

## BOARD OF DIRECTORS MEETING (Open)

Date: 12 December 2018

Item Ref:

04

<b>TITLE OF PAPER</b>	<b>Sheffield Dementia Strategy – Draft Commitments</b>
<b>TO BE PRESENTED BY</b>	<b>Clive Clarke, Deputy Chief Executive</b>
<b>ACTION REQUIRED</b>	Members to receive the report and provide comment on the draft commitments paper and SHSC Dementia Group initial response to inform the formal SHSC response currently under development

<b>OUTCOME</b>	Members are informed and assured that appropriate and robust processes are in place to develop a formal response to the Dementia Strategy Implementation Group by end of Jan 2019 and have the opportunity to shape that response.
<b>TIMETABLE FOR DECISION</b>	Formal SHSC response to be drafted in time for sign off by Board Feb 2019
<b>LINKS TO OTHER KEY REPORTS / DECISIONS</b>	CQC Local System Review (Published June 2018) Prime Minister's 2020 Challenge on Dementia Lancet Commission - Dementia prevention, intervention and care
<b>STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER &amp; DESCRIPTION</b>	Strategic Aim: Strategic Objectives: A3 03: Provide effective community care and A4 02: We will adapt some of the services we provide in response to demand and market conditions
<b>LINKS TO NHS CONSTITUTION &amp; OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC</b>	
<b>IMPLICATIONS FOR SERVICE DELIVERY &amp; FINANCIAL IMPACT</b>	Potential changes to service specifications and models for dementia services delivery across all dementia specialist services (in particular, G1, Woodland View, Birch Avenue, Dementia Rapid Response Home Treatment and Memory Service)
<b>CONSIDERATION OF LEGAL ISSUES</b>	CHC and Section 117 processes

<b>Author of Report</b>	Kathryn Robertshaw
<b>Designation</b>	Dementia Strategy Programme Manager
<b>Date of Report</b>	3 <sup>rd</sup> December 2018



## SUMMARY REPORT

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**Report to: BOARD OF DIRECTORS**

**Subject: Dementia Strategy – Draft Commitments**

**Author: Kathryn Robertshaw, Dementia Strategy Programme Manager**

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### 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>
		✓	✓		

### 2. Summary

#### 2.1 Context

An overview of the development of the Dementia Strategy was presented to SHSC Executive Director Group on 20<sup>th</sup> September 2018. The report at this time gave an overview of the Trust's Delivery Objectives related to dementia and detail about the programme of work that was taking place to develop a new Dementia Strategy for Sheffield.

Since that report, the citywide Dementia Strategy Implementation Group (DSIG) has met and agreed a set of draft commitments that will make up the main body of the new Dementia Strategy for Sheffield. A copy of the draft commitment statements is attached under Appendix I.

The draft commitments have now entered a period of wider engagement with stakeholder organisations and the public. The engagement period will last until the end of January 2019.

The Board will have time to review the draft commitments, the implications for current services and the Trust's contribution and response during the planned development session in January 2019.

#### 2.2 Outline of the engagement plan

2.2.1 A citywide engagement planning group has been established. The work is being led by the CCG engagement team but includes representation from STH, SHSC, SCC, Healthwatch, Sheffield Dementia Action Alliance, Alzheimer's Society and Age UK Sheffield.

- 2.2.2 Following the agreement of the draft commitments by DSIG at the end of October 2018, the engagement group has been preparing a pack of materials to support the engagement process (this will include an easy read version of the statements, illustrated version and presentation slides). It is anticipated these will be available from the end of November 2018 and will particularly be used to support public and service user engagement.
- 2.2.3 Alongside the public engagement exercises will run engagement sessions with key statutory and voluntary sector partners to seek their views on the commitments.
- 2.2.4 The SHSC Dementia Group held an extended session 22<sup>nd</sup> November to consider the commitments and the potential implications for the Trust. Key clinical staff currently working in some of the SHSC dementia services were present at this session.
- 2.2.5 The commitments were generally well received by the group and the level of ambition was welcomed. There was recognition that the Strategy commitments alone would not effect change and SHSC should remain closely involved in the programme going forward in order to influence the implementation plan being developed to support the strategy.
- 2.2.6 The group raised some points of accuracy as well as some more general points which should be included in any SHSC response. Key points from the group are outlined in 2.3
- 2.2.7 The Commitments have also been shared with the Health and Well Being Board on 29<sup>th</sup> November 2018. Again, the draft commitments and the process undertaken to develop them were well received.

### **2.3 Key messages for inclusion in SHSC response**

- 2.3.1 SHSC welcomes the new strategy commitments, in particular the focus on equality of access to services and support and the need to link into wider community assets to provide post diagnostic support to people with dementia as well as their families / carers.
- 2.3.2 Need to ensure any action plan to support the strategy is linked into the on-going programme of service specification reviews being undertaken with the CCG.
- 2.3.3 Due to the lack of strong data and information about what the level of need in the city will be going forwards over the next 10+ years additional work with public health and the dementia outcomes development group is required. SHSC should commit to supporting this work.
- 2.3.4 SHSC welcomes the commitment for continuing provision for the most complex patients within Sheffield.
- 2.3.5 SHSC welcomes the pilot of dementia assess to care beds in the city and the trial of accessing the 5Q process for discharges from G1 and Dovedale wards. SHSC are keen however that commissioners move quickly from these pilots and trials to a longer term commitment for this type of provision and SHSC are keen

to work closely with the commissioners and other providers in the city to develop the model for this.

