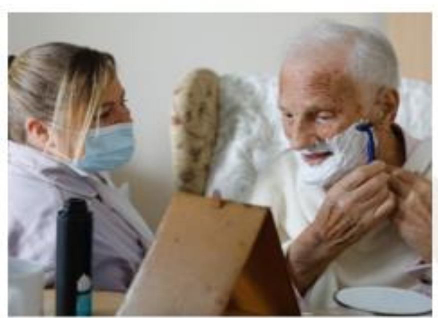
ANNEX B

York Dementia Strategy Delivery Plan

2022-2027



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Our Vision

Our vision is to make sure that people with dementia, their families and carers, are supported to live life to their full potential. We want the people of York to be able 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

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to

Preventing Well

"The risk of people developing dementia is minimised"

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Campaigns	Ensure Public Health have a forward plan for preventative 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		
	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)		
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		
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		
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'.		
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?)		

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Diagnosing Well

Timely accurate diagnosis, care plan and review within first year

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
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 cognition, and of the steps to take to assist someone to receive a diagnosis.		
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 complications around delirium		

	Improve the memory service referral pathway, to include direct referrals from acute services and minimise unnecessary 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 people while on waiting lists to minimise this.		

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Supporting Well

"Access to safe high-quality health and social care for people with dementia and carers"

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Info 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.		
Covid impact	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.		
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		
Evidence based support interventions	Work to develop evidence based, person centred interventions and support 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 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		
	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		
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		
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.		

data around the number of people with dementia who have multiple professionals involved

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Living Well

"People with dementia can live normally in safe and accepting communities"

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
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		
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).		
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	Explore opportunities to simplify the process for booking short-term 'as needed' respite support for carers of people living with dementia.		

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Dying Well

"People with dementia die with dignity in the place of their choosing"

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
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 management 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.		

THEME	KEY ACTION	LEAD PERSON	TO BE ACHIEVED BY
Campaigns	Ensure Public Health have a forward plan for preventative campaigns which include regular reference to reducing the risk of vascular dementia		
Info and Advice	Develop a Dementia landing page on Live Well York?		
Hubs	Ensure in-reach from community connectors to Dementia Hubs		
Info 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.		

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THEME	KEY ACTION	LEAD PERSON	TO BE ACHIEVED BY
training			
	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 cognition, and of the steps to take to assist someone to receive a diagnosis.		

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THEME	KEY ACTION	LEAD PERSON	TO BE ACHIEVED BY
monitoring & reporting	Develop monitoring and reporting processes to track the time people are having to wait between referral and diagnosis		
	Audit care records to establish where support may have been suspended due to the coronavirus and seek assurance that work is underway to remedy this.		
covid impact			