NHS
Vale of York
Clinical Commissioning Group

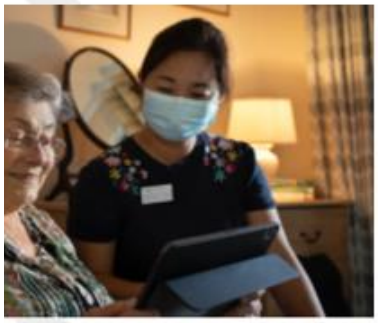
York Dementia Strategy Delivery Plan

2022-2027

Our Vision

Our vision is to make sure that people with dementia, their families and carers, are supported to live life
say:

- I live in a dementia friendly community
- I know who/where to turn to for information, advice and support
- I can live a life of my own
- I have access to the right support that enables me to live well at home for as long as possible
- My voice is heard and makes a difference
- I know that when the time comes, I can die with dignity, in the place of my choice



e to their full potential. We want the people of York to be able to

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Campaigns	Ensure Public Health have a forward plan for sensitive campaigns which include regular reference to reducing the modifiable risk factors linked to dementia and address issues such as gender representation and comorbid issues such as frailty, depression and loneliness. Also to making tangible progress towards York being a carbon net zero city.		
	Ensure reach into existing campaigns (such as the changing habits programme at York Drug and Alcohol service) to connect to cognitive decline		
	Contribute to the work of the Ageing Well partnership around York being a Dementia Friendly City.		
	Consider visibility of campaigns in post-pandemic environment (e.g., when physical GP attendance is a lot lower). Consider the		
	Increase engagement with people from ethnic minorities who may be experiencing cognitive decline		
Info and Advice	Develop a dedicated space for information and advice about Dementia on Live Well York (an information and advice community website for all adults in the City).		
	Ensure we have the right advice for each stage of the Dementia Pathway, in accessible formats		
	Promote the Healthwatch directory so its more readily available		
Primary Care interventions	Work with public health and our local GPs (e.g., through Nimbus Care) to develop what is included in, and how performance is measured on the NHS health checks in the City. Work with GPs to ensure that health checks for people with LD are on track to		
	Review the number of face to face appointments being offered where there is cognitive decline and how successful virtual appointments are		
	Develop assurance around diagnosis and treatment of associated conditions such as depression and frailty in older adults in the City		
	Make every contact count- capture the voices of those seldom heard, and ensure that holistic needs are considered within appointments		
Hubs	Ensure in-reach from community connectors to Dementia Hubs, to promote the support that people can access within their own communities either instead of or in addition to formal ‘care’.		
	Ensure the availability of social befriending and/or social activities that address loneliness across the different communities in the city		

Measure Impact	Monitor the impact of prevention activity in the City, as it specifically relates to people with Dementia (e.g., can we monitor the impact of focussed interventions to tackle loneliness on a person's cognitive decline? Do health champions/move mates etc., manage to reduce risks associated with dementia?)		
	Increase our awareness around the needs of local people from marginalised groups		

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Workforce development	Deliver universal training to the health and social care workforce to ensure skills in identifying the symptoms of dementia, knowledge of the impact of common physical health problems on acute		
Primary Care Interventions	Develop a programme of targeted support for GP practices to increase the rate of diagnosis, supported by Dementia Coordinators.		
	Improve the integration of dementia advice and community support within GP practices		
Measuring Impact	Develop monitoring and reporting processes to track the time people are having to wait between referral and diagnosis		
Improving the Diagnosis Pathway	Set clear expectations around how and when diagnoses are delivered and what people can expect in terms of support and advanced care planning at this stage		
	Raise awareness and increase the use of the DiADeM tool (the Diagnosis of Advanced Dementia) to support GPs in diagnosing dementia for people living with advanced dementia.		
	Work with the ICS to develop and implement technological solutions for shared care records to support an easier diagnosis pathway		
	Consider our local approach to diagnosis where there are complicaitons aroudn delirium		
	Improve the memory service referral pathway to: * address current bottlenecks resulting in long wait; * include direct referrals from acute services and minimise unneccessary waits between stages; * Explore alternative pathways to diagnosis from community and specialist settings * Improve communication for patients and their families while waiting for assessment to provide a better experience both practically and emotionally of the diagnosis process. * Explore the reasons for high DNA rates and options for supporting peope while on waiting lists to minimise this.		

Diagnosing Well

Timely accurate diagnosis, care plan and review within first year

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Information and Advice	Ensure that information, advice and guidance is readily available, accessible and provided in different formats, including in person. Explore the idea of Dementia Hubs, which provide a physical space for people with dementia and their carers to visit to access information, advice and support.		
	Educational videos, needs to be developed to support people who struggle with English language literacy		
Improving the Pathway	Monitor and contribute to work underway to develop a local shared care record.		
	Work to develop a clear pathway of support following diagnosis, both in the short term and throughout the person's lifespan		
	Work to ensure meaningful annual reviews which consider the holistic support needs of the person and, where applicable, their carer		
	work to address inequities in follow up support for people with non-Alzheimer's disease dementia types		
	Work to embed annual reviews which are meaningful, and pilot a person-centred approach to this (? At Acomb Garth)		
Evidence based support interventions	Work to develop evidence based, person centred interventions and support (particularly daytime activities and company) for people with dementia and their carers		
	Work alongside people with dementia to look at best practice examples from across the country (e.g., the Bristol Dementia Wellbeing Service, the Islington Memory Navigation Service, the Debenham project, the TRIO befriending project) and think about how we can mirror such developments here.		
	Work to ensure appropriate and regular medication reviews for people with dementia and continuity of GP access where possible (known benefits of safer prescribing, reduced risk of delirium and incontinence, fewer hopsitalisations and lower mortality) or of dementia support workers		
	Explore the need for local pharmacological research with the ICS		
	Work to develop how the system supports people through crises, to ensure choice and control and minimise the negative consequence of intervention		
	Develop the work of the Care Homes and Dementia team and the skills of clinical leads within Care Homes to ensure appropriate diagnosis, assessment, care planning and review for people with Dementia.		
	Learn from good practice locally around hospital discharge, to increase the number of people who have a safe discharge from hospital at the right time, to the right place, with the right level of support.		
	Explore good practice around carer support particularly access to psychological support and counselling		
	Contribute to local research and testing of assistive technology to ensure that the needs of people with dementia are represented		
	Offer equitable access to non-pharmacological interventions as per national guidance, such as cognitive stimulation therapy (CST), and ensure all memory services have access to CST by April 2024.		

	Explore the current offer in the city for non-pharmacological/psychosocial interventions such as reminiscence therapy and cognitive rehabilitation; cognitive stimulation therapy and evidence based interventions such as coaching, or occupational therapy training for carers. Consider what our 'interventions of choice' are and how we ensure easy access to these		
	Engage in the DReAMs project to understand how sleep interventions can impact upon people with dementia and their carers		
	The York IAPT service isn't able to work with people presenting with severe difficulties and cognitive functioning or impairment which would requires intervention from a specialist service, but is open to people with mild to moderate impairment. The service is currently looking at guidance (alongside the MH Services for Older People Team) for clinicians for determining if IAPT is the most appropriate intervention. This is currently in draft and its impact will require monitoring		
	Work with the continence service to understand our current offer of continence aids in the city, and whether these promote dignity for people with dementia		
Workforce development	Complete exercise to understand best training standards framework for the City, and embed training within this, ensuring that there are contractual obligations to deliver a dementia specific approach		
	Work to develop training/in-reach for staff on general wards within hospital and healthcare settings		
	Monitor and review impact of new training offers/approaches		
	Ensure occupational therapists, psychologists and other allied health professionals have protected time to carry out post-diagnostic support at memory service level alongside their diagnostic responsibilities, including home visits if appropriate, in line with patient need and symptom deterioration		
	Explore whether occupational therapists in the city are trained to deliver cognitive rehabilitation and if indeed they do this.		
Measuring Impact	Work to develop a minimum data set which allows us to monitor progress in how we support people with dementia and their carers; and to consider gaps in knowledge or provision which warrant research.		
	Explore ability to extract data around the number of people with dementia who have multiple professionals involved (do people need to tell their stories multiple times? Could those professionals work better together?). International research has shown a shared care approach between different professionals within primary care improves care and outcomes.		
	Improve recording of statistics for people living with dementia (typically from primary care) according to race, religion, sexuality and gender re-assignment so we can establish the diverse needs of people with dementia in the city.		
	Improve recording (and most likely diagnostic rates) for people living in the city with a learning disability and dementia (numbers currently suggest we have 22 – 11 male/11 female)		

