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Module Title:

**LCHS7003 – Community Care and
Management of Longer Term
Conditions**

Assessment Component:

**Component 1 – Information Booklet of
Long Term Condition Management**

Assignment Title:

**Understanding and Managing Dementia:
A Person-Centred Approach to Long-
Term Condition Care in the UK**

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1. Starter : Defining Dementia

Dementia is a liberal and irreversible neurological syndrome that causes deterioration in memory, reasoning, and communication, severely affecting daily operational (NICE, 2018). It results from structural and chemical changes in the brain that impair neuronal connectivity and cognitive processing. Dementia is a generally term used to refer to disorders to result in progressive cognitive impairment. Alzheimer disease, the most prevalent one, comprises 60-70% of the cases and is caused by the displacement of brain functions by beta-amyloid plaques and tau tangles. Vascular dementia occurs due to impaired cerebral blood circulation, which frequently follows strokes (Alzheimer's Society, 2024). Lewy body dementia is characterised by uncharacteristic protein deposits that result in hallucinations, movement challenges and disturbed attention. Frontotemporal dementia impacts the frontal to temporal lobes and changes behavior and verbal. Mixed dementia is a form of dementia that is diagnosed in the same brain but is a combination of several pathologies (usually Alzheimer's and, in some cases, vascular) (WHO, 2023).

Dementia is a disease that has been estimated and impact about 55 million people globally, with close to 10 million individuals diagnosed each year (WHO, 2023). In the United Kingdom, the prevalence of the condition is about 944,000, with a figure likely to reach over one million in 2030 (Alzheimer's Society, 2024). The socioeconomic burden is significant, reaching PS34.7 billion/year, including healthcare spending, lack of care, and lost productivity (Alzheimer's Society, 2024). Major risk factors are ageing, hereditary vulnerability, heart diseases, diabetes, poor educational level, and social loneliness (WHO, 2023). Dementia is a priority in the NHS England Long Term Plan (2019), which emphasises early diagnosis, multidisciplinary care, and enhancing the daily living of older adults. The purpose of this booklet is to improve the knowledge of dementia definition, prevalence and causes to form the basis of the critical analysis of its management, person-centred care and policy background in health and social care systems in the UK.

2. Physical, Psychological, and Social Impacts

2.1 Physical Impacts

Individuals with dementia have worsening memory, loss of movement and increasing weakness. Balance and coordination are impaired by motor deterioration, which makes falls and hospitalisation more probable (Alzheimer's Society, 2024). Incontinence also frequently causes discomfort and risk of infection. According to the GOV.UK (2025) 34 % of individuals diagnosed with dementia in England permanently live in care homes, which is an indication of high-level reliance on long-term care services (Office for National Statistics, 2025). This observation demonstrates that the physical consequences of dementia go way beyond cognitive disruption. Similarly, Engel (1977) developed a biopsychosocial model that highlights the fact that physical symptoms are intertwined with psychological and social factors. Brain degeneration thus affects mood, motivation and engagement in life. This interdependence gives the importance of integrated interventions that encompass medical, rehabilitative, and community-based interventions. Moreover, McCarroll, Van't Riet and Halter (2020) stated that dementia-specialist nurses, dietitians, occupational therapists, and physiotherapists are important to maintain physical

functionality and avoid secondary complications. Therefore, proper nutrition and physical activity are proven to boost circulation and slow down deterioration.

2.2 Psychological Impacts

Dementia is an emotionally distressing condition as people realise that they are experiencing loss of control. Anxiety and depression often go hand in hand, as they are brought on by the consciousness of memory lapses and the fear of dependency (Alzheimer's Society, 2024). Moreover, identity loss is severe; patients tend to say that they feel like a different person because familiar cognitive skills are lost (Caddell and Clare, 2011). Such experiences may hasten behavioural changes, sleeping disturbance and withdrawal of social interaction. Carers, too, are exposed to extreme psychological stress. According to WHO (2022), more than 70 % of unpaid carers are women, and most of them spend more than five hours of care daily. Such pressure causes stress, fatigue and mental-health degradation. In addition, Rababa et al. (2023) highlighted

that carers' well-being directly influences the person with dementia's psychological stability. Well-trained, supported, and rested carers achieve better patient outcomes.

2.3 Social Impacts

Social impacts are also important. Sometimes families can be under economic stress, displacement, and conflict of roles. When the emotional and physical capacity of support surpasses the long-term support, it results in carer burnout. Dementia stigma may lead to marginalisation, whereby most families hide the diagnosis out of fear (Costello et al., 2019). In addition, Holt-Lunstad (2021) indicated that social involvement decreases due to the increased severity of communication problems, which amplifies loneliness and isolation. These inequalities are aggravated by social determinants of health. Individuals in the deprived or minority groups tend to receive a delayed diagnosis, reduced access to the memory clinics, and fewer community services. Moreover, Joyce et al. (2022) pointed out that the risk of dementia is higher with lower education levels and in poverty, and the cognitive decline

is worsened with social isolation. These results indicate that medical therapy alone cannot be used in dementia care, but it should also consider the social setting, equity, and inclusion. Programmes based on communities and culturally sensitive should thus be considered necessary. Initiatives like the Dementia-Friendly Communities empower the local organisations to enhance accessibility and decrease stigma (NHS England, 2019). Prevention is also important in the reduction of the Likelihood of developed dementia. There is an indication that lifestyle modification can be used to prevent up- 40% of the cases - dementia (Livingston et al., 2020). Such factors as hypertension, diabetes, smoking, obesity, and physical inactivity can be addressed in order to reduce risk greatly. Therefore, the promotion of healthy ageing and cardiovascular health through public health initiatives is a critical measure in ensuring that the dementia burden in the future is decreased.

Prevention is also important in the reduction of the risk to dementia. There is an indication that existence modification can be used to foil up to 40% of the cases of to the dementia (Livingston et al., 2020). Such factors as

hypertension, diabetes, smoking, obesity, and physical inactivity can be addressed to reduce risk greatly. Additionally, cognitive resilience is facilitated by the promotion of education, social participation, and hearing health. The promotion of healthy ageing and cardiovascular health through public health initiatives is thus a critical measure in ensuring that the dementia burden in the future is decreased.

3. Diagnosis and Assessment

Effective management of dementia involves proper and timely diagnosis. In the United Kingdom, the diagnosis often starts at the primary care level, when a general practitioner notices such symptoms as memory loss, confusion, or personality change. Structured assessment is then given to the patients by a specialist memory clinic (Low et al., 2019). This pathway must facilitate early intervention, informed decision-making, and cohesive care planning. Cognitive screening tests: MMSE, ACE-III, and MoCA assess cognitive domains like attention, memory and executive function. They are neuroimaging (mostly magnetic resonance imaging) and blood tests to eliminate

reversible causes, such as depression, infection, or metabolic disorders (Senda et al., 2020). There is evidence that early diagnosis positively affects the quality of life and boosts medication efficacy and carer support. On the same note, Liss et al. (2021) indicate that early identification enables families to plan finances and emotionally, which prevents future crises. Despite clear national guidance, workforce shortages and unequal access to memory clinics persist. Comorbidities like cardiovascular disease, depression, and diabetes can further delay or obscure dementia diagnosis (Thomas, Best and Mitchell, 2020).

Diagnosis Multidisciplinary diagnosis is necessary, which involves collaboration between GPs, neurologists, community nurses, occupational therapists, and social workers to attain the holistic assessment. According to Steenkamer et al. (2020), shared responsibility encourages a continuum of health and social care. However, communication between services is usually disjointed, which slows down the diagnosis and care plan implementation. Further, the available evidence shows that Black-Asian, and Ethnic groups are still

underdiagnosed due to cultural stigma, language barriers, and lack of awareness. In addition, Vincent - illustrated that the rural population also has limited access to diagnostic services that expose them to inequity in the NHS. Globally, the World Health Organisation's *Global Dementia Observatory* (2021) highlights similar disparities. Dementia cases are underdiagnosed in many low- and middle-income nations, with less than half of the expected cases due to a shortage of resources and specialists. This contrasts with the UK, where it is an organised system of diagnosis, where policy alone is not sufficient, without local capacity and education (Khan and Raza, 2021). Therefore, diagnosis should not just be done but also prolonged.

4. Management and Treatment

4.1 Pharmacological Management

Dementia is treated using drugs, which are used to improve symptoms as opposed to curing the illness. NICE (2018) prescribes acetylcholinesterase inhibitor (AChEIs)-donepezil, rivastigmine and galantamine to mild and

moderate cases of Alzheimer and memantine to severe or AChEI-intolerant cases. Likewise, Steiner-Lim et al. (2023) also found that AChEIs have slight short-term cognitive effects but minimal long-term efficacy. Further, the existence of a small and significant enhancement in cognition and daily functioning, but with a decrease in benefits in 12 months. Adverse effects can decrease adherence through adverse effects like nausea, bradycardia and insomnia (Moreta et al., 2021). This emphasises the frequent review of medications and the education of carers. In addition, comorbidities such as cardiovascular disease and frailty need to be considered when prescribing. In addition, Matsunaga et al. (2018) illustrated that the NMDA-receptor antagonist memantine has a moderate but little effect on behavioural symptoms and little effect on disease progression. Such results suggest that pharmacological intervention is supportive, but never transformative.

More importantly, the biomedical emphasis on drugs may override psychosocial aspects of service. Calhoun (2024) claims that pharmacotherapy is dangerous because it might disregard personalized, holistic interventions. As

stated by Engle Pharmacological dealing be incorporated in multidisciplinary, person-centred care models. Although medication helps in relieving the symptoms, it does not deal with the complicated biopsychosocial problems of dementia. Other comorbidities like cardiovascular disease, diabetes, and depression further affect treatment decisions, and effective and safe treatment plans involve serious coordinated and holistic care planning (Chertkow et al., 2018). In general, medication helps the symptoms relief, but it cannot resolve the complex biopsychosocial burden of dementia.

4.2 Non-Pharmacological Management

The focus of quality-of-life improvement lies in pharmacological interventions. Cognitive stimulation therapy is a popular treatment for slight to the moderate dementia. In a study by Woods et al. (2023), CST can be used to improve cognitive functions and socialisation considerably when administered in a group. Similarly, Rost et al. (2022) affirmed long-term positive cognitive change

post-structured CST programmers up to six months. Nonetheless, it is subject to the facilitator's ability and the involvement of participants. Some other interventions like reminiscence therapy, music therapy and physical exercise also have psychosocial benefits. In addition, De Medeiros et al. (2020) illustrated that meta-analysis found that regular exercise enhances physical health and might defer institutionalization. Moreover, nutritional optimisation, such as omega-3 supplementation and balanced diets, aids general well-being. It cites comorbidity factors such as arthritis, mobility difficulties, and cardiovascular disease as limiting participation in therapies (Bovaird and Loeffler, 2019). These conditions require adapted, safe, and inclusive non-pharmacological programmes to ensure accessibility and effectiveness.

However, Nevelsteen (2018) argued that the evidence is still mixed; the methodology is diverse, and no concrete statements can be made regarding the persistence of effects. These interventions are improved using a multidisciplinary team (MDT). As stated by Copley et al. (2024), the collaboration of nurses, psychologists, physiotherapists, occupational therapists and dietitians

allows customising programmes based on personal objectives. Training and peer support of the carers is essential and can be found in the voluntary sector, especially the Alzheimer's Society (WHO, 2020). Therefore, this kind of collaboration reflects the co-production and self-management values that are emphasised in the Declaration.

5. Models and Frameworks

The House of Care (HoC) model, created by NHS England (2014), offers a systematic UK model of the management of long-term conditions based on collaboration and personalisation. It has four pillars that are interdependent to symbolise its architecture. Moreover, Bovaird and Loeffler (2019) illustrated that the foundation signifies commissioning and partnership designs that facilitate joined-up services. The roof refers to organisational systems and information processes that integrate care. The walls symbolise concerned, knowledgeable people on the one hand and able, enthusiastic health practitioners on the other hand. At the heart of this model is a conversation between practitioner and patient regarding self-

management and goal setting through shared care planning. In addition, Park (2020) claims that HoC develops person-centred care by enabling patients to co-produce their care. The model has not been fully implemented. Multidisciplinary and digital care is used in some areas, and it is poor in commissioning and workforce shortages. Inadequate assessment in underprivileged areas demonstrates the problem of capacity.

The World Health Organisation Innovative Care for Chronic Conditions (ICCC) Framework (WHO, 2002) presents a global view. It suggests three levels of coordinated action, micro (individuals and families), meso (health organisations and communities) and macro (policy and governance). The framework focuses on community involvement, prevention and system coordination of chronic disease management sustainability (Lall et al., 2018). As stated by Donkin et al. (2018), its advantages are that it enhances global policy coherence and acknowledges social determinants of health. Likewise, it aids in capacity building of low and middle-income countries, where the issue of resources is critical. However, it is also frequently criticised based on being

conceptually wide and hard to translate into the context of various national settings (World Health Organisation, 2021). Overall, both frameworks are complementary to each other as applied to dementia care.

6. Policy and Political Context

The NHS Long Term Plan (2019) that underpins UK dementia policy highlights early diagnosis, personalised care and dementia-friendly communities. It promises to raise the rate of dementia diagnosis to over 66 per cent and develop post-diagnostic care using primary and community care (NHS England, 2019). Nonetheless, it has been indicated that there are regional differences in meeting these goals, and there is a delay in follow-up after diagnosis. Moreover, Thomas, Best and Mitchell (2020) claim that the plan encourages the idea of whole-person care, but the practice relies heavily on the capacity of the workforce and local commissioning priorities. The Dementia Action Plan of Wales 2018-2022 is a rights-based approach to dementia prevention. It aims to increase awareness, decrease stigma and support carers (Chertkow et al., 2018). In addition, Smith and Surr (2024)

illustrated that national standards towards memory assessment services enhance the uniformity of health boards. However, evaluation reports show that there have been minimal improvements in integrated community delivery because of uneven funding.

The well-being principle and a statutory duty of health-social-care integration were introduced because of legislation in the Care Act (2014). It acknowledges carers as equal partners, which guarantees assessment rights and support eligibility (Department of Health and Social Care (DHSC), 2014). Equally, the priorities of reform, digital innovation and workforce investment are set in the Adult Social Care White Paper - People at the Heart of Care (2021). The policy includes PS1.7 billion of workforce training and PS300 millions of housing adaptation (McCance et al., 2021). However, Allison (2020) observes that unsuccessful underfunding, wage disparities and staffing deficits are endangering its sustainability. The World Health Organisation has created a complete framework of seven strategic objectives in the Global Action Plan on the Public Health Response to Dementia (2017-2025) on an international scale (World Health

Organisation, 2021). They are dementia awareness, reduction of risks, diagnosis, treatment, research, data collection, and support to caregivers.

The plan sets achievable global accountability indicators and promotes national dementia strategies. Nevertheless, it is still not being widely implemented: only 40 % of WHO member states have formalised dementia policies (WHO, 2023). As stated by Lightbody and Escobar (2021), the UK has stronger governance, but it still does little compared to equitable access and community involvement. There is a lack of consistency in post-diagnostic support and poor coordination of health and social care. Therefore, person-centred dementia care is still confronted with the issue of variable implementation and insufficient outcome measures.

7. Self-Management and Co-Production

Self-management can be described as empowering people to manage their health and wellbeing independently by means of knowledge, planning and goal setting (NHS England, 2019). It helps individuals with

dementia to make well-informed choices and remain independent even in the face of progressive cognitive impairment. Co-production, which is defined in Our Declaration: Person-Centred Care, takes this principle further by enhancing equality of partnership between service users, carers and professionals. Both ideas take on the trend of traditional paternalistic care because they appreciate lived experience in addition to professional expertise (Badano, 2019). In addition, Soares et al. (2024) highlighted that empowerment can be attained by education, digital inclusion and peer support. Health-literacy programmes and education enhance knowledge of symptoms, medication, and community resources. On the same note, Kallmerten (2021) argued that digital services like memory applications, tele-monitoring, and electronic care plans can support self-efficacy and communication among care networks.

In addition, peer and carer groups promote emotional well-being and minimise the feeling of isolation through exchanging coping mechanisms to face everyday pressures. However, Wiegand et al. (2023) evaluated that personalised Care and Self-Management Support models

are designed to enhance collaboration planning, customised intervention, and multidisciplinary dementia hubs in ICSs. Therefore, digitally enabled co-produced care links medical and social support, promoting sustainable, person-centred dementia care.

8. End of the Life and Palliative - Care

The dementia end-of-life care is centred on dignity, comfort and emotional care. The King Fund End-of-Life Framework (2010) focuses on the importance of compassionate communication, holistic assessment and family engagement. In the same way, the Gold Standards Framework (GSF) informs the early identification and proactive care planning to maintain continuity between settings (GSF, 2010). In addition, Zwakman et al. (2018) illustrated that advance care planning enables individuals to give their preference on how they want to be treated even when they lose the ability to communicate. This practice encourages independence and minimises suffering for families and clinicians. Moreover, Swami and Case (2018) illustrated that proper palliative care involves physical symptom management along with psychological

and spiritual encouragement. This interdisciplinary teamwork between nurses, GPs, social workers and voluntary agencies will guarantee coordinated provision. Nonetheless, Iupati et al. (2023) argued that practice has been shown to vary and have little access to specialist dementia palliative services. Equity and quality could be enhanced through the strengthening of communication training, the inclusion of carers and community-based palliative networks.

9. Recommendations and Conclusion

9.1 Recommendations

The services and memory clinics should be expanded to ensure the timely detection and intervention. Early diagnosis enables proper treatment, care planning and assistance before severe deterioration (NICE, 2018). Additionally, better access will minimise hospitalisation and institutional dependency. Training of carers and the provision of respite will enable the families to provide informed and caring services. Competent carers decrease behavioural crises and maintain autonomy at home

(Alzheimer's Society, 2024). Career wellbeing is a legal obligation under the Care Act (2014). Dementia outcomes can be enhanced with a more solid emphasis on prevention, public health efforts, and early interventions. As stated by Hung et al. (2021), the inclusion of the House of Care model and the encouragement of dementia-friendly community design can improve collaboration, personalisation, and safety which can in turn facilitate equitable and sustainable dementia care in the UK.

9.2 Conclusion

Person-centred, evidence-based, and practice-as-a-whole practice is the core of successful dementia care. Health, social, and voluntary intersection facilitate continuity and removes service fragmentation. Integration of common decision-making and co-production principles promotes autonomy, trust and respect between professionals and family. The future of dementia care lies in the investment in the workforce, the availability of services in the community, and their cultural inclusion. Finally, the partnership and evidence-based support of people and

carers preserve dignity, resilience, and well-being during dementia journeys.

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