of the population that was lower than the Victorian rate[33]. This finding suggests that the Gippsland Region may have a greater future need for dementia services per capita compared to Victoria as a whole.

A.2.3 Relevant policies and plans

Within Gippsland, there are a number of policies and plans relevant to the provision of dementia-specific services. These include the *Gippsland Regional Plan 2010-11*(Department of Health), and the Gippsland subacute service review.

The Gippsland Regional Plan outlines the actions to be taken to achieve the Victorian Department of Health's strategic objectives. The plan has a particular focus on[34]:

- service development activities, including the implementation of the acute service model and the assessment framework associated with the HACC program
- Aboriginal health and services: the plan aims to improve the health and wellbeing of Aboriginal people in Gippsland through the implementation of the Gippsland Close the Health Gap Plan. The development of a new HACC Aboriginal plan aims to improve community care services for Aboriginal people
- partnership approaches to service system planning and integration
- workforce development and training.

As many of the focus areas are system based, such as workforce development and developing partnership approaches across services, dementia-specific services are likely to be included in many of these initiatives, and hence should benefit from the implementation of the plan.

The *Gippsland subacute service review*, published in 2010, presents a number of findings relevant to the Gippsland Dementia Plan. These include[35]:

- wait times for subacute ambulatory services are noted to be up to six months for CDAMS and six months for falls and mobility clinics

32 Access Economics, *Projections of dementia prevalence and incidence in Victoria 2010-2050*, Access Economics, Canberra and Victoria in future 2008 website

33 Ibid.

34 Department of Health, *Gippsland Regional Plan 2010-11*, Department of Health, Gippsland, 2010.

35 Department of Health, *Gippsland subacute services review – final report*, Department of Health, Gippsland, 2010.

- the current levels of utilisation of geriatric evaluation and management services is closely matched to demand across the region, however there is an expectation that demand will increase in the future
- levels of complexity of inpatients within subacute services are considered to be similar to the statewide average.

The findings from the subacute review of services suggest that outpatient-based subacute ambulatory care services have difficulty meeting demand inpatient demand appears to be met by the provision of services. However, with projected increases in prevalence of dementia and age in the Gippsland Region, it is possible that demand may exceed capacity in the future, with increasingly complex presentations.

It is important to note that in response to the current waitlists that exist for the CDAMS clinic, a recommendation has been made that provision of the clinic occurs within a partnership arrangement with West Gippsland Healthcare Group, to increase capacity and coverage across the region. In addition it identifies, as a priority for the region, a CDAMS clinic at Latrobe Regional Hospital in the future.

A.2.4 Relevance for Gippsland Dementia Plan

The key themes relevant to the Gippsland Region from this section are outlined below.

- The Gippsland population has a higher proportion of people aged over 65 years, and a higher population of people with dementia than the whole of Victoria. Further, Gippsland is projected to increase both of these levels at a faster rate than the whole of Victoria, suggesting an increased demand for dementia-specific services within the region both now and into the future.
- Within Gippsland, LGAs demonstrate varying levels of ageing populations and prevalence of dementia. Bass Coast and East Gippsland LGAs have the highest ageing populations and rates of dementia in the region, both currently and projected into the future, which suggests that dementia-specific services will experience greater demand in these LGAs than the rest of the region. Different levels of demand within different LGAs will also have implications for the location of dementia-specific services.
- A higher proportion of the CALD population is aged over 65 compared to the non-CALD population in Gippsland. As age is the most significant risk factor for the development of dementia, it is likely that prevalence of dementia will be higher amongst these communities in Gippsland. This may mean that demand for CALD-specific dementia services may increase.
- Policies specific to the region may assist those people with dementia and their carers.
- Demand for subacute ambulatory services exceed supply, resulting in long waiting times.

A.3 Service strengths and limitations

This section outlines the strengths and limitations of dementia-specific services provided in Gippsland. The findings in this section were obtained from a consultation process undertaken within the Gippsland Region. For more details on the nature of the consultations, refer to Appendix B.

A.3.1 Strengths

Numerous examples of good practice were identified throughout the Gippsland Region during the consultation process. Of note, many of the examples of service strengths outlined below can and do assist people with dementia across more than one stage of dementia.

Early stage – early difficulties, such as short term memory loss and word finding difficulties

- **Gippsland and East Gippsland Aboriginal Co-Operative – My Personal Journey**
  An information sharing tool has been developed for use within the Aboriginal community for those with dementia, their families, and the staff involved in their care. Research has shown that a record of a client's life story (including medical, family, career, likes/dislikes information) is beneficial for staff to provide culturally appropriate care and conversation, the client to develop more meaningful relationships, and the family to hold in order to keep the story of their loved one. This booklet has had a high positive result from the local community and health-related services. With use of the booklet, Elders, and the family of Elders, have reported more culturally appropriate care and positive experiences with visiting health staff and within residential facilities.
- **DBMAS**
  Stakeholders identified that information provided by DBMAS was a strength within the Gippsland Region. The depth and breadth of the knowledge supplied, the timely responses given by the service and the resources available were specifically highlighted. One program provided by DBMAS, Pathways to Dementia, was highlighted as a particularly good example of an education package. The program is primarily aimed at workers in RACS, and educates workers about the process and requirements of care associated with dementia-based clients. Stakeholders also acknowledged that services provided by DBMAS assist people with dementia across the many stages of dementia.
- **AAV Living with Memory Loss program**
  This program provides people with dementia and their carers with information, emotional support and an opportunity to share experiences. In Gippsland, the program has been provided in a 'retreat' format, requiring participant involvement for a full two-day period. More generally, stakeholders also commented positively on the overall quality and breadth of information provided by AAV in relation to dementia.
- **CDAMS**
  The quality of assessment and the information service offered by CDAMS was considered a strength. Assessments provided by neuropsychologists, combined with a comprehensive knowledge of the dementia process, were specifically mentioned as CDAMS's strengths
- **Joint assessments**
  Assessments which reduced the need for people with dementia to repeat information, and to numerous service providers, were considered a strength. For example, assessments undertaken in conjunction with HAS and the District Nursing Service or HAS and ACAS reduced anxiety amongst people with dementia and created a more efficient initiation of service delivery.
- **Dementia-specific – planned activity groups**
  Planned activity groups with a specific focus on people with dementia were considered to be an example of good practice, as they offered people with dementia and their carers an opportunity for socialisation, an opportunity to network with others in the same situation, and the opportunity to perform physically and mentally engaging activities in a supportive environment.
- **HACC Active Service Model Partnerships Project**
  The project, with funding received through HACC, seeks to develop partnerships with HACC providers and other services to improve service coordination and efficiency between aged care services. Amongst the participating services (currently South Gippsland Shire, Southern Health and Foster Hospital), common assessment processes are in development to reduce duplication

of assessment processes. People with dementia are part of the target group, and the project aims to optimise the service experience of people with dementia and their carers.

Moderate stage – a reduced capacity for independence

- **Creative ways to care**
  The program (initially developed through the Commonwealth Respite and Carelink Centre Southern Region) comprises six workshops, where carers for people with dementia learn about, and are connected to, dementia-specific services in their region.36 The program is run by Latrobe Community Health Service on an outreach basis throughout the Gippsland Region. Stakeholders identified the program as a particular strength of the suite of dementia-specific services in Gippsland.
- **Service to service (S2S) referral system**
  The S2S referral system provides an electronic means by which service providers can refer their clients onwards for new services or treatment within a particular region. Although stakeholders identified the concept as a strength, as it increased the efficiency of referral processes, it was noted that the nature of the electronic referral form (long field entries, too many mandatory fields) meant that in reality, many of the expected efficiencies have not yet been realised.
- **Latrobe City Council services**
  Stakeholders identified services provided by the Latrobe City Council could be considered good practice. A specific example provided was the flexible respite program with a 'couples day', where a husband and wife (one of which is a person with dementia) are taken on an outing together. This filled a gap in service, as most outings are based on respite services (and hence the carer is taken on the outing individually), and do not involve couples.

