

BOARD OF DIRECTORS MEETING (Open)

Date: 13 February 2019

Item Ref:

04

TITLE OF PAPER	Dementia Strategy – Trust response
TO BE PRESENTED BY	Clive Clarke, Deputy Chief Executive/Director of Operations
ACTION REQUIRED	To review and endorse the proposed response to the draft Sheffield Strategy and Commitments for Dementia

OUTCOME	For the Trust to inform and support the development of city wide strategy for dementia.
TIMETABLE FOR DECISION	February board meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	None
STRATEGIC AIM STRATEGIC OBJECTIVE	Strategic Aim Quality & Safety: A1 02, A1 03, A1 04. Strategic Aim Future services: A3 01, A3 02, A3 03, A3 04.
BAF RISK NUMBER & DESCRIPTION	BAF Risk A1 04 Timely Access To Effective Care Failure to produce a citywide dementia strategy could impact on the coordination of citywide commissioning for dementia services.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	None directly.
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Future implementation plans for the strategy will shape the development of a number of current services provided by the Trust. These will be reviewed and confirmed through the contract review process.
CONSIDERATION OF LEGAL ISSUES	None highlighted.

Author of Report	Jason Rowlands
Designation	Director of Strategy and Planning
Date of Report	February 2019

SUMMARY REPORT

Report to: BOARD OF DIRECTORS

Subject: Dementia Strategy – Trust response

Author: Jason Rowlands, Director of Strategy and Planning

1. Purpose

<i>For Approval</i>	<i>For a collective decision</i>	<i>To report progress</i>	<i>To seek input from</i>	<i>For information</i>	<i>Other (please state below)</i>
X					
For the Board of Directors to review and confirm the Trusts response to the Sheffield Dementia Strategy Commitments.					

2. Summary

2.1 Background and context

The Dementia Strategy Implementation Group was established in 2017 with delegated authority from the Mental Health, Learning Disability and Dementia Delivery Board to establish a coherent city wide approach to designing and agreeing the strategic direction within Sheffield to ensure:

1. People their families are supported to live to their full potential with dementia
2. The right level of care and support is provided in the right place by the people with the right skills.
3. That improved quality and efficiency is achieved so supporting the Sheffield Quality, Innovation, Productivity and Prevention (QIPP) Programme.

The Dementia Strategy Implementation Group has produced a revised Dementia Strategy and Commitments to shape developments within Sheffield over the next five years (2019-2024). Consultation and engagement on the proposed Commitments has been underway across the city.

The draft commitments have been reviewed by the Trust’s Dementia Project Group, Executive Directors Group and the Trust’s Board of Directors in its formal meeting in December and a development meeting in January. This has informed the proposed Trust response at Appendix 1.

Appendix 2 for reference is the proposed Dementia Strategy and Commitments for Sheffield which has previously been reviewed by Board.

2.2 Key points from Trust review of the Strategy and Commitments

The key points from discussion and debate within the Trust is summarised as follows;

- a) Overall the strategy and draft commitments are welcomed and they provide a helpful framework and direction of travel. They have been developed through a collaborative approach across all organisations and public/ service user stakeholder groups.
- b) The agendas covered by the proposed 13 Commitments reflect the development needs within the city and the Trust supports them as a framework for change and improvement.
- c) It is essential that effective progress is now made in moving forward because it is clear that some people living with dementia in Sheffield aren't always benefiting from a socially inclusive approach to providing support and care.
- d) There is a need to ensure consensus regarding the implications and conclusions drawn from the public health and epidemiology data and information. The Trust would support this and actively participate in on-going review and analysis with partners in the city to reach a clear and shared view, owned by all parties.
- e) The focus and direction of travel in respect of prevention, living well, dementia friendly communities and access to community based information, help and support is clearly defined and welcomed.
- f) The commitments relating to care and support for people with complex needs are focussed in the right areas, however the solutions for the way forward are not as well defined. Further work is now required across the whole system to define the changes required to ensure the Commitments in these areas are effectively planned for and delivered.
- g) Key areas that the Trust feels need to be progressed effectively are
 - Rapid response service model shifting to an enhanced home treatment model, supported by access to short term care capacity and high quality emergency respite/ crisis support – to provide effective community focussed care and treatment at times of crisis.
 - Assess to care approach to be defined in respect of step up and step down options of support optimisation of future care, supported by clear partnerships with dedicated and skilled nursing home providers
 - Developing our approaches to high dependency care with revised specifications for inpatient services and support for other providers to support care provision within Sheffield.
- h) Considerable transformational change has been delivered within Sheffield supported by agreed risk share arrangements and the adoption of principles to support and ensure whole system management. This has resulted in the development of experience and expertise within the Trust and health and social care commissioners working collaboratively to support change. The Trust believes there may be benefits from exploring further how these

principles may help support the effective delivery of the Strategy Commitments, particularly in the areas of complex care needs.