	Look at local data around hospital admissions for people with dementia and target community support accordingly. Evidence suggests that hospital admission of people with dementia is strongly associated with multimorbidity (having two or more health conditions), polypharmacy (being on multiple medications), lower functional ability, unintentional weight loss and falls. Urinary tract infections, pneumonia/chest infections and delirium as well as falls – common reasons for admission – are potentially preventable admissions.		
	Explore data around the use of Social Prescribing by people with dementia in York. The Alzheimer's Society suggest that nationally the numbers of people with dementia who are referred to social prescribing are low.		
	Audit health and care records to establish where support may have been suspended due to the coronavirus and seek assurance that work is underway to remedy this.		
	Consider research into predictors of people needing care home support, to see if we can prevent, reduce or delay this. The Alzheimer's society state that the median time to someone with a dementia needing to be admitted to a care home or similar is 47 months after diagnosis. Predictors of people needing care home support more rapidly include severity of dementia, greater functional impairment, greater unmet needs in activities of daily living, severity of behavioural and psychological symptoms, fewer caregiving hours and higher caregiver stress.		

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Campaigns	Contribute to the work of the Ageing Well Partnership to promote dementia friendly services and buildings		
	Improve way finding and signage in public buildings, consider dementia friendly shopping hours, access to toilets etc.		
	Contribute to campaigns and intergenerational projects being developed through the Ageing Well Partnership		
	Ensure symbiosis between the dementia strategy delivery plan and the carers strategy delivery plan to ensure the right opportunities and support are available for carers of people living with dementia.		
	Contribute to York's inclusive transport strategy to ensure that the issue of non-visible disabilities is acknowledged and addressed		
	Consider work with licensing, around encouraging people such as taxi drivers and publicans to develop their awareness of dementia		
Info and Advice	Information, guidance and advice developed to address the different stages of the Dementia Well Pathway includes reference (e.g., to things like the Disabled Facilities Grant).		
	Consider the development of dementia champions in places like York Racial Equality Network and York LGBT forum to ensure that people with protected characteristics who access these services, have the best support to live well with dementia		
Coproduction	Consideration given to the spaces, places and people who can encourage open and ongoing conversations about creating the right City in which people with dementia and their carers can live good lives.		
Evidence based support interventions	Expolre opportunities to simplify the process for booking short-term 'as needed' respite support for carers of people living with dementia.		
	Explore the local implementation of discretion in the award of blue badges for people with dementia. Promote ease of access wherever possible to enhance quality of life ahead of loss of mobility.		

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Workforce development	Identify and deliver appropriate workforce development around advanced care planning and end of life care, ensuring that directly delivered or commissioned services meet the National Gold Standards Framework		
Evidence based interventions	Ensure we have the appropriate support in place for families and carers for when their loved one is diagnosed as end of life		
	Consider holistic interventions for pain managemetn in end of life care, for example https://www.alzheimers.org.uk/Care-and-cure-magazine/spring-19/namaste-care-research-update		
	Consider how we embed advanced support planning into practice with health and social care professionals (scope who we expect to do this and where advanced care plans may be stored)		
	Consider the local options around place of death and how hospice support can be utilised		
	Consider whether we have consistency of approaches to assessment and intervention in end of life care and how we may achieve this to ensure best practice across the system (e.g., Research appropriate use of tools to base clinical judgement within end-of-life care, so advance care plans can be honoured)		
Info and Advice	Alongside people with dementia, consider the information important to people at the end of life (for example setting up authorities for decision making, meeting emotional, sensory and spiritual needs, and stating preferences for last places of care) and how best to ensure people have the right information at the right time to make the right choice for them.		
Market sufficiency	Conduct a review of the capacity and access to palliative care in care home settings, and at home, and set out a framework of monitoring and review to ensure sufficiency.