Advanced stage – the emergence of significant difficulties with activities of daily living

- **Complex care meetings**
  The meetings comprise representatives of community-based services, such as HACC and the District Nursing Service, who meet on a fortnightly basis to discuss the current needs of older people with complex needs (including people with dementia). The meetings enable information sharing, discussion about client progress or deterioration, and alterations to service plans for dementia to ensure client needs are met on an ongoing basis. The meetings currently operate within the South Gippsland Shire, in two locations, Leongatha and Foster.
- **Client Health Record**
  This is a document that is kept by the person with dementia, that records the current services they are receiving, on what days and for how many hours. The document acts as an information transfer device, whereby multiple service providers (who enter the client's home for example) have access to an up-to-date record of services received by the person with dementia. This assists in streamlining service provision, and maintaining an effective service continuum.
- **Geriatric evaluation and management and falls and mobility clinics at Latrobe Regional Hospital**
  Geriatric evaluation and management clinics provide an early and definitive dementia diagnosis when timely referral is made with relevant (medical) investigations completed. The falls and

36 Latrobe Community Health *2010 Quality of Care report viewed* 7/6/2011, accessed at: <http://www.lchs.com.au/assets/files/Quality%20of%20Care%20Report/LCHS_Quality_of_Care_Report_2010.pdf>

mobility clinic also provides a comprehensive referral and assessment service for people with dementia.

- **Person-centred care**
  Stakeholders repeatedly identified person-centred care as an example of good practice. Service providers stated that the ability to tailor dementia-specific services for people with dementia and/or their carer improves outcomes for the client.

End-of-life stage – incapacity and a high dependence on care

- **Aged care channel**
  The aged care channel is an online resource that provides training to staff who work in residential aged care facilities. Although not region specific, stakeholders identified the channel as an example of good practice in relation to education and training. The site provides live training modules on various topics specific to residential aged care facilities, as well as developing workplace competencies and self-directed learning opportunities.
- **Latrobe Regional Hospital – Flynn and Macallister Units**
  The Flynn Unit is an acute adult psychiatric unit, whilst the Macallister Unit is comprised of aged acute psychiatric beds and RACS beds. These units were recognised as strengths within the dementia service continuum in Gippsland. The high level of specialised care provided by knowledgeable and professional staff were specifically highlighted as service strengths.
- **Aboriginal-specific education and training**
  Training for Aboriginal people within the aged care environment can be provided by the Replay group.[37] At the Domain Lakes residential aged care facility, the employment of Aboriginal people who have completed this training was identified as an example of good practice. In employing Aboriginal staff, Domain Lakes was able to provide culturally appropriate aged care services (including those related to dementia) for Aboriginal residents.
- **Residential aged care services programs**
  Programs within RACS directed specifically at people with dementia were identified as examples of good practice. Examples raised were 'sundowning activities', which included diversionary or other programs to deal with the sundowner phenomenon; and the 'Snoozelin room' in one particular RACS, that provided visual and audio stimulation, specifically for those with dementia, to improve quality of life. Another RACS also held café mornings, providing residents and their carers/families with opportunities for socialisation and to develop support networks with others facing similar challenges relating to dementia.
- **Palliative care**
  Within the East Gippsland and Wellington Shires, specialist nurse practitioners have been employed to provide palliative care services. Although in its infancy, the ability to provide specialist care and knowledge to people with dementia at the end stage of life was identified by stakeholders as an example of good practice, and in particular, anticipated for the future. The palliative care aspect of the Gippsland Regional Integrated Cancer Service was also identified as an example of good practice that could be applied to people with dementia at the same stage of life. Regular team meetings are held that include a number of different health professionals, such as GPs, social workers and nurses. This enables case discussion to optimise outcomes for patients at the end stage of life.

37 The Replay Group <http://www.replay.com.au/employing_indigenous.htm> accessed 8/6/2011

A.3.2 Opportunities for service improvement

Stakeholders identified a number of limitations associated with dementia-specific services in the Gippsland Region during the consultation process. During the course of the gap analysis, three key priority areas, were identified:

Priority area one: Service coordination

- Highlights the gaps currently present in the Gippsland Region relating to service coordination amongst dementia-specific service providers. This includes services both at a local LGA and region-wide level.

Priority area two: Access and service provision

- Highlights the current deficiencies in dementia-specific services in the Gippsland Region, including lack of service continuity, and a lack of individually tailored, flexible dementia care to meet the needs of people with dementia and their carers

Priority area three: Knowledge and understanding

- Gaps identified by stakeholders relating to the lack of knowledge and understanding of dementia as a condition, dementia-specific services, and a dementia-specific service continuum, amongst both service providers and the general public.

The following provides a summary of stakeholder's views of the current service gaps and limitations within each of these priority areas.

Priority area one: Service coordination

Lack of awareness between service providers of what each service offers

- The majority of service providers noted that although they were aware of other provider's services, they were not aware of the full suite of services offered by each provider. In some cases, services identified that they were also unaware of the totality of services available within the region. One service stated they are "still stumbling across services that they are unaware of".
- A potential symptom of this lack of awareness is the duplication of services. Stakeholders stated that services providing information were in some cases duplicating each other. This suggests that a lack of awareness of services is also creating inefficiencies within the dementia-specific service system.

Lack of understanding of how services fit together and can best support the person with dementia and their carer(s)

- Service providers identified that they were often working in silos, and were unaware of the appropriate service continuum that would best support the person with dementia and their carer. Particular examples were used in reference to the medical profession. GPs were identified as lacking a pathway for referral to specialist services, and therefore a sufficient understanding of the service continuum. This has led to a number of examples of GPs not referring on to specialists (and other service providers) appropriately.
- A lack of linkages between community respite and acute/subacute facilities was identified as a reason for a number of social admissions to acute care facilities. Stakeholders felt that these admissions could have been avoided if the two services had worked collaboratively. It was also noted that there is a poor referral rate from acute and subacute services to community

services for people with dementia. This was attributed to insufficient staff knowledge about when community services should be engaged and what they can offer.

Limited communication between services providers to support service coordination

- Stakeholders identified that in many cases service providers are not communicating sufficiently to ensure appropriate service coordination. Specific examples were provided where case managers of people with dementia were not communicating appropriately with service staff (such as allied health providers) about the needs of the client, resulting in a lack of coordination of services. A common theme noted was the lack of communication between services in relation to updating the clinical status of the people with dementia, and whether deterioration and/or an increased need for services was identified.
- Stakeholders reported a significant communication barrier between RACS and community care providers. Stakeholders identified this as a significant gap, as the transition period for people with dementia from the community to a RACS is traumatic. If service providers are not communicating to ensure a smooth and orderly transition, that takes into account the individual needs of the person with dementia, the associated trauma with the event is heightened.

Priority area two: Access and service provision

Gaps between service provision/providers

- Stakeholders identified a number of gaps between the provision of services. The lack of a service pathway for dementia was specifically highlighted as it resulted in some services not referring appropriately (either through lack of knowledge of other providers, or not being sufficiently aware of an appropriate dementia service continuum).
- The way in which packages are structured resulted in service gaps for people with dementia and their carers. As an example, many stakeholders identified that the difference between the services offered in a Community Aged Care Package (CACP) and Extended Aged Care at Home Dementia (EACHD) is too great, and that a 'bridging' package should be available. Service providers also noted that sources of funding contribute to a breakdown in the service continuum. An example provided was when people with dementia lose access to services provided under HACC funding when their condition deteriorates and they require more services (such as CACPs). Relationships between the person with dementia and service providers, as well as the service provider's knowledge of the person with dementia's condition, are lost when the service provider changes. In addition the long waiting list for EACH and EACHD results in delays in accessing the service needed, and its benefits.

Challenges in the provision of individualised services to meet the needs of people with dementia and their carer(s)

- Many of the carers consulted reported that services provided to them were not tailored to individual need. For example, cleaning services provided that were not required by the person with dementia and their carer and respite care provided within the home, when the carer preferred a community respite service that took the person with dementia out of the home. Service providers also acknowledged the issue of provision of individualised services; but cited restrictions associated with packages and funding, as well as workforce availability, as impediments to being able to tailor services to individual needs.

Lack of dementia-specific support groups for carers

- The majority of carers and service providers consulted reported a distinct need for more dementia-specific carer support groups. These support groups are highly valued by carers and their importance for carers is acknowledged by service providers. Therefore, the lack of these groups is a significant service gap. One example, which demonstrated the value of carer groups, was the establishment, by carers, of an informal support group in a region where no formal group existed.

Lack of flexibility in service provision for respite

- Carers identified lack of flexibility in the provision of respite as a significant gap in service. Carers noted that in most cases there is no availability of respite services on public holidays or weekends. This impacts upon a carer's capacity to participate in activities held on these days, but more importantly, if an emergency occurs on a weekend or public holiday, there is no respite assistance available. Carers also reported that emergency respite generally was either not available, or in very limited supply, which meant that in a crisis there were no available options involving respite.
- Majority of carers consulted stated that the nature of respite provided within RACS was not appropriate for the person with dementia they cared for. Respite in RACS is provided in two week blocks. In many cases (as identified by service providers and carers), people with dementia have significant difficulties in adapting to new surroundings and dealing with new routines. People with dementia therefore have difficulty adapting to the surrounds of the RACS, but due to the length of time they are away from home, they then also have difficulty in adapting back to their original environment (one carer stated reorientation to home took another two weeks). Carers also reported that respite was not usually required for a full two weeks.
- Carers receiving respite in the home also highlighted the need for respite to be more flexible. Many carers stated that the respite received was not long enough for the carer to be able to perform any meaningful activities, and they would rather be able to save respite for use over a longer time frame (such as saving two blocks of three hours to use as a single block of six hours).

Access issues for specialist services

- Stakeholders frequently highlighted the waiting times and location for specialist dementia assessments as a gap in service. The service offered by CDAMS is based in Drouin, with outreach clinics to other parts of Gippsland. Due to the long distances between Drouin and locations in the east of Gippsland, many stakeholders believe the location should be more central, as the current location impedes the ability of people with dementia and their carers to attend. However, it should be noted that CDAMS is staffed by specialists that travel from Melbourne. If the CDAMS location were moved further to the east of Gippsland, the ability to maintain consultant medical staff may be compromised.
- Waiting times for specialist dementia assessment services in many cases is a six-month process, meaning that early diagnosis and implementation of services for early stage dementia is compromised. An initial assessment usually occurs in the first three months and referrals can be made at this point. Waiting times and assessment services are affected by the lack of specialist practitioners within the region – for example, there is no specialist psychogeriatrician in the region, and more general consultant psychiatry services are insufficient. Waitlists for ACAS were also highlighted by many stakeholders as being too long.
- Stakeholders identified poor access to occupational therapy driving assessments, due to a lack of staff (only one provider, based in Bass Coast for all of Gippsland), as a service gap. People from East Gippsland with dementia have reduced access due to increased cost.

Priority area three: Knowledge and understanding

Gaps in knowledge and understanding of diagnosis, intervention and management by health professionals

- Stakeholders identified GP's lack of knowledge of dementia and when and where to refer a person with dementia as a significant gap in dementia services in Gippsland. Some carers consulted reported that their GP had informed them that dementia is a 'normal part of aging', or that the person with dementia was 'stressed'. In one situation a carer was told by their GP that a memory problem was 'normal for people in their 50s'.
- Service providers also noted a lack of knowledge amongst GPs in relation to dementia. Hospital referrals by GPs for patients with dementia were, in many cases, inappropriate (including under-diagnosis of delirium). It was also noted by hospital staff that in some cases, patients were discharged with appropriate dementia management plans, only to have these changed by the GP, resulting in deterioration of the person with dementia.
- Service providers felt that the lack of timely referrals meant that people with dementia are not being linked with appropriate services and information for early stages of dementia. In some situations this resulted in the person with dementia and their carer presenting unnecessarily to services (including emergency departments) due to preventable crises.
- Within the hospital setting stakeholders noted insufficient knowledge amongst medical staff to enable appropriate differential diagnosis of dementia and delirium. Inappropriate referrals and admissions of patients suffering with delirium were being made to dementia-specific wards, resulting in inefficient use of hospital resources. This view is further supported by Improved Care for Older Person and Long Stay Older Persons (LSOP) projects in five health services across the Gippsland Region, which recommended as a number one priority, whole-of-health dementia, delirium and depression management.

Gaps in knowledge and management strategies of paid carers (community and residential) in managing people with dementia

- Carers and people with dementia reported a lack of awareness and knowledge of dementia amongst community care staff. Carers gave examples of paid care staff performing ACAS assessments on people with dementia without fully recognising the signs and symptoms of dementia, and subsequently assessing them as having higher levels of function than was representative of their current condition. In one example a person with dementia answered yes to all questions asked; however, according to their carer, these answers did not reflect the person with dementia's current function, but was not further investigated by the assessor. In another example only the physical function of the person with dementia was assessed and used as the basis for a decision on what level of assistance was required. Carers also identified in-home respite care staff as having insufficient knowledge of people with dementia's needs, resulting in an inadequate level of service provided, including basic care such as help with showering.
- In another example of poor management of a person with dementia by paid care staff, a carer's husband was informed by an ACAS assessor that he would need to be placed in a RACS, before his condition necessitated it. This caused him undue and prolonged stress.
- Many carers noted that following respite services within RACS, the person with dementia significantly deteriorated, both physically and mentally. Hospital staff also reported a lack of dementia-specific knowledge amongst RACS staff. There were examples provided of RACS residents whose dementia had deteriorated so significantly that they required hospital admission.

Appropriate management, earlier intervention and greater knowledge of dementia within the RACS would have prevented these admissions.

Lack of information for carers of people with dementia on what care is provided/what they are entitled to within their care packages

- Many carers identified that the information provided in relation to community care and care packages was insufficient. Information provided did not adequately describe the totality of what services provide, what services carers are entitled to and the funding available for these services. One carer exemplified this by stating that "nobody tells you the difference between CACPs, EACH and EACHD packages". Another carer stated that she had purchased equipment for care needs independently, but was subsequently informed that she could have received funding through her package. A carer receiving an EACHD package was informed that she was also eligible for palliative care services. As the carer was not aware of this, she had foregone a significant amount of assistance at a time of great need. Carers of people with younger onset dementia reported that attempting to gather information on what community care services are available is particularly challenging.

Significant amounts of information available - people are not aware of where to locate it, receive too much information, information not at the most appropriate time or in language that is not understandable for people

- The majority of people with dementia and their carers at the early stages of dealing with dementia are unaware of the services and support available to them, and do not know where to go to find out. As an example, a carer of a person with dementia who was unaware of the services available to her, "collapsed in the end due to the lack of support".
- Once people with dementia and their carers are linked into services, another set of challenges arises. Service providers and carers identified that the information available for the public was overwhelming. Many carers stated that due to the volume of information received, they were not able to read it all. Carers also voiced a preference for being told what they needed to know, rather than being told everything there is to know about dementia and related services, as too much information resulted in confusion and an inability to work out which services were most relevant to their situation.
- The manner in which information is provided was also identified as an issue. One carer reported not understanding the numerous acronyms that were associated with dementia services, such as ACAS and CACP. Another carer reported their experience with CDAMS to be traumatic, due to differing expectations on what the service provided. The person with dementia and the carer were under the impression that the service was to provide them with memory exercises to improve function. However, CDAMS is an assessment process, and upon being assessed the person with dementia and their carer were not prepared for the confirming diagnosis and highlighting of memory deficiencies, which took a number of months to reconcile.