- i) There is broad recognition across the Sheffield ACP of the benefits of the mental health focussed whole system/ risk share model, and an interest to explore and examine how learning from this can shape approaches across other pathways. This would suggest a level of interest in exploring this further. However there will also be risks in this area. Current arrangements and organisational needs, commitments and interests across the commissioning and provider partnership will need to be defined and understood to inform any way forward towards adopting a broader whole system approach underpinned by risk share arrangements.
- j) The Trust welcomes and fully supports the Commitment to ensure clear programme governance and monitoring of the delivery of the Strategy under the ACP Governance structures. To further support this there is a need to establish a financial plan to support the delivery of change for this programme.

In moving forward the Trust will actively engage with and support the development of an implementation plan and to assess with partners the development of proposals and business case to support change.

2.4 Draft response

A proposed/ draft response is attached at Appendix 1. The key messages in the draft response are summarised as

- General support for the Strategy and Commitments
- Welcome the focus on prevention, living well, neighbourhood and community developments
- The Commitments focussed on people with complex care needs are welcome, however further work is required to develop and agree the intended responses and ways forward in respect of service models.
- The Trust supports the need to develop effective training and education programmes and has expertise to offer to support this in the areas of complex needs and challenging behaviours.
- The further clarity is required to develop and agree next steps and plans around key services that support people with complex needs, and the Trust wishes to actively support further work in this area.
- That there may be benefits of exploring how learning from related whole system/ risk share models in the mental health system may support the delivery of the Strategy and Commitments.

3 Next Steps

To inform the Consultation

- a) Formal feedback to the Strategy consultation

To inform and shape progress post consultation

- a) On-going engagement work around the development of implementation plans in respect of complex care pathways and services
- b) Engagement and scoping of interest in exploring benefits of whole system/ risk share approaches to shape and inform a potential future case for change.
- c) Continue to review the developing and emerging implications for current Trust services, define the implications and the need for change to support the city strategy. Consider and scope business and contractual implications when indicated.

4 Required Actions

To review and endorse the proposed response.

5 Monitoring Arrangements

This will form part of Trust objectives for 2019-20 and be monitored through the year

6 Contact Details

Jason Rowlands, Director of Strategy & Planning.
Michelle Fearon, Director of Operations and Transformation

DRAFT**SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST
RESPONSE TO SHEFFIELD DEMENTIA STRATEGY COMMITMENTS****1. Introduction**

- 1.1. Sheffield Health and Social Care NHS Foundation Trust (SHSC) welcomes the development of a new citywide strategy for dementia care and support for the city of Sheffield.
- 1.2. The objectives of the strategy align well with the strategic objectives of the trust, in particular the provision of effective community care and treatment.
- 1.3. The draft commitments have been reviewed by the SHSC Dementia Project Group, SHSC Executive Directors Group and the SHSC Board. Informed by this the Trust's response is summarised below.

2. SHSC Response

- 2.1. The Trust welcomes the cross organisational partnership approach to the development of the strategy commitments. SHSC will continue to support the work of the Dementia Strategy Implementation Group and support wider engagement of stakeholders wherever beneficial to the implementation of the commitments.
- 2.2. The agendas covered by the proposed 13 Commitments reflect the development needs within the city and the Trust supports them as a framework for change and improvement. It is essential that effective progress is now made in moving forward because it is clear that some people living with dementia in Sheffield aren't always benefiting from a socially inclusive approach to providing support and care.
- 2.3. The focus and direction of travel in respect of prevention, living well, dementia friendly communities and access to community based information, help and support is clearly defined and welcomed. SHSC supports the further development of the links being built with the neighbourhoods and People Keeping Well Partnerships across the city to advance this agenda.
- 2.4. The on-going reviews by NHS Sheffield CCG of specifications for SHSC dementia services are being carried out with reference to the commitments in the emerging strategy, and the Trust welcomes this approach as a positive step. This includes the following services:
 - Dementia inpatient care on G1 (Grenoside Grange)
 - Older Adults Home Treatment Team (previously named Dementia Rapid Response Team)
 - The Memory Service
 - Nursing care provision at Woodland View and Birch Avenue Homes
 - Dementia assess to care provision at Woodland View and Birch avenue

- 2.5. The Trust agrees that there is a lack of consensus about the level of need for dementia care in Sheffield over the next 10+ years. It is crucial that this is resolved and a shared view is reached about the conclusions to be drawn from the available information to inform on-going plans. SHSC will commit to supporting the work with public health and the outcomes development group to reach a consensus.
- 2.6. The Trust recognises the gap in the city for provision of consistent high quality education and training for health and social care staff on dementia awareness and dealing with challenging behaviours. The Trust has considerable expertise in this area and would be keen to support the development and provision of training on complex behaviours as part of the future plans to support the implementation of the strategy.
- 2.7. The Trust is committed to ensuring people receive the level of care and support from health and social care to which they are legally entitled. To this end SHSC will continue to work with the local authority in reviews of individuals currently on Section 117 Aftercare.
- 2.8. There is a lack of consensus currently about the future model for complex dementia care in the city. In particular, in relation to the number of specialist beds required and how best to support a shift to more community based care for people with complex care (including at time of crisis). Uncertainty around the future numbers of beds and use of beds at Woodland View and Birch Avenue makes planning for those services challenging. Therefore prioritising decisions in relation to these services would be welcomed.
- 2.9. The pilot of dementia assess to care beds on Woodland View and Birch Avenue has expedited some discharges from G1 and Dovedale and has enabled step up from the community at times of crisis. The Trust welcomes the longer term ambition to provide an equivalent pathway in Sheffield.
- 2.10. The commitments relating to care and support for people with complex needs are focussed in the right areas, however the solutions for the way forward are not as well defined. Further work is now required across the whole system to define the changes required to ensure the Commitments in these areas are effectively planned for and delivered.
- 2.11. Key areas that the Trust feels need to be progressed effectively in respect of support for people with complex needs are
 - Rapid response service model shifting to an enhanced home treatment model, supported by access to short term care capacity and high quality emergency respite/ crisis support – to provide effective community focussed care and treatment at times of crisis.
 - Assess to care approach to be defined in respect of step up and step down options of support optimisation of future care, supported by clear partnerships with dedicated and skilled nursing home providers
 - Developing our approaches to high dependency care with revised specifications for inpatient services and support for other providers to support care provision within Sheffield.

- 2.12. The Trust is committed to actively exploring, as part of the city wide programme, how we can make progress in the above areas (2.7-2.11) to support the development of clear plans to effect change in support of the Strategy and Commitments.
- 2.13. Considerable transformational change has been delivered within Sheffield supported by agreed risk share arrangements and the adoption of principles to support and ensure whole system management. This has resulted in the development of experience and expertise within the Trust and health and social care commissioners working collaboratively to support change. The Trust believes there may be benefits from exploring further how these
- 2.14. The Trust recognises the opportunity for the system to better use technology to support people to remain independent for longer and would support work to take this forward.
- 2.15. We need to ensure we have clear plans to move forward in implementing the Strategy and the Trust welcomes the commitments in this regard to ensure we effectively review progress. There is a need to clearly articulate in the final document the governance of the dementia strategy programme of work and how it links to Sheffield Accountable Care Partnership and potentially the wider South Yorkshire and Bassetlaw Integrated Care System.
- 2.16. As we move forward to develop plans it would be beneficial and helpful to define the costs of the current system and which elements of care costs will form part of the future programme.

3. Next Steps

- 3.1. It is understood that the strategy commitments will be supported by an implementation plan to be developed early 2019. The Trust would welcome the opportunity to be involved in the development and oversight of the plan.
- 3.2. SHSC will continue to support the development of the strategy through their membership of the Dementia Strategy Implementation Group and the appropriate working groups associated with the work.
- 3.3. The next steps and implementation plans need to be developed alongside key messages and requirements outlined in the NHS Long Term Plan.

Draft Commitments

1	Sheffield will become a dementia friendly city.
2	We will ensure preventative health become an integral part of the dementia work
3	We will improve access to the diagnosis of the diseases that cause dementia at the earliest possible stage for the people of Sheffield.
4	For people with dementia support in Sheffield will be more personalised, local and accessible to help people to remain independent for as long as possible.
5	We will provide high quality support to families and carers of people with dementia in Sheffield to help people with dementia maintain their independence for as long as possible
6	Sheffield will continue to provide out of hospital emergency assessments and short term care when people need it and in the most appropriate setting
7	Sheffield will continue to provide specialist inpatient assessment and treatment for people who are unable to receive care in their own homes.
8	We will make sure that more people get access to personalised, good quality palliative and end of life care when they need it
9	We will improve care for people with dementia attending A&E and those admitted to Sheffield Teaching Hospitals
10	Care homes will take account of the needs of people with dementia
11	We will support the clinical and non-clinical research community in Sheffield.
12	We will provide guidance to clinicians in relation to the best medicines for dementia, including when to initiate and review medication.
13	We will monitor the strategy and the implementation plan supporting it.

COMMITMENT 1: Sheffield will become a dementia friendly city.

There is still an unacceptable stigma surrounding dementia which can often lead to poor experiences for people living with dementia. To overcome this we need to improve awareness and understanding of dementia across all sectors of society. Working with partners to explore the potential to promote and support increased participation in dementia friendly initiatives and dementia befriending. Linking into the local neighbourhoods and the People Keeping Well Partnerships that currently exist in the city, will be key ways we deliver on this commitment.

There are currently over 14,500 people registered as Dementia Friends and 92 Dementia Champions in Sheffield. Sheffield was one of the first cities in the country committed to being a Dementia Friendly Community. A dementia-friendly community is where cities, towns, villages and local businesses and organisations support people to live well with dementia, helping them remain independent for longer. By working towards being a dementia friendly city, Sheffield aims to encourage the inclusion of people with dementia, carers and their relatives to be heard.

A strong theme running through all groups and ages of people we spoke to through our engagement work was that people want to be able to continue with hobbies and interests that they have or maintain contact with activities that they have participated in since their diagnosis. Sheffield has a wealth of dementia activities provided by a wide range of providers but they can sometimes be hard to find and lack of coordination.

Driving and transportation were also topics that were regularly discussed through our engagement work. As dementia progresses it has greater effects on people's ability to drive and as a result, everyone with dementia will eventually lose the ability to drive safely. From the feedback we received through our engagement work, it seems likely that for some people, the psychological consequences of having to stop driving are not fully addressed by current services.

What will be different?

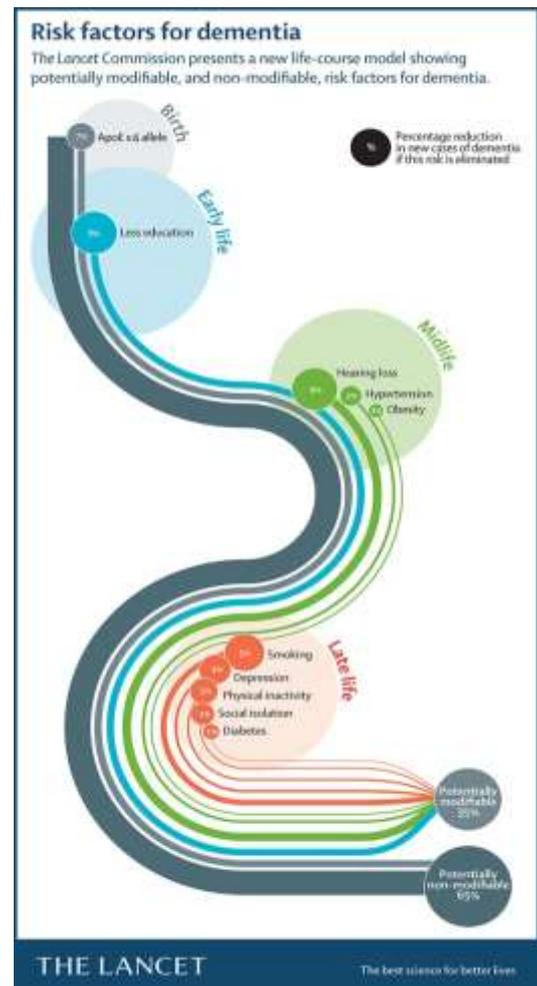
- All public sector employees in the city will receive the appropriate level of dementia training for their role
- Inter-generational programmes will link nurseries / schools with care homes and dementia cafes / lunch clubs
- Sheffield Dementia Action Alliance partners will support the development of dementia friendly businesses across the city.
- Dementia Friends training will be offered to all front line health and social care staff and the use of digital communities of practice to support this will be explored
- More local (neighbourhood based) information will be included in the Alzheimer's Society Dementia Connect website
- There will be linkage better link between the dementia strategy programme and the Age Better Programme led by South Yorkshire Housing Association
- More dementia friendly public transport and taxi drivers.

COMMITMENT 2: We will ensure preventative health become an integral part of the dementia work

Dementia is not an inevitable part of aging. The Projecting Older People Population Information system (POPPI) estimated that in 2017 a total of 6,709 people aged 65 and over have dementia in Sheffield. This is set to rise to 10,186 by 2035.

The Lancet Commission (2017) on dementia prevention, intervention and care provides a number of suggestions for reducing the risk of dementia throughout the life-course, starting with more childhood education. From their review the following interventions could delay or prevent a third of dementia cases:

- Increasing levels of physical activity
- Maintaining social engagement
- Reducing smoking
- Managing hearing loss
- Managing depression
- Managing diabetes
- Managing and reducing obesity
- Active treatment of hypertension in people without dementia of middle age (45-65 years) and in later life (aged 65 and over).



What will be different?

- Increased awareness about the risk factors and progression of dementia in health and social care staff
- People with hypertension will be identified and managed appropriately. All people in Sheffield with a diagnosis of hypertension will be in active treatment by 2020.
- Dementia risk awareness will be included in existing public health work

COMMITMENT 3. We will improve access to the diagnosis of the diseases that cause dementia at the earliest possible stage for the people of Sheffield.

Although there is currently no cure for dementia, a timely diagnosis unlocks the door to appropriate care and treatment. It also gives the person living with dementia the best opportunity to ensure their wishes are taken into account in the development of their care plan and more chance in taking part in research if they wish to do so.

Sheffield continues to have high dementia diagnostic rate, however it is unclear whether this high rate is equal across all groups of society. There is work to do to understand the rates of diagnosis in different groups. We will therefore look at information about people currently being diagnosed, to see whether any groups are underrepresented.

There is a commitment in the Prime Minister's Challenge on Dementia 2020 to increase the numbers of people of black, Asian and minority ethnic (BAME) and other seldom heard groups who receive a diagnosis of dementia. This will be done through greater use by professionals of diagnostic tools that are linguistically or culturally appropriate.

The prevalence of dementia in people with learning disabilities is higher than in the general population. However, the early stages are more likely to be missed or misinterpreted, particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated and problems with communication may make it more difficult for others to assess change. It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored, particularly where the person involved does not use words to communicate.

The engagement work which took place to shape this strategy identified that work to date to understand the experiences of people from BAME groups, people with learning disabilities and people with young onset dementia has been limited and it was recommended that more work needs to be done to actively seek their views. We also found that not all people presenting to their GP with memory problems are offered or want to be referred to a specialist memory service and this can limit their access to post diagnostic support.

What will be different?

- We will have a better understanding of the prevalence of dementia in BAME and other minority groups (e.g. people with learning disabilities, under 65s).
- There will be more active engagement with these groups to inform future support and service design through the implementation plan.
- We will ensure the leads for the different pathways for dementia diagnosis work more closely together and review the linkages between them – this will include people who are admitted to Sheffield Teaching Hospitals and diagnosed (informally) during their inpatient stay.
- There will be improved access to linguistically or culturally appropriate materials to support diagnosis and post diagnostic care in Sheffield.
- Equality impact assessments will have been completed for all dementia specialist services in the pathway to help guide how we address any issues identified.
- A baseline functional assessment will be captured for all people with Down's syndrome to aid future diagnosis.

- There will be improved awareness in primary care of the different pathways for diagnosis and dementia care with everyone given a choice by their GP to access a specialist memory service.
- Specialist dementia services working more closely with primary care to offer a more integrated, flexible (person centred) approach to diagnosis for all groups.
- There will be earlier access to post diagnostic support for people diagnosed with dementia and their families / carers.
- Greater use of new technologies to support the diagnostic process.
- Improved screening in primary care for cognitive function (include in annual health checks for over 70s)
- Improved screening for cognitive function in Community Mental Health Teams for Older Adults

COMMITMENT 4: For people with dementia support in Sheffield will be more personalised, local and accessible to help people to remain independent for as long as possible.

The Prime Minister's Challenge for Dementia 2020 states that every person with a diagnosis of dementia should have meaningful care following their diagnosis, which supports them and those around them, in line with the NICE Guidance (2018). This should include having a care plan, a named person to support them, and an assessment of any help they may need with day to day activities.

Following diagnosis by a specialist memory service people receive a wealth of information about health and social support available to them and about their diagnosis. Feedback from patients and carers is that this information can be overwhelming and a more personalised, flexible approach to this post diagnostic support could be beneficial.

For those going through the specialist memory service in Sheffield, they will also have a care plan agreed with them and an opportunity to make advanced care plan decisions. However, communicating about this plan back to other health and social care providers involved with a person is variable. Increased personalisation of care plans, focusing on a person's functional wellbeing and coordination of local information will help people to access activities most suited to them in the future, help people maintain their independence and potentially remain living in their own homes for longer

A case management service is also available, which people living with dementia or their carers can access for support anytime post diagnosis.

There are a wealth of community based services and support networks available throughout Sheffield. The feedback from people with a dementia diagnosis is that they find it hard to find out about services local and relevant to them. Raising the profile of Sheffield's many community based assets, many of which are run by the voluntary sector, will be a key part of achieving this commitment.

There are many potential uses of technology to help support people living with dementia and their families / carers. Technology including assistive technology can help people to live independently for longer and potentially enhance their quality of life. Sheffield is committed to ensuring people are aware of what is available, as well as utilise technology in service provision as far as possible to monitor health, reduce social isolation and connect people.

What will be different?

- There will be a standardised set of information for people with dementia and the people who support them to ensure consistency to support flexible, personalised/local approach to post diagnostic information provision and on-going support.
- There will be improved support already provided by the voluntary sector to ensure availability of relevant and accessible support.
- There will a greater use of technology to support people with dementia to remain independent for longer.
- There will be a smooth transition from the point of diagnosis into local community activities supported through neighbourhood to ensure a person with dementia and their carer/ family remain linked into their local community networks.
- Closer working between specialist dementia services and local communities.

- Care plans will be shared (with the appropriate permissions) to all relevant people involved in a person's care and support.
- Care plans (including any advanced care planning statements) will be reviewed at least once a year by the person most appropriate to a person's care.
- A review of the support available to people with young onset dementia across Sheffield is planned for 2018/2019.
- People diagnosed under the age of 65 will have equal access to appropriate high quality post diagnostic support.
- An offer of support will be developed to support younger people with a dementia diagnosis to support their independence and remain in work.
- There will be improved linkage to existing support for people with a learning disability who are diagnosed with dementia to ensure equal access to appropriate post diagnostic support.
- Information will consistently be offered after a diagnosis of dementia and through support in relation to legal requirements.
- Develop local guidelines for practitioners who are responsible for advising people with dementia to stop driving, including information about the emotional impact this may have.
- Staff working with people with dementia will keep up to date with the latest technology available to enable them to promote the use of memory aids & assistive technology to reduce risk and promote independence.
- Sheffield commissioners and providers will work closely with the digital workstream of the Accountable Care Partnership to ensure Sheffield residents benefit from the developing innovations locally.
- Explore the use of a quality of life score for people living with dementia

COMMITMENT 5: We will provide high quality support to all families and carers of people with dementia in Sheffield to help people with dementia maintain their independence for as long as possible