- 2.3.6 SHSC recognise there is a gap in the city for provision of consistent high quality education and training for health and social care staff across the city relating to behaviours that are challenging that arise from a persons dementia. Should such training be commissioned in future, SHSC would be well placed to support the design and potential delivery of this training

## **2.4 Points for the Trust to consider**

- 2.4.1 There is a lack of consensus across the health and social care partners in Sheffield, about the future model for complex dementia care in the city. There is uncertainty in relation to the amount of short term specialist bed based care required and a potential move to more community based complex care (including at time of crisis). This has led to uncertainty around the future numbers of beds and use of beds currently provided by SHSC.
- 2.4.2 Should the dementia assess to care beds be de-commissioned before an alternative model is in place there will be an impact on patient flow (both out of Dovedale ward and on the dementia rapid response teams ability to avoid acute admissions).
- 2.4.3 There is recognition for the need for increased training and education in relation to dementia and behaviours that challenge. This cannot be done without adequate resourcing and should not be taken on without the additional capacity to manage it.
- 2.4.4 The timeline for the development of the strategy is not aligned to commissioner timelines (NHS Sheffield CCG and Sheffield City Council) for reviewing service specifications and contract tenders. Commissioning of dementia services is underway whilst the strategy commitments are still in draft and out for comment.
- 2.4.5 Closer working between the Trust and neighbourhoods / localities to develop new models of provision of services in the community is a likely outcome
- 2.4.6 Provision of long term specialist care for people with complex needs related to their dementia is likely to be commissioned on an on-going basis in the city. The provider and location of these services will need to be debated.
- 2.4.7 Joint working with SCC and CCG to review 117 placements (particularly out of city) is on-going.
- 2.4.8 Provision of specialist assessments for people with complex needs related to their dementia (in their own home or other setting) will be an on-going requirement in the city.
- 2.4.9 Increased use of technology to support people living with dementia in the community and maintain their independence should be considered in any future models of care

The Board will have opportunity to consider these points in detail at the Board development session planned for 9<sup>th</sup> January 2019.

### **3 Next Steps**

- 3.1 Dementia Programme Manager to work with the Director of Strategy and Planning to develop a formal SHSC response to the commitments to be agreed by SHSC Board in February.
- 3.2 Revisions to the strategy following the engagement exercise will take place through February/March 2019 with a final version circulated to partner organisations for formal sign off by each Board (or equivalent) spring 2019.
- 3.3 The current workstream action plans will continue to develop and will form the basis of the Strategy Implementation Plan in 2019.
- 3.4 Continue review of SHSC dementia services in partnership with CCG and SCC

### **4 Required Actions**

The Board are asked to:

- Receive the Draft Dementia Strategy Commitments
- Discuss the Strategy Commitments included in the paper, taking into consideration the key messages outlined in sections 2.3 and 2.4 to help inform the formal SHSC response.
- Agree next steps outlined in section 3

### **5 Monitoring Arrangements**

In addition to the monthly workstream reporting through the Dementia Strategy Implementation Group, monthly highlight reports are submitted by the programme manager to the Clinical Operations; Change & Improvement Meeting at SHSC and the Mental Health and Learning Disabilities Transformation Steering Group.

### **6 Contact Details**

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# Sheffield Dementia Strategy Commitments 2019-2024

## What is Dementia?

The word 'dementia' describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. A person with dementia may also experience changes in their mood or behaviour. The specific symptoms that someone with dementia experiences will depend on the parts of the brain that are damaged and the disease that is causing the dementia.

Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes. Alzheimer's disease is the most common cause of dementia, but not the only one. Dementia is more common in people over the age of 65, with symptoms generally starting to show in someone's seventies. It is estimated that there are over seven thousand people living with dementia in Sheffield. This is just over 1% of the population.

More information about dementia in Sheffield can be found in the [Sheffield Joint Strategic Needs Assessment \(JSNA\) for dementia](#)

## Why do we need a new Dementia Strategy in Sheffield?

The Department of Health launched the 'Prime Minister's 2020 Challenge on Dementia'<sup>1</sup> in 2015, building on work from the previous strategy launched in 2012. The document calls for local action to agree and work together on local plans and approaches to help transform dementia care.

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 dementia for those living with dementia to enable them to live life to their full potential. The development of the Sheffield Dementia Strategy Commitments and the action plans to deliver on the commitments forms our response to the Prime Minister's Challenge document.

The Dementia Strategy has a strong focus on living well with dementia and delaying the onset of dementia. On average, a person can live with dementia for a further 10 to 15 years. Given the rise in the number of people living well into their seventies and eighties in the UK, this means dementia is an increasingly important factor in relation to healthy life expectancy (how long we can expect to live in good health).

## What is the vision for Sheffield?

The vision in Sheffield is to ensure that people of all ages and their families are supported to live to their full potential with dementia. To achieve this vision, 4 key objectives have been set.

1. Preventing or delaying the onset of dementia by modifying lifestyle and behaviours in mid-life
2. For all people living with dementia and their families/carers to feel empowered and know where to go to seek information, advice and help.
3. To be able to access timely care and support that enables them to live well at home for as long as possible and to die with dignity.
4. To live in dementia friendly communities. A dementia friendly community is a place where people with dementia are understood, respected and supported.

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<sup>1</sup> <https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020>

## How have the draft commitments been developed?

The draft commitments outlined over the following pages have been developed to the objectives. They have been influenced by national guidance and best practice as well as through conversations with people living with dementia, their carers, volunteers and professionals who support people living with dementia from both health and social care.

There is an on-going pledge to ensuring that the voices of people living with dementia and caring for those living with dementia are heard and used to develop the actions plans that will drive the delivery of the commitments once they are agreed.

There is also a commitment to setting clear outcomes against which the success of the strategy can be measured against. These will be based on the outcomes that people living with dementia and their carers tell us are important to them.

## **Draft Commitments**

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

## ***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?***

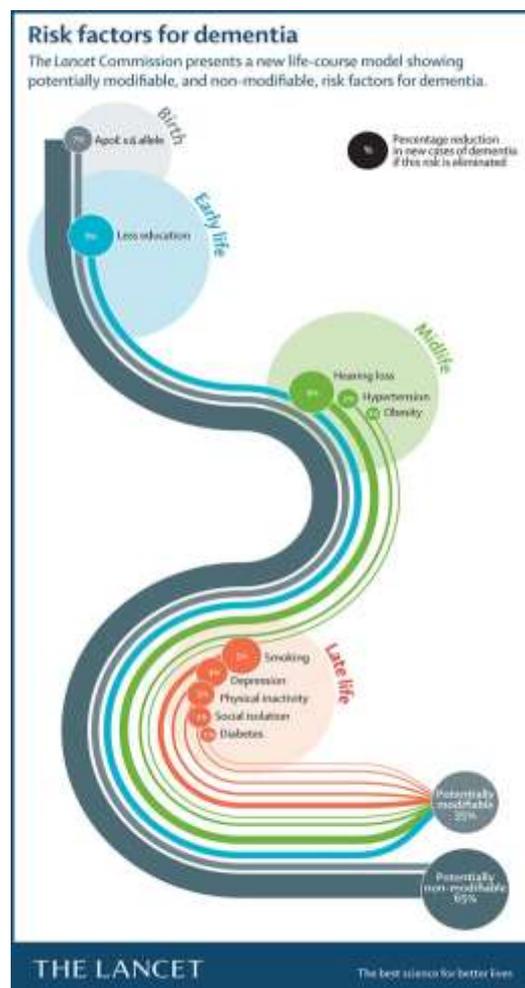
- All public sector employees in the city will receive the appropriate level of dementia training for their role
- Inter-generational programmes will link nurseries / schools with care homes and dementia cafes / lunch clubs
- Sheffield Dementia Action Alliance partners will support the development of 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 a learning disability 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.

**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 be 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 support offer 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 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.

## **COMMITMENT 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**

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
- 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.

**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.

## **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?**

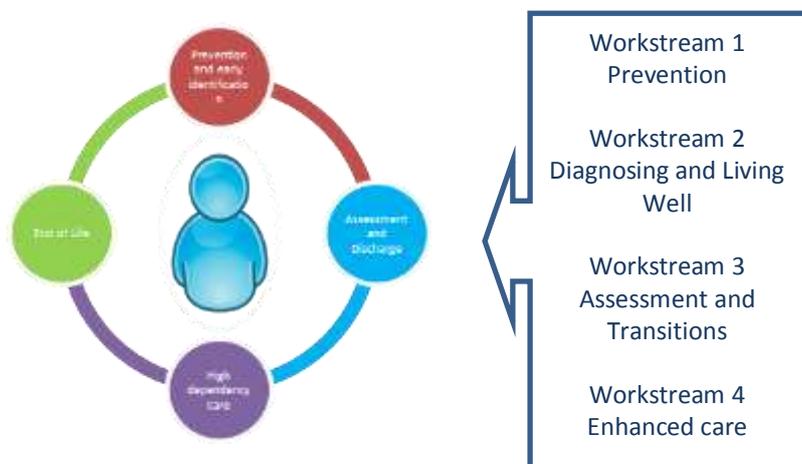
- There will be a local review of prescribing guidance in light of NICE dementia guidelines published in 2018, including the initiation of acetylcholinesterase (AChE) inhibitors in primary care.
- There will be an improved awareness in GP services and hospital services regarding the association of some commonly prescribed medicines with increased anticholinergic burden, 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 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