Limited use of advance care planning (ACP)

- Service providers repeatedly identified the lack of use of ACP as a service gap. Many stakeholders claimed that service providers, including RACS, demonstrated a lack of understanding of what ACP is, and how best to use it. It was noted that stakeholders felt that service providers did not understand that dementia leads to death, and this contributed to underutilisation of ACP.
- The lack of an advance care plan resulted in adverse effects. An example given was the propensity of RACS to call ambulances inappropriately or prematurely when dealing with end-

of-life issues. This process created undue distress for the person with dementia and their family/carers, as in most cases the person with dementia would be returned to the RACS. It also places an unnecessary load on the acute service system.

- Further contributing to the limited use of ACP is the lack of awareness of legal processes associated with end-of-life issues, including processes in relation to enduring power of attorney. Stakeholders identified that education that addresses the legal aspects associated with advance care plans as a significant need.

Lack of coordinated information for public – lack of a single access point

- Most people with dementia and their carers in the early stages of dealing with dementia-specific services reported service contact to be haphazard and fortuitous. The majority of carers reported that following initial assessment, they were not told what services they would need, what was available or what they were eligible for. However, many carers were surprised to be contacted by organisations such as AAV a few weeks following assessment, unaware that their details had been passed on. A sense of helplessness was created amongst people with dementia and their carers during the process following assessment, when the person with dementia and their carer knew of their diagnosis, but not what to do next. One carer stated that "there are not enough people around to explain things to you, and how they work."
- Information provided by stakeholders suggested that an element of luck is involved regarding services and information received by people with dementia and their carers following diagnosis. This can depend on where assessment services direct their referral, and where in Gippsland they are located (which affects availability of services).
- Stakeholders did identify that a number of public forums providing dementia-specific information had been held on an ad hoc basis. For each one that was held, attendance was oversubscribed.

The issues outlined above suggest that there is a significant gap in being able to disseminate information to the public in a coordinated manner that allows appropriate entry and ongoing participation in the dementia-specific service continuum.

Other opportunities for improvement

Workforce – retention and recruitment

- Throughout the consultation period, stakeholders identified the retention and recruitment of workers within the dementia-specific service system as a significant shortcoming. Lack of an appropriately skilled workforce affects the quality and availability of services for people with dementia. A number of service providers stated that the provision of packages (CACP, EACHD) was impeded by the lack of available staff. Knowledge retention, both in relation to dementia and the dementia-specific service structure, was also poor within services due to the relatively high staff turnover. A lack of cultural awareness (Aboriginal and CALD) was also highlighted as a workforce shortcoming.

Transport

- A number of stakeholders identified transport as a significant issue within the region. Many clients and carers were unable to attend services, or found it very difficult to do so, due to the large travel distances involved and the lack of transport services available. An example provided by stakeholders was the CDAMS location (in Drouin), which meant that residents in the east of Gippsland found it very difficult to attend the clinic.

Lack of CALD-specific, Aboriginal and younger onset dementia services

- A small number of stakeholders highlighted the lack of dementia-specific services available for those from vulnerable groups (such as CALD and Aboriginal backgrounds). Stakeholders also noted that there is a lack of dementia-specific services available for those with early onset dementia. This was reinforced by a carer of a person with early onset dementia who stated that she had had numerous difficulties in attempting to access services, as the age of the person with dementia had excluded him from receiving many of the normally available services. ACAS currently requires any person under 65 to go through disability services' intake processes which can result in considerable delay in accessing services for people with younger onset dementia.

A.4 Training survey

To determine current levels of dementia-specific education and training, and to identify future need, a stakeholder training survey was undertaken with 268 responses received from across the Gippsland Region. These were sorted into different respondent groups and results obtained specifically from medical centres, residential aged care facilities, community care services and hospitals are outlined below.

Medical centres

Within medical centres, 42.9 per cent of staff identified themselves as possessing an 'average' level of knowledge of dementia and associated care matters, with 28.6 per cent rating themselves as 'poor'. Only 28.6 per cent identified themselves as having a 'good' knowledge of dementia. Within the last three years, 90.5 per cent of respondents have not received any dementia-specific training, and 68.4 per cent of respondents stated that the current provision of dementia training does not meet their needs. Of note, no respondents had accessed dementia information from DBMAS, whilst 19 per cent had done so from AAV. In the survey, 85.7 per cent of respondents identified an interest in more dementia training. The top five training needs identified as the most relevant to the respondent's roles are:

- carer support (72.2 per cent)
- basic dementia understanding and care (66.7 per cent)
- falls prevention (61.1 per cent)
- medication issues (61.1 per cent)
- assessment and diagnosis (50 per cent)
- strategies for managing behaviours (50 per cent).

Residential aged care facilities

Of staff surveyed in RACS 52.2 per cent rated their knowledge of dementia as 'good', 13 per cent as 'excellent' and 31.5 per cent as 'average'. Within the last three years, 52.7 per cent of respondents have not received any dementia-specific training and 90.9 per cent of those who received training reported that it changed their practice. Staff in RACS had accessed information from both AAV and DBMAS, at 54 per cent and 48.7 per cent respectively and 95.6 per cent of RACS staff expressed an interest in dementia training. Training needs identified by the highest number of respondents were:

- strategies for managing behaviours (65.1 per cent)
- advanced dementia understanding (64 per cent)

- end of life/palliative care (57 per cent)
- falls prevention (43 per cent)
- younger onset dementia (43 per cent).

Community services

Amongst staff working in community services, 51.1 per cent rated their knowledge of dementia as 'good', 34.1 per cent as 'average' and 51.2 per cent had not received any dementia-specific training in the last three years. Of those who had, AAV provided the training for 66.7 per cent of respondents and 88.1 per cent of respondents indicated further interest in attending dementia training. The training topics with the highest levels of interest were:

- younger onset dementia (58.1 per cent)
- strategies for managing behaviours (56.8 per cent)
- carer support (54.1 per cent)
- advanced dementia understanding (51.4 per cent)
- dementia and active service model (goal-orientated care) (45.9 per cent).

This result differs considerably given the responses of stakeholders during the consultation period. Although younger onset dementia was identified as an issue, it was not highlighted as a priority.

Hospitals

Amongst staff working in hospitals, 47.8 per cent rated their knowledge of dementia as 'average', 32.6 per cent as 'good' and 71.7 per cent of respondents had not attended any dementia-specific training in the last three years. Current dementia training does not meet the needs of 64.1 per cent of those surveyed and 88.6 per cent of respondents expressed an interest in dementia training. The training topics with the highest levels of interest were:

- strategies for managing behaviours (71.1 per cent)
- falls prevention (52.6 per cent)
- carer support (50 per cent)
- clinical management (50 per cent)
- end of life/ palliative care (50 per cent).

All service staff

When considering responses from all service staff, 46.1 per cent of respondents considered their knowledge of dementia to be 'good', and 36.3 per cent 'average'. In the previous three years 41.7 per cent of respondents had attended dementia-specific training, 91.1 per cent of respondents indicated an interest in further training and 58.1 and 43.6 per cent of respondents had accessed information from AAV and DBMAS respectively.

Summary of findings from survey

Results from the survey reinforce the service limitations as highlighted in section A3.

- Staff in medical centres displayed the lowest levels of dementia-specific knowledge and training. This is consistent with responses from stakeholder consultation, which highlighted a lack of dementia knowledge amongst GPs and medical clinics.
- There is a need for a more coordinated approach to training, and training which is more targeted to particular groups in its delivery and format.

- An overwhelming majority of respondents in all surveys expressed a desire for further dementia-specific training. The findings suggest there is significant demand for more dementia-specific training in the region.
- The two subgroups of community and RACS, and the overall results of the survey identified distance as the main barrier to attending training, while respondents from medical centres reported that the requirement to attend training in their own time was the main barrier.
- Workplaces and advertising flyers were identified as the primary sources of information about training opportunities. This has implications for delivery and advertising of training when developing the strategies within the Gippsland Dementia Plan.