People with dementia can feel more vulnerable and increasingly rely on other people to do things for them as their disease and symptoms progress. Caring for someone with dementia can be frustrating and stressful at times, it's therefore important for the physical health and psychological wellbeing of the carer that they are supported with their caring responsibilities. In many cases A&E attendances and hospital admissions for people with dementia are due to carer stress and carer breakdown rather than an acute health needs. Carers are more likely to struggle to continue to study or work; be unwell (twice as likely as the rest of the population); suffer financial hardship and be lonely and unable to have a social life. Sheffield already has a Carer's Strategy containing six carer principles which are that by 2020 every carer should have appropriate opportunities to:

1. Access at the right time, the right type of information and advice for them, their family and the person they care for
2. Understand their rights and have access to an assessment
3. Have a voice for themselves and the person they care for
4. Have regular and sufficient breaks
5. Continue to learn and develop, train or work (if they wish to)
6. Look after their own health

Through the Dementia Strategy Implementation Group we will work with the Carer's Strategy Implementation Group to ensure that the needs of people caring for individuals with dementia are recognised and they are supported to continue in their caring role independently as long as they wish to.

What will be different?

- There will be improved identification and recording of carer status to ensure people are offered support
- There will be an increased awareness across health and social care staff about the issues faced by carers and the importance of providing timely support
- All carers for someone living with dementia will be made aware of their right to a carer's needs assessment at the time of diagnosis
- Carers for someone living with dementia will have access to an effective intervention to reduce the risk of depression
- Timely and appropriate respite will be available for people living with dementia and/or their carer
- There will be an improved quality of life scores for people caring for someone with dementia.
- There will be an improved offer of bereavement support pre and post their loved ones death

COMMITMENT 6: Sheffield will continue to provide out of hospital emergency assessments and short term care when people need it and in the most appropriate setting

People with dementia and their families / carers currently can access support from a specialist dementia team 7 days a week between 8am and 8 pm and from alternative community mental health staff outside those hours. Feedback on the care provided by this team from families is generally very positive:

However, feedback from referrers to the service and from carers of people with dementia suggests that there is confusion regarding how to access help in times of crisis (particularly out of normal office hours) , a need for a quicker triage response and for better linkage between this team and the out of hours cover.

Accessing timely short term care either in a person's usual place of residence or for those who can no longer safely remain in their own home an alternative location is often difficult to put in place in a timely way in emergency situations.

What will be different?

- There will be a clear route for accessing support at times of crisis which will be well communicated regardless of the type of need (physical health, mental health, social care etc.)
- Everyone living with dementia and their carers will know who to contact in a crisis (whatever time and whatever day of the week)
- Carers and people living with dementia will be supported, as part of the care planning process, to complete and maintain an emergency plan.
- Dementia care plans will be linked into existing citywide care plans such as 'OK to Stay'
- A faster response to requests for emergency assessments in the community and the timely provision of emergency support
- Improved access to emergency placements and care when required.
- Reduced inappropriate admissions to hospital and care homes for people with dementia.

COMMITMENT 7: Sheffield will continue to provide specialist inpatient assessment and treatment for people who are unable to receive care in their own homes.

Even with comprehensive community based support for people living with dementia, there are occasions when people can no longer stay in their own home and need to receive care in a different setting. This can be for many reasons, for example a short period of respite, an assessment of needs following an emergency admission to hospital, rehabilitation following a physical health problem or palliative care at the end of life.

Sheffield has an inpatient service for people who are actually unwell where service users receive a full psychological and physical assessment and appropriate treatment and management. Patients admitted to this service have behaviour that is highly complex and unstable, presenting significant challenges to their usual care givers. The number of patients admitted to this acute inpatient service are low and consequently Sheffield has a very low number of Mental Health Act detentions for dementia (approx. 45 per year) putting it in the lowest 25% nationally.

Sheffield has a very low number of people that have to go outside of the city for specialist dementia care (up to five per year). The strategy will review this and look to the possibility of providing this higher level of on-going care within the city. Currently there is a lack of consensus about what the level of need in the city will be going forwards over the next 10+ years. Additional work with public health and outcomes development group is required.

What will be different?

- There will be an agreed Sheffield model to provide inpatient and other levels of care for people with dementia
- Agreed longer term plan for dementia assess to care beds following conclusion of pilot
- Equal access to rehabilitation and reablement services for people with dementia – reablement is the range of services provided by the NHS and local authorities aimed at helping people recover from illness as quickly as possible.
- Improve physical health support in SHSC inpatient settings to reduce the need for moves to STH

COMMITMENT 8: We will make sure that more people get access to personalised, good quality palliative and end of life care when they need it.

Each person with a diagnosis of dementia is unique. It is therefore key that the wishes of the person, as far as it is possible to do so, are understood and carried out, allowing them to die with dignity, free from pain and in the place of their choice.

The percentage of deaths in their usual place of residence can be taken as a good proxy for preferred place of death and therefore a measure of the quality of end of life care. In 2015 almost 70% of people with dementia died in their usual place of residence in Sheffield. This is broadly similar to the national average and compares well against other core cities.

