Shropshire's Dementia Strategy 2014-16

Action Plan

Shropshire's Dementia Strategy 2014-16 – Action Plan

1.0. Strategy objective: a) To raise awareness and understanding of dementia within communities b) To better identify those with and at risk of dementia					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve?**	**Actions**	**Outcomes & how will they be measured?**
*a)**Better Care Fund priorities:** Prevention; Early intervention.* *b) **Objective 1. Of the NDS:** Improving public and professional awareness and understanding.* *c)**Objective 13 NDS:** An informed and effective workforce for people with dementia*	• Compassionate Communities initiative. • Building community capacity and resilience. • Development of dementia friendly communities in Oswestry/Ageing Well prototype in Wem/MAYSIE in Church Stretton • Health & Wellbeing Board declared 2014 year of dementia training. • Shropshire council & SaTH signed up to the local Dementia Action Alliance. • Dementia Enhanced Service (ES)		• Continue public awareness raising following on from work around Dementia Awareness Day • Increase number of dementia friends across Shropshire • Create a dementia friendly Shropshire • Work closely with Public Health to raise awareness about "Brain Health" • Raise awareness around prevention through healthy lifestyles including reducing risk factors e.g. obesity/dietary/smoking which increase risk of vascular dementia. • Ensure hard to reach groups such as BME groups, sensory	• Evaluate May's Dementia Awareness Day and organise further awareness day for south Shropshire in October 2014. • To develop a new local dementia CQUIN for 2015/16 with the aim to improve identifying people who are at risk of dementia & provide; to consider extending the "case finding" element of the CQUIN to include patients aged 65 and over instead of 75. • Display dementia awareness information at existing SCCG/SC and other local events such as Dignity Event/Future fit, as promotion. • Further support delivery of Dementia ES • Include "Brain Health"	***a)All communities across Shropshire will have awareness and understanding of dementia.*** ***b)Early access to support and intervention following an early diagnosis.*** ***c)People with dementia receive care from staff appropriately trained in dementia care*** *<u>Measured by:</u>* *a)Numbers of dementia friends in Shropshire – information obtained from Alzheimer's Society.* *b)Questionnaire feedback from primary care carers support groups, dementia café's and diamond drop in sessions evidencing carer's and people with dementia feel better*

*d)**Joint Health & Wellbeing Strategy:** Making Shropshire a dementia friendly county; making it easier for the public and professionals to access information* *e)**Patient/public feedback:** Early identification and identification of unmet need & community development*	• National Dementia CQUIN scheme in place 2013-14 & 2014-15. • Roll out of Community & Care Coordinators across 44 practices in Shropshire. • Alzheimer's Society & Local health and social care partners organised dementia awareness day 23rd May 2014. • Dementia Friends information sessions delivered to patient groups/staff groups • Collaborative working with the Shropshire Alzheimer's Society • Dementia Action Alliance steering group formed • Butterfly scheme sing up by SaTH, Community trust and RJAH to improve care of in patients with dementia • Memory service		impaired, homeless • Know about dementia and what local services are available • Raise awareness of dementia among young people within schools and educate about reducing risk of developing dementia through healthy lifestyles. • Support the education and training of general practitioners and wider primary care teams • Further develop Dementia Action Alliance and complete recognition process to achieve dementia friendly Shropshire status • Commissioners to identify and give clear guidelines with regard to staff dementia training for all providers • Ensure people under the age of 65 years and those with learning disabilities are diagnosed in a timely way and supported to be independent – their needs are different to	information on public facing "Healthy Lifestyles" website • Organise a local "Brain Health" awareness campaign with Public Health team. • Raise awareness of increased risk of dementia for those with diabetes, cardiovascular disease, parkinson's, MCI or high blood pressure. • Work with health promotion and preventative services to help people look after their health. • Work with Public Health to create dementia friendly leisure centres. • Workforce development work with local health and social care staff within voluntary, statutory and private sectors • Work with the Young Health Champions to develop a targeted approach to providing information to schools and youth groups • Deliver dementia friends sessions to faith groups, sensory impairment	*supported and able to live well with dementia.* *c)Reduction in admissions to care home for those diagnosed with dementia.* *d)Increased diagnosis rate from 43.7% to 67%* *e)Increased number of health and social care staff who have accessed the proposed local dementia training programme.* *f)Increased numbers of referrals to the memory clinic.* *g) Reduce the variation of diagnosis rates between practices by 20%.*