Appendix B: Consultation records

The following consultations were undertaken in order to develop the Gippsland Dementia Plan:

- Consultations with Alzheimer's Australia Vic, Department of Health Victoria, Latrobe Regional Hospital Aged Persons Mental Health Service, Cognitive Dementia And Memory Service, Central West Gippsland Division of General Practice and General Practice Alliance South Gippsland.
- One focus group and six individual consultations with carers of people with dementia.
- Three workshops with service providers, held at Leongatha, Traralgon and Bairnsdale.
- A validation workshop with service providers and other organisations.

B.1.1 Workshops

The following stakeholders and organisations attended the three consultation workshops.

Table 8: Leongatha workshop attendees

Leongatha – 16 May 2011	
Name	**Organisation**
Carina Ross	Domain Seahaven
Lesley Hammond	Bass Coast Shire Council
Karen Price	Alzheimers Australia
Robyn Holman	Latrobe Community Health Service – ACAS worker
Kaye Jarvis	Baptcare
Judy Pryce	Baptcare
Sara Cox	South Gippsland Shire Council
Tania Ryan	South Gippsland Shire Council
Angela Richmond	Latrobe Regional Hospital
Vivian Caroll	Gippsland Southern Health Service
Leanne Charlton	Gippsland Southern Health Service
Sheney Perrepedam	Gippsland Southern Health Service
Jenny Fitzgerald	Gippsland Southern Health Service
Saskia Turra	Department of Health
Theresa Elliott	Department of Health
Melissa Brennan	Department of Health
Gabrielle Forsyth	Bass Coast Regional Health
Chrissy Stojanoff	Bass Coast Regional Health
Vanessa Fisher	Bass Coast Regional Health
Gaetan Nermorin	Bass Coast Community Health Service
Natalie Miskolczy	Bass Coast Community Health Service

Leongatha – 16 May 2011	
Name	**Organisation**
Joanne Stringer	LaTrobe Community Health Service
Karen Wheeler	Latrobe Regional Hospital Aged Persons Mental Health Service
Hank McKenna	Latrobe Regional Hospital Aged Persons Mental Health Service
Amy Roberts	Gippsland Southern Health Service

Source: KPMG and Department of Health

Table 9: Traralgon workshop attendees

Traralgon – 19 May 2011	
Name	**Organisation**
Mary Broshe	Yarram and District Health Service
Sarah Calvi	Latrobe Regional Hospital
Pauline Guyatt	Southern Cross Care Vic
Ryan Peace	Latrobe Community Health Service
Dr. Madam Saha	Latrobe Regional Hospital
Bruce Campbell	Latrobe Regional Hospital
Jenny Hansch	Hazelwood House Hostel
Mary Dawkins	Calvary Silver Circle
Dolores O'Dowd	Latrobe Regional Hospital Aged Persons Mental Health
Maria Rodda	Latrobe Regional Hospital Aged Persons Mental Health
Melissa Brennan	Department of Health
Janet Moore	Andrews House – West Gippsland Health Service
Laelie Balcombe	Andrews House – West Gippsland Health Service
Jan Bennett	Andrews House – West Gippsland Health Service
Vivianne Everett	Latrobe Community Health Service
Kay Jellis	Latrobe City Council
Alison Haber	Latrobe City Council
Carolyn Thatcher	Latrobe Regional Hospital – Staff Development Unit

Source: KPMG and Department of Health

Table 10: Bairnsdale workshop attendees

Bairnsdale – 20 May 2011	
Name	**Organisation**
Diane Scott	Alzheimers Australia Victoria
Marianne McVeigh	Domain Principal Group
Sonya Hanratty	Maffra District Hospital
Janice Preston	Latrobe Community Health Service
Tim Rowley	Stretton Park Hostel
Linda Hall	Stretton Park Hostel
Lyne Brown	Stretton Park Hostel
Jenny Keenan	Stretton Park Hostel
Tracey Hibbson	Orbost Regional Health
Melinda Fairley	Orbost Regional Health
Joyce Timmons	Orbost Regional Health
Geraldine Atkins	Gippsland and East Gippsland Aboriginal Co-Operative
Gwenda Peters	Bairnsdale Regional Health Service
Vicki Gillick	Bairnsdale Regional Health Service
Josephine Mooney	Bairnsdale Regional Health Service
Tania Harris	Ramahyuck
Andrea Johnson	Central Gippsland Health Service
Barbara Phillips	Gippsland Lakes Community Health
Gail Weate	Gippsland Lakes Community Health
Mick Egan	Latrobe Community Health Service – Carer services
Kelly Day	East Gippsland Primary Health Alliance
Therese Elliott	Department of Health
Melissa Brennan	Department of Health
Greg Blakeley	Department of Health

Source: KPMG and Department of Health

B.1.2 Validation workshop

The validation workshop was held on 14 June at Traralgon. Stakeholders at this workshop are listed below.

Table 11: Validation workshop attendees

Traralgon – 14 June 2011	
Name	**Organisation**
Marion Byrne	Carer representative
Dolores O'Dowd	Latrobe Regional Hospital
Janet Moore	West Gippsland Healthcare Group
Mary Hartwig	Central Gippsland Health Service
Pam Odgers	Central West Gippsland Division of General Practice
Karen Price	Alzheimers Australia Vic
Wendy Gilbert	Department of Health – Manager Mental Health and Drugs Gippsland
Greg Blakeley	Department of Health – Manager Acute Health and Aged Care
Jen Doultree	Department of Health – Aged Care Team Leader
Melissa Brennan	Department of Health – Aged Care
Therese Elliott	Department of Health – Aged Care
Richard Adams	Department of Health – Aged Care
Paul Butler	Department of Health – Director
Audra Fenton	West Gippsland Healthcare Group
Robyn Cotterill	Stretton Park Hostel
Maria Rodda	DBMAS
Alison Skeldon	Latrobe Community Health Service – Manager Carer Services
Vicki Powell	Alzheimers Australia Vic
Sue Fletcher	Latrobe Community Health Service
Amy Roberts	Gippsland Southern Health Service
Claire Kent	Latrobe Regional Hospital – Geriatric and Evaluation and Management unit
Julie Wells	ACAS – Latrobe Community Health Service

Source: KPMG and Department of Health

B.1.3 Stakeholder survey respondents

Table 12: Respondents to stakeholder survey

Respondents	
Aged persons mental health service	Fairview Village
Alzheimer's Australia Vic	Korumburra Medical Centre
Armitage House	Latrobe City Council
Baw Baw Shire Council	Latrobe Community Health Service
Bass Coast Shire Council	Latrobe Regional Hospital
Benetas	Latrobe Regional Hospital – Macallister unit
Cann Valley Bush Nursing Centre	La Trobe Valley General Practice
Cowes Doctors	Latrobe Valley Village
Cognitive Dementia Memory Advisory Service	Lotus Aged Care Services – Brookfield park nursing home
Dutch Care Ltd	Mallacoota District Health and support services
Dr. Bruce Osborne	Moogji Aboriginal Council
East Gippsland Shire	Omeo District Health
Gelantipy Bush Nursing	Orbost Regional Health
Gippsland OT services	Phillip Island Medical Group
Gippsland Lakes Community Health Service	Southern Cross Care
Gippsland and East Gippsland Aboriginal Cooperative Limited	South Gippsland Hospital (Foster)
Gippsland Southern Health Service	South Gippsland Shire Council
GPs from Wonthaggi/Inverloch	Stretton Park Hostel
Girffiths Point Lodge	Swifts Creek Bush Nursing Centre
Jane Baxter	West Gippsland Healthcare Group
JFK McDonald Wing	Yarragon Medical Centre
Kirrak House	Yarram and District Health Service

Source: KPMG

Appendix C: Project steering committee

The development of the Gippsland Dementia Plan was overseen by a project steering committee. The membership of the committee is outlined in Table 13.