A cross organisational workshop looking at end of life care for people with dementia was held in Sheffield in September 2018 to look at how this could be improved. The workshop included commissioners of services and providers from the statutory, voluntary and private sectors. The key challenges the group highlighted included:

- The lack of public awareness that end stage/advanced dementia is a terminal illness and how the end stages of dementia will impact on a person
- The need for early conversations (post diagnosis) with people living with dementia and their families / carers about advanced care planning. Many professionals found it difficult to initiate these conversations
- The difficulties sharing information (care plans) across organisational boundaries, particularly in times of crisis, meant that the persons wishes were often not heard or acted upon.

What will be different?

- Family and carers will be better supported to maintain care at the home and avoid unnecessary hospital admissions at end of life.
- Health and social care providers will be better skilled to facilitate those early conversations about advanced care planning.
- People diagnosed with dementia will be offered early and on-going opportunities for advanced care planning.
- A robust step up and step down process will be agreed with providers as appropriate, with the least disruption to the person receiving the care.
- Care planning information will be shared better across organisational boundaries.

COMMITMENT 9. We will improve care for people with dementia attending A&E and those admitted to Sheffield Teaching Hospitals

National data shows that in the UK people living with dementia who are over 65 occupy approximately 25% of beds in hospitals. 42% of people over 70 who have an unplanned admission to an acute hospital have dementia; 20% of hospital admissions of people living with dementia are for preventable conditions. The readmission rate for people living with dementia is also far higher than for people without, 8.2% vs. 3.5% for planned care and 25% vs. 17% for emergency care.

Once in hospital people with dementia often have longer stays than people without dementia and there can also be delays in supporting them to leave hospital. In Sheffield between Aug 2017 and July 2018, 42% of the nights people with dementia spent in a hospital bed were after they were medically fit for discharge. Delays in discharging people from hospital are a system wide problem and will require the whole health and social care system to work together to resolve. For emergency hospital admissions, 36.4% of people living with dementia are discharged to a different residence to when they were admitted.

Someone who has dementia can find changes, such as moving to an unfamiliar place or meeting new people who contribute to their care, unsettling or distressing. Having some basic information about the person when they are admitted to hospital can help health and social care professionals to build a better understanding of who the person really is and therefore make that move less difficult.

One of the goals of the Prime Minister's Challenge on Dementia 2020 was to increase training of NHS staff to ensure that people living with dementia received the best possible care in hospital.

What will be different?

- Improved screening for cognitive impairment in A&E and /or at point of admission to a ward.
- Reduced numbers of people with dementia being inappropriately admitted from A&E onto a ward.
- Improved sharing of information about the person's preferences and basic personal information at point of admission (e.g. using a tool like the 'This is Me' document).
- Improved reviews of drugs to reduce use of antipsychotic and reduce anticholinergic burden for people admitted with dementia.
- Reduced length of stay in hospital for people with dementia.
- Sheffield Teaching Hospitals NHS Foundation Trust staff will receive the appropriate level of dementia training for their role.
- More activities will be available on the wards for people with dementia.

COMMITMENT 10: Care homes will take account of the needs of people with dementia.

Dementia and cognitive impairment are estimated to affect around 80 per cent of care home residents. Supporting people with dementia in non-specialist homes can enable them to stay there.

Sheffield is working with partners across South Yorkshire to implement the Enhanced Health in Care Homes (EHCH) Framework. The EHCH model seeks to overcome some of the challenges faced by these people by improving health care support within care homes and by improving access to secondary care and to mental health services in the community. Key parts of the work include:

- Timely diagnosis of dementia and support following a diagnosis.
- Shared care planning to deliver high-quality, personalised care planning and life planning.
- Ensuring timely access to secondary care, specialised mental health services and end of life services.
- Education, training and professional development help ensure that carers, families, and staff employed by social care providers feel supported.
- Medication reviews. Reducing polypharmacy and optimising antipsychotic medication are key for people with dementia.
- The physical environment for residents. Well-designed facilities, such as sensory environments and home environments, have been shown to improve the quality of life for persons living with dementia.
- Use of the 'This is Me' tool, which helps NHS services ensure that all care home residents' needs are met, both when NHS staff attend the care home and when residents attend NHS services as outpatients, day patients, or in-patients.

What will be different?

- Reduced numbers of unnecessary admissions to care homes.
- Care homes will receive on-going specialist dementia training.
- Dementia specialist services will offer a proactive approach to supporting, day care providers, domiciliary care providers and care homes.
- Increased use of technology to support care homes to monitor their residents and share information with health and social care colleagues.
- Guidance will be provided to care homes on what is a good physical environment for people with dementia.

COMMITMENT 11: We will support the clinical and non-clinical research community in Sheffield.

As part of the Prime Minister's Challenge on Dementia 2020, the Government committed to a further £300m for funding for dementia research by 2020.

Sheffield already has an active dementia research community and is committed to providing more opportunities for people with dementia and their carers to get involved in research and to improving collaboration across the sector by creating new opportunities, encouraging inter-disciplinary working and innovation in research.

There is an on-going portfolio of commercial and non-commercial research being undertaken in Sheffield some of which focuses on drug trials, other work focuses on innovation and the use of technology. Sheffield Health and Social Care Trust is the only mental health trust within Yorkshire and Humber to deliver commercial research for dementia. The University of Sheffield has a dedicated website outlining the dementia research it is involved in <https://www.sheffield.ac.uk/dementia>.

Working with clinical and research leaders in Sheffield and discussions with the public it is clear that there is an appetite to ensure that any research undertaken is focused on being applicable to practice and can where successful can be quickly adopted to improve care.

What will be different?

- Offer early and on-going opportunities for people with a diagnosis of dementia and their families /carers to get involved in research trials.
- Improved cross organisational working to collaborate on bids for research funding.
- Raised profile of research in the city and nationally.
- Ensure capacity to support recruitment to drug trials and continued links with industry.

COMMITMENT 12: We will provide guidance to clinicians in relation to the best medicines for dementia, including when to initiate and review medication.

As the prevalence of dementia increases in the population and GPs encounter more dementia patients in their day to day work, we need to ensure they are able to treat their patients with confidence and consistency. The NICE dementia guidance was updated in 2018. This included significant changes to prescribing guidance including:

- After a specialist diagnosis of dementia, the first prescription of cognitive enhancer medicines can now be made by a GP. These are medicines which can improve cognitive functions like memory.

As the person's dementia progresses GPs can now consider the addition of a second medication, however advice can still be sought from specialists as needed. The use of cognitive enhancer medication should only be part of a wider package to support patients with dementia. Non-pharmacological social support and assistance with day-to-day activities should also be in place as needed as the disease progresses.

NICE guidance says that certain medicines can reduce a person's cognition (anticholinergics). Increased awareness and promotion of reviewing the use of these medicines is promoted in the guidance and will be shared with health care professionals.

A lot of work has already taken place in the city to reduce the inappropriate use of antipsychotics to manage behaviour that challenges in people with dementia. Training in this area has already been established to increase peoples knowledge of alternative approaches to using antipsychotics. We will continue to monitor the use of antipsychotics to ensure appropriate use is maintained.

What will be different?

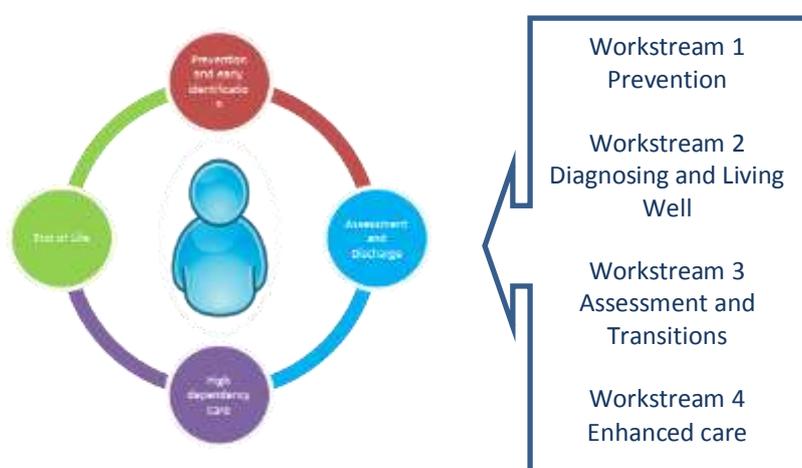
- There will be a local review of prescribing guidance in light of NICE dementia guidelines published in 2018, including the initiation of acetylcholinesterase (AChE) inhibitors in primary care.
- There will be an improved awareness in GP services and hospital services regarding the association of some commonly prescribed medicines with reduced cognitive abilities, and therefore cognitive impairment.
- We will improve GPs access to expert advice in relation to prescribing for people with dementia.
- There will be a reduction in inappropriate prescribing of antipsychotic medication for people with a diagnosis of dementia.
- There will be a reduction in the variation in prescribing levels across Sheffield for people with dementia.

COMMITMENT 13: We will monitor the strategy and the implementation plan supporting it.

Public, voluntary, community and private sector organisations across Sheffield have committed to work together to improve the care and support for people of all ages living with or caring for those living with dementia for those living with dementia to enable them to live life to their full potential.

There is an on-going commitment to ensuring that the voices of people living with dementia and caring for those living with dementia are heard and used to develop a strategy for the city and services.

We have established a Dementia Strategy Implementation Group to focus on 4 areas of work, known as workstreams, (listed below) to achieve the commitments outlined in this document, using the latest evidence base as well as the voices of the service users and their carers.



What will be different?

- Each partners' organisation will formally agree to supporting the commitments outlined in the strategy
- The existing workstreams and projects will be reviewed to ensure they have dedicated leadership to drive through the plan that supports this strategy
- The Dementia Strategy Implementation Group will continue to meet and will report on a regular basis into the Mental Health Transformation Steering Group and Board as part of the Accountable Care Partnership governance arrangements
- There will continue to be joint leadership by NHS Sheffield CCG and Sheffield City Council to drive the work forward and ensure dementia is linked into other relevant strategies across the city (e.g. the mental health strategy currently under development).
- We will engage the public throughout the life of the strategy to provide transparency on progress and to ensure the strategy continues to listen to and meet the needs of the population of Sheffield
- Integration of working practices across organisations