	have provided some training for care home staff • New staff employed by SaTH now receive dementia training as part of their induction • Joint training team delivers Dementia awareness training for all staff • Regional workforce competency frameworks developed (ADASS) • Limited Young Onset (YOD) service commissioned and provided by SSSFT – often diagnosis is delayed due to professional hesitancy to diagnose • Variable level of service provided to those with Learning disabilities (LD)		those aged over 65years.	support groups • Explore through co-commissioning opportunities to reduce variation and improve quality of care through training. • Establish closer working with Housing support organisations to help identify those at risk of dementia • Ensure continued awareness raising amongst staff within SaTH and Shropshire Community Health Trust • Ensure dementia awareness is an integral part of staff mandatory and induction training • Raise awareness of dementia services amongst community and primary care staff • Scope current service provision for YOD and perform gap analysis and implementation • Scope current service provision for LD and perform gap analysis and implementation of recommendations	

2.0. Strategy objective: a)To ensure early diagnosis and early intervention					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
*a)**Better Care Fund priorities:** Prevention; Early intervention.* *b)**Objective 2 NDS:** Good quality early diagnosis and intervention for all* *c)**Joint Health and Wellbeing Strategy:** Outcome 3 – Making Shropshire a dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia* *d)**Patient/public feedback:** Early identification and identification of*	• SSSFT Memory service teams commissioned across the county with the expectation to provide comprehensive assessment; accurate diagnosis, information and advice to patients and carers that meet their needs. • Dementia enhanced service • Guidelines for GP's undertaking annual review of people with dementia • Dementia pathway defined and memory service single point of access for diagnosis • National indicator set for increasing diagnosis rates to 67%. Local target set for 51%		• Further integrate the memory service into primary care to facilitate 2% case management of frail and complex (including dementia patients) and improve diagnosis rates • Further develop Shropshire's dementia pathway • Ensure appropriate and consistent coding for dementia • Dementia enhanced service continues for 2014-15	• Undertake proof of concept pilot across 6 practices, roll out to all areas if successful • Complete South East pilot of single assessment point for frail and vulnerable, learn from findings and implement across other localities • Integrate the memory service into the Integrated Community Service to support rehabilitation of people with dementia on discharge • Work with the memory service to refresh and further develop GP annual review guidelines to support effective review of medicines and review of needs of the person	**a)All people with suspected dementia receive assessment and full diagnosis from the memory service** **b)A well-coordinated and seamless patient journey throughout the diagnosis process.** **c)People feel supported to live well with dementia** **d) Reduction in episodes of crisis as a result of dementia, leading to admission into acute care.** <u>Measured by:</u> *a) Increase Shropshire's dementia diagnosis rate from 43.7% - measured by dementia prevalence calculator* *b)Number of admissions made by GP's – primary care data.* *c)Increased numbers of referrals into the memory services.*