Table 13: Project steering committee members

Name	Title	Organisation
Karen Price	Dementia Consultant	Alzheimer's Australia Vic.
Vicki Powell	Rural Support Coordinator	Alzheimer's Australia Vic
Dolores O'Dowd	Acting Coordinator	Aged Persons Mental Health Service
Heidi Losic-Smith	Aged and Disability Service Manager	Baw Baw Shire
Kaye Beaton	Director of Community Services	Bass Coast Regional Health
Vicki Farthing	Director of Nursing	Bairnsdale Regional Health Service
Audra Fenton	Manager	CDAMS
Dr Bruce Osborne	Psychogeriatrician	CDAMS/ Latrobe Regional Hospital
Robyn Cotterill	Nurse Unit Manager	Central Gippsland Health Service
Margaret Bogart	Acting CEO	Central West Gippsland Division of General Practice
Marion Byrne	Carer Representative	
Melissa Brennan	Program and Service Advisor	Department of Health Gippsland Aged Care
Jennifer Doultree	Aged Care Team Leader	Department of Health Gippsland Aged Care
Michael Mihaly	Manager Department of Veterans' Affairs	Department of Veterans' Affairs
Julie Hawke	Elders, HACC & Disability Services Coordinator	Gippsland & East Gippsland Aboriginal Coop
Amy Roberts	Assistant DON	Gippsland Southern Health Service
Alison Skeldon	Manager Carer Support	Latrobe Community Health Service
Maria Rodda	Senior Clinician	DBMAS
Sue Fletcher	Senior Lecturer, Social Work	Monash University / Latrobe Communty Health Service
Annette Wheatland	Manager	Southern Cross Care
Jan Bennett	ADON-Aged Care	West Gippsland Healthcare Group
John Sammons	LSOP/Subacute service	Department of Health Gippsland Acute Care
Denise Bromiley	Acting Team Leader	ACAS

Appendix D: Current services and programs within Gippsland

This appendix lists current relevant services and programs for dementia, and available education and training, within Gippsland. The services and programs listed have been compiled through information obtained at the consultation workshops and from the stakeholder survey and therefore is not a complete listing.

Services and programs are summarised in the first part of this appendix according to the stages of dementia, as outlined in Section 3, listed under the stage of dementia most relevant to that service/program. However, it is noted that many of the services/programs listed provide services to people with dementia across the service continuum. This is reflected in the following tables, where services/programs and their relevance to all stages are identified.

The second part of this appendix provides a detailed description of services provided by individual organisations and facilities (including education and training facilities). These services are arranged alphabetically.

D.1 Summary of relevant services within the Gippsland Region

Table 14: Early stage - early difficulties, such as short term memory loss and word finding difficulties

Services	Early stage	Moderate stage	Advanced stage	End stage
Alzheimer's Australia Vic (AAV)	✓	✓	✓	✓
Aged Care Assessment Service (ACAS) (part of Latrobe Community Health Service)	✓	✓	✓	✓
Carers Victoria	✓	✓	✓	
Cognitive Dementia and Memory Service (CDAMS)	✓	✓		
Centrelink	✓	✓	✓	
Department of Veterans' Affairs	✓	✓		
Geriatric evaluation and management	✓	✓		
General practitioners and practice nurses	✓	✓	✓	✓
Gippsland Multicultural Services	✓	✓		
Men's sheds	✓			
Retirement planners/advisors	✓	✓		
Solicitors/State Trustees – including power of attorney issues	✓	✓	✓	
Specialists (geriatrician, neurologist, psychiatrist,n europsychologists)	✓	✓	✓	✓

Source: KPMG

Table 15: Moderate stage – a reduced capacity for independence

Services	Early stage	Moderate stage	Advanced stage	End stage
Aged persons mental health service		✓	✓	
Community health services/allied health		✓	✓	
Council-based services		✓		
Community Aged Care Packages (CACP)		✓		
Consultation liaison (mental health service)		✓		
Continence advisors and aids assistance scheme		✓	✓	✓
Dementia Behaviour Management Advisory Service (DBMAS)		✓	✓	
Dementia-specific planned activity groups		✓	✓	
Dementia-specific carer groups		✓	✓	
Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) packages		✓	✓	
Hospital Admission Risk Program (HARP)		✓		
Home and Community Care (HACC)		✓		
Koori liaison officer as consultative role in acute setting		✓	✓	
Lifestyle and activity coordinators		✓	✓	
Multi-purpose services (Orbost)		✓	✓	
National Respite for Carers Program		✓	✓	
Respite-dementia and general-RACS		✓	✓	✓
Social work/counselling		✓	✓	
Subacute services		✓	✓	
Support for Carers Program		✓	✓	
Transitional Care Programs (home-based and facility-based)		✓	✓	

Source: KPMG

Table 16: Advanced stage - significant difficulties with activities of daily living

Services	Early stage	Moderate stage	Advanced stage	End stage
Bush nurses			✓	
Hospital In The Home (HITH)			✓	✓
Local hospitals			✓	✓
Mental health nurse practitioners in emergency departments			✓	
Palliative care services (community, hospital, residential)			✓	✓
Residential aged care services (RACS)			✓	✓

Source: KPMG

Table 17: End stage - terminal phase and a high dependence on care

Services	Early stage	Moderate stage	Advanced stage	End stage
Pathway for Improving the Care of the Dying (PICD)				✓
Pastoral care				✓

Source: KPMG

D.1.2 Education and training

Table 18: Education and training organisations in Gippsland

Organisations offering education and training specific to dementia	
Alzheimer's Australia Vic	On line training providers (for example Aged Care Channel, Rural Health Education Foundation)
DBMAS	Replay group
Tertiary learning (TAFE, University)	Dementia Education and Training for Carers
The Victoria and Tasmania Dementia Training Study Centre	Latrobe Community Health Service

Source: KPMG

D.2 Description of services provided by organisation/facility

This section provides a detailed breakdown of the services provided by each organisation and/or facility, and of education and training providers. Residential aged care services, and education and training services are listed in section D.2.2 and D.2.3.

D.2.1 Description of services by facility/organisation

Table 19: Services by organisation, location and type

Organisation/facility	Location	Services provided
Aged Care Assessment Services	Latrobe Community Health Service	Dementia assessment and diagnosis Residential-permanent and respite care approval Package care – EACH, EACHD, CACP approval
Alzheimers Australia Vic (AAV)	Moe Lakes Entrance	Memory Lane Café Mind your Mind program Living with Memory Loss program Dementia Care Essentials Younger onset dementia program Counselling Information and support Telephone outreach program Carer support groups Carer education Community awareness/information/ education Telesupport National Dementia Helpline
Anglican Aged Care services	Lakes Entrance	CACP
Aged Persons Mental Health Service	Traralgon – Latrobe Regional Hospital	Aged Inpatient Psychiatry Unit Community aged psychiatry service Consultation liaison aged psychiatry service to general beds with the Latrobe Regional Hospital Dementia nurse specialist providing educational resources
Bass Coast Shire	Wonthaggi	Planned activity group Respite Carer retreats
Bairnsdale Regional Health Service	Bairnsdale Paynesville Community Health	Planned activity group Acute care services Geriatric evaluation and management Rehabilitation Subacute ambulatory care service

Baw Baw Shire Council	Warragul Drouin Trafalgar	Respite HACC (home care, personal care/shopping, property maintenance) Meals on Wheels Adult day activity support service Volunteer services – gardening, transport, library program Carers support group Dementia carers support group
Baptcare	Morwell Korumburra	CACP EACHD
Bass Coast Community Health	San Remo	Flexihealth- CACP EACH
Bass Coast Regional Health	Wonthaggi	Acute care services Geriatric evaluation and management Subacute ambulatory care services – community rehabilitation centre and specialist clinics
Benetas	Services cover Bass Coast, South Gippsland, Wellington and East Gippsland LGAs	EACH CACP Dementia carer support groups (Orbost, Lakes Entrance and Sale)
Cann Valley Bush Nursing Centre	Cann River Area (East Gippsland)	Remote area nursing CACP EACH HACC Planned activity group
Calvary Silver Circle	Morwell	CACP EACH
Carers Victoria	Victoria	Counselling, information and support for carers.
CDAMS	Drouin Outreach clinics in: Korumburra Bairnsdale	Diagnostic services, provided by: • neuropsychologists • psychogeriatricians • geriatricians Education Follow up services Linkages and referrals (both for people with dementia and their carers)

Central Gippsland Health Service	Heyfield Hospital Loch Sport Community Health Centre Maffra Campus Stretton Park – Maffra Rosedale Community Health Centre Sale Campus	Acute care services Geriatric evaluation and management services Subacute ambulatory care services-community rehabilitation centre
Centrelink	Across Gippsland	Financial information and assistance
DBMAS	Traralgon	Advice, assessment, intervention, education and support service for managing behaviours associated with dementia. 24-hour telephone support
Dementia-specific carer groups	Lakes entrance Orbost Sale Wonthaggi Traralgon	Provides carer support and information
Department of Veterans' Affairs	National	Provides financial and service assistance (including health care) for those who have served in the defence forces
DutchCare ltd	Baw Baw, Latrobe and Wellington LGAs	CACP
East Gippsland Shire	Bairnsdale Lakes Entrance Orbost Omeo Paynesville	HACC CACP
Fairview	Warragul	CACP
Gelantipy Bush Nursing Centre	Gelantipy	Gelantipy Bush Nursing Centre Support services Personal care Referrals Home nursing Family social support
General practitioners and practice nurses	Across Gippsland	Diagnosis, assessment and referral service
Gippsland and East Gippsland Aboriginal Cooperative Limited	Services are provided predominantly in East Gippsland, some services region wide	CACP HACC Planned activity group Disability respite Aged care respite

Gippsland Multicultural Services	Morwell/Sale	Settlement and support services – to individuals and service providers
Gippsland occupational therapy services	Bass Coast	Driver assessment
Gippsland Lakes Community Health	Lakes Entrance Bairnsdale Bruthen Metung	HACC CACP Meals on Wheels Volunteer transport Sunset Jamboree Program Creative respite options Gallery Program In-home respite
Gippsland Southern Health Service (GSHS)	Tarwin Lower and District Community Health Centre Mirboo North Community Health Centre Loch Community Health Centre Korumburra Community Health Centre Leongatha Memorial Hospital Korrumburra Hospital	Afternoon Club Planned activity group Community Allied Health Team (CATS) Carers support group Acute care services Geriatric evaluation and management services Low-care and high-care residential facilities
Latrobe Community Health Service	Bairnsdale Churchill Korumburra Moe Morwell Sale Traralgon Warragul	Carer services Commonwealth Respite Centre Mayfair House Planned activity group(Latrobe City only) ACAS Creative Ways to Care for Carers Dementia respite National Respite for Carers Program Respite and carer support CACPS, EACH and EACHD
Latrobe City Council	Traralgon	Home care Personal care Respite care Property maintenance Planned activity groups Meals on Wheels

Latrobe Regional Hospital	Traralgon	DBMAS Aged persons mental health service Acute Inpatient aged psychiatry unit Psychogeriatric nursing home beds Community aged psychiatry service Consultation liaison aged psychiatry service to general beds Latrobe Regional Hospital Dementia nurse specialist providing educational resource Gippsland wide Geriatric evaluation and management services Rehabilitation Subacute ambulatory care services – community rehabilitation centre and specialist clinics
Mallacoota District Health and support services inc.	Mallacoota	HACC services CACP National Respite for Carers Program Centrelink Planned activity group SAAP Emergency relief Dental
Mens Shed	Mirboo North Sale Traralgon Boolarra	Provides socialisation and support opportunities for men
Omeo District Health	Omeo	HACC District nursing Social worker/counsellor HACC respite Residential respite
Orbost Regional Health	Orbost	Multipurpose service - low care and high care PAGs (‘Fun for Fellas’) Home-based care Respite PAGs - ‘Slick Chicks’ Home-based support
South Gippsland Hospital Foster	Foster	Planned activity group Podiatry District nursing Falls prevention Strength and mobility classes

South Gippsland Shire Council	Leongatha	Respite Home care Personal care Home maintenance Meals on Wheels
Southern Cross Care (Vic)	Central office – Oakleigh Morewell – CACP	EACH and EACH D CACP Veterans' Home Care Program
Villa Maria	Sale	CACP EACH EACHD
West Gippsland Health Care Group	Warragul (Head Office) Andrews House – Trafalgar Baw Baw Health and Community Care Centre – Drouin Community Services – Warragul Community Services – Trafalgar Cooinda Lodge – Warragul Rawson Community Health Centre Warragul Linen Service	Acute care services Community services CDAMS Geriatric evaluation and management services Subacute ambulatory care services – community rehabilitation centre and specialist clinics
Uniting Care	Sale	CACP
Yarram and District Health Service	Yarram	Community nursing Planned activity groupHome help In-home respite Referral pathways to Commonwealth Carer Respite Service and ACAS Staff trained in dementia care Carer's group Resources, literature Acute care services Geriatric evaluation and management services Subacute ambulatory care services-community rehabilitation centre

D.2.1 Residential aged care services in Gippsland (current as at 30/06/10[38])

Table 20: Residential aged care services

Organisation/facility	Location	Beds	High care	Low care
Alchera House Gippsland Southern Health Service PSRACS	6–8 Gordon Street Korumburra, 3950 Phone (03) 5654 2752	Total	20	
Amberlea Aged Care Facility	5 Pearson Road Drouin Phone (03) 5674 1700	Total	30	61
		Respite		1
		Secure dementia		15
		Extra services	30	
Andrew House West Gippsland Healthcare Group PSRACS	40–42 School Road Trafalgar Phone (03) 5637 4100	Total	20	30
		Respite	1	1
		Secure dementia	5	5
Armitage House Bass Coast Regional Health PSRACS	Baillieu St West Wonthaggi, 3995 Phone (03) 5671 3284	Total	30	
Ashleigh House	20–24 Bergin Crescent Sale, 3850 Phone (03) 5144 4484	Total	15	60
		Respite		1
		Secure dementia	15	
Banksia Lodge Prom Country Aged Car	2 Jones street Foster, 3960 Phone (03) 5683 9600	Total		30
		Respite		2
Brookefield Park Nursing Home	67–69 Liddiard Street Traralgon, 3844	Total	30	
Carinya Lodge	Carinya Crescent Korumburra, 3950 Phone (03) 5655 2125	Total		43
		Respite		2
Cooinda Lodge West Gippsland Healthcare Group PSRACS	41 Landsborough Street Warragul Phone (03) 5623 0761	Total	60	
		Respite	1	
Crossley House Hostel Yarram District Health Service PSRACS	14 Nicol Street Yarram, 3971	Total		30
		Respite		1

38 Australian Government – Department of Health and Ageing statistics

Organisation/facility	Location	Beds	High care	Low care
Dalkeith	49-53 Hazelwood Road Traralgon, 3844 Phone (03) 5174 1759	Total		54
		Respite		2
Domain Bairnsdale	79 Harnham Drive Bairnsdale, 3875 Phone (03) 5152 3744	Total	75	15
		Extra services	15	
Domain Sale	12 Sale-Maffra Road Sale, 3850 Phone (03) 5143 143	Total	50	15
Domain Seahaven	119 Cashin Street Inverloch, 3996 Phone (03) 5674 1700	Total	50	60
		Secure dementia	20	
		Respite		1
		Respite – secure dementia	1	
Domain Paynesville	3-5 Fort King Road Paynesville, 3880 Phone (03) 5674 1700	Total	40	60
		Secure dementia		15
Domain Lakeview	35A Lakeview Drive Lakes entrance, 3909 Phone (03) 5155 3995	Total	33	43
		Respite	1	1
Fairview Village	30 Sargeant Street Warragul, 3820 Phone (03) 5623 2752	Total	16	52
		Respite		1
Grossard Court	1A Leslie Avenue Cowes, 3922 Phone (03) 5951 2020	Total	22	58
		Secure dementia		20
		Respite		2
Griffiths Point Lodge Bass Coast Regional Health PSRACS	20 Davis Point Road San Remo, 3925 Phone (03) 5678 5311	Total	29	
		Respite	1	
Hazelwood House Dalkeith	5 Phillip Parade Churchill, 3842 Phone (03) 5678 5311	Total	38	
		Secure dementia	14	
		Respite – secure dementia	2	
Heritage Manor Aged Care	147–163 Maryvale Road Morwell, 3840 Phone (03) 5101 1111	Total	34	62
		Secure dementia		15
		Respite	1	2
		Extra services	32	

Organisation/facility	Location	Beds	High care	Low care
Hillside Lodge Gippsland Southern Health Service PSRACS	77 Bridge Street Korumburra, 3950 Phone (03) 5654 2733	Total		30
		Respite		2
Kirrak house Bass Coast Regional Health PSRACS	Baillieu St West Wonthaggi, 3995 Phone (03) 5671 3250	Total	30	
Koorooman House Gippsland Southern Health Service PSRACS	Sloan Avenue Leongatha, 3953 Phone (03) 5667 5547	Total	36	
Kooweerup Regional Health Service Westernport Nursing Home & Killara Hostel PSRACS		Total	20	40
		Secure dementia		10
		Respite		2
Latrobe Regional Hospital PSRACS	Princes Highway Traralgon, 3844 Phone (03) 5173 8324	Total	10	
		Secure dementia	10	
Latrobe Valley Village	5 Ollerton Avenue Moe, 3825 Phone (03) 5127 7488	Total	30	60
		Secure dementia	18	
		Respite		3
		Respite – secure dementia	1	
Lakes Entrance Aged Care Facility	23 Alexandra Avenue Lakes Entrance, 3909. Phone (03) 5155 2054	Total	60	15
		Respite	1	1
		Secure dementia	21	
Laurina Lodge Hostel Heyfield Hospital PSRACS	14 Licola Road Heyfield, 3858. Phone (03) 5139 7979	Total	25	26
		Respite	2	2
Lyrebird Village For The Aged	8 Neerim Street Drouin, 3818. Phone (03) 5625 2026	Total		64
		Respite		2
		Secure dementia		17
Lochiel House Orbost Regional Health PSRACS	115 Stanley Street Orbost, 3888. Phone (03) 5154 6613	Total		20
		Respite		1

Organisation/facility	Location	Beds	High care	Low care
Maddocks Gardens Bairnsdale Regional Health Service PSRACS	125 McKean Street Bairnsdale, 3875 Phone (03) 5150 3659	Total	17	73
		Respite	1	
		Respite – secure dementia		1
		Secure dementia		31
Maffra district Hospital., McDonald Wing Central Gippsland Health Service PSRACS	48 Kent Street Maffra, 3860 Phone (03) 5147 0100	Total	30	
Margery Cole Residential Care Services	Matthews Crescent Traralgon, 3844 Phone (03) 5132 3500	Total	64	32
		Respite		1
		Secure dementia	16	
Melaleuca Lodge	1 Watchorn Road Cowes, 3922 Phone (03) 5952 3266	Total		37
		Respite		2
Mitchell House	127 Vary Street Morwell, 3840 Phone (03) 5133 9099	Total		56
		Respite		3
Narracan Gardens	17 Amaroo Way Newborough, 3825 Phone (03) 5127 8462	Total	107	60
		Respite	1	1
		Secure dementia	17	
Neerim District Health Service	29-39 Main Road Neerim South, 3831 Phone (03) 5628 1226	Total	30	
		Respite	1	
O'Mara House Aged Care Facility St Vincent De Paul	15 Hunter Road Traralgon, 3844 Phone (03) 5174 4628	Total	17	49
		Respite	1	1
Omeo District Health PSRACS	12 Easton Street Omeo, 3898 Phone (03) 5159 0100	Total	10	4
Prom View Lodge	25 Welshpool Road Toora, 3962 Phone (03) 5686 2585	Total	30	
Rose Lodge	225-233 Graham Street Wonthaggi, 3995 Phone (03) 5672 171	Total		70
		Respite		3

Organisation/facility	Location	Beds	High care	Low care
St Elmo's Nursing Home Yarram District Health Service PSRACS	14 Nicol Street Yarram, 3971 Phone (03) 5182 0222	Total	15	15
		Respite – dementia secure		1
		Secure dementia		14
St Hiliary's	16 Elgin street Morwell, 3840 Phone (03) 5120 3002	Total	40	11
		Respite		1
Stretton Park Hostel Central Gippsland Health Service PSRACS	Cnr George & Kent Street Maffra, 3860 Phone (03) 5147 2331	Total		42
		Respite		2
Mirboo North Aged Care Strzelecki House and Grandridge	Brennan Street Mirboo North, 3871 Phone (03) (03) 5668 1202	Total	30	30
		Respite	1	1
Waratah Lodge Orbost Regional Health PSRACS	Boundary Road Orbost, 3888 Phone (03) 5154 6678	Total	17	
Wilson Lodge Central Gippsland Health Service PSRACS	155 Guthridge Parade Sale, 3850 Phone (03) 5143 8540	Total	50	
Woorayl Lodge	71 McCartin Street Leongatha, 3953 Phone (03) 5662 2053	Total		40
		Respite		2

D.2.3 Education and training

Table 21: Organisations providing education and training

Organisation	Location	Education and training provided
Aged Care Channel	Online	Training and education TV channel for staff in RACS – delivered online
Alzheimer's Australia Victoria	Moe Lakes Entrance	Dementia Care Essentials Education regarding dementia to both service providers, family carers and community
Chisholm institute of TAFE	Wonthaggi	Certificate III in Aged Care
Dementia Care Australia	On line	Educational and training resource for dementia – specifically providing the Spark of life program

Organisation	Location	Education and training provided
Latrobe Community Health Service	Across Gippsland	Dementia Education and Training for Carers Training and information sessions for carers and family.
DBMAS	Traralgon	Pathways to Dementia Various education and training programs related to dementia, for service providers and the public
East Gippsland Institute of TAFE	Bairnsdale Sale	Certificate III in Aged Care
GippsTAFE	Leongatha Yallorn Warragul	Certificate III in Aged Care Certificate III in Home and Community Care Certificate IV in Home and Community Care Palliative Care in an Aged Care Setting
Rural Health Education foundation	Based in Canberra	Delivery of evidence-based education and training concerning health issues, through satellite, online and DVD media Provides a specific DVD education tool relating to dementia.
Replay group	Melbourne	Training for Aboriginals to work within RACS. Traineeships
Southern GP training	Churchill	Delivers general practice training in general and rural pathways
The Victoria and Tasmania Dementia Training Study Centre	Melbourne	TIME for dementia (translation, innovation, mentoring and education) Aims to provide flexible, multidimensional education to allied health, medical and nursing professionals Provides on-line educational modules

Glossary

AAV	Alzheimer's Australia Vic
ACAS	Aged Care Assessment Services
ACP	Advance care planning
ASM	Active service model (HACC)
CACP	Community Aged Care Package
CALD	Culturally and linguistically diverse
CDAMS	Cognitive Dementia and Memory Service
DBMAS	Dementia Behaviour Management Advisory Service
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
ED	Emergency department
GP	General practitioner
HACC	Home and Community Care Services
HAS	HACC assessment services
HITH	Hospital in the home
IRSED	Index of relative socioeconomic disadvantage
LSOP	Long stay older persons
LGA	Local government area
NFAD	National Framework for Action on Dementia
RACS	Residential aged care services
RDMS	Regional Dementia Management Strategy (Loddon Mallee)
S2S	Service to service
SAAP	Supported Accommodation Assistance Program
SACS	Subacute ambulatory care services
SEIFA	Socio-economic indexes for areas