unmet need					*d)Number of GP practice staff who are dementia friends.*
3.0. Strategy objective: a) To ensure all people diagnosed with dementia and their carer's have access to high quality care and support services					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
*a)**Better Care Fund priorities:** Prevention; Early intervention; Living Independently for Longer* *b)**Objective 3 NDS:** Good quality information for those diagnosed with dementia and their carers* *c)**Objective 5 NDS:** Development of structured peer support and learning networks* *d)**Joint Health and Wellbeing Strategy:** Outcome 3 – Making Shropshire a*	• SSSFT commissioned to provide information at point of assessment and diagnosis • Alzheimer's Society Carer's Information and Support programme commissioned by SCCG • SCCG Patient self-care programme in place to develop education materials and peer support groups with in practices and local communities • Signposting by community and care coordinators/community enablement teams/care link workers to national and local information/resourc		• Further roll out of community and care coordinators across 44 practices will provide the opportunity for increasing signposting to information • Ensure key health and social care staff are able to offer advice or signpost • Develop targeting information to raise awareness of preventative and early intervention services • Ensure people with dementia have the right information at the right time	• Undertake demand and capacity review of memory service, update service specification • Ensure C&CC's are trained and are aware what information and local dementia support services are available to ensure effective signposting • Establish an electronic platform to house information and resources for public access – including prevention/healthy lifestyles information • Ensure information available on the community directory website including prevention/healthy lifestyles information • Ensure information about dementia is available for all key public facing services e.g. people2people, primary care, housing association.	**a)Ensure people have the information they need when they need it** **b)Empowering people to self-care, maintain independence and reduce episodes of crisis** **c)Increase knowledge and understanding of dementia** <u>Measured by:</u> *a) Questionnaire (pre & post intervention) feedback from primary care carers support groups, dementia café's and diamond drop in sessions evidencing carer's and people with dementia feel better supported and able to live well with dementia.* *b)Alzheimer's society quarterly audit reports number of positive patient stories* *c)Community and care coordinators number of positive patient stories*

dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia *Outcome 5 – Making it easier for the public and professionals to access information, advice and support* *e)**Patient/public feedback:*** *Education and support;* *Services working better together*	es • Long term conditions patient self-care programme developed with project manager appointed; education event undertaken in February 2014 for patients and carers • Two new dementia peer support groups initiated in Craven Arms and Radbrook Green surgeries • Local professionals presentations recorded and educational videos made • Local Alzheimer's Society commissioned to provide dementia cafés • Age UK deliver "Diamond drop in" sessions to offer peer support • Plethora of information provided by local Alzheimer's Society			• Develop peer support groups practice and/or community based with access to information resources • Build community capacity and resilience	*d)Number of carers attending training courses held by the Alzheimer's Society (CrISP) or the rural community council.* *e)Numbers of carer's providing positive feedback regarding support given through Rural Community council*

	Shrewsbury based office and website				
4.0. Strategy objective: To ensure people are able to live well with dementia and reduce the risk of crisis					
Cross cutting objectives	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**
*a)**Better Care Fund priorities**: Early intervention; Living Independently for Longer; Managing & supporting people in crisis* *b)**Objective 4 NDS:** Enabling easy access to care, support and advice* ***c)Objective 6 NDS:** Improved community personal support services* ***d)Joint Health and Wellbeing Strategy:** Outcome 3 – Making*	• Alzheimer's Society commissioned to provide dementia support workers for those with a confirmed diagnosis • Access to and appropriate prescribing of dementia medications • ESCA's in place for medications to treat Alzheimer's disease • Cognitive stimulation therapy delivered by the memory services • Rural community council provide carer support and training/educational programmes commissioned by Shropshire council • Cross reference with Shropshire dementia strategy objective 1		• Closer links with and further utilisation of People2People to ensure timely and easy access to support services • Further reduce the prescribing of antipsychotic medication • Ensure people have the opportunity to discuss and make informed decisions while still have capacity about Advance statements and preferred care	• Achieve target set by quality indicator monitoring antipsychotic prescribing September 2015. • Develop closer working of the memory service with P2P. • Integrate memory services into Integrated Community Service to reduce risk of readmission and admission due to crisis.	**a)People and their carer's will feel included, valued and well supported** **b)Ensure carer's are well supported and have a high quality of life** **c)Ensure the physical and mental health of carer's is prioritised and maintained** *<u>Measured by:</u>* *Cross reference to measures a,b,c,d,e, detailed in 3.0.* *b)Reduction in admissions due to dementia related crisis – measured by number of admissions made by GP to acute care e.g. SaTH or Redwoods.* *c)Numbers of practices holding a carer's list* *d)Numbers of carer's receiving*

Shropshire a dementia friendly county to enable earlier diagnosis and improved outlook for people with dementia ***e)Patient/public feedback:*** *Services working better together*					*needs assessment* *e)Development of a joint carer's strategy*
f)Objective 7 NDS: *Implementing the carer's strategy* ***g)Joint Health & Wellbeing Strategy*** *Outcome 4: Prevent isolation and loneliness amongst older people, those with LTC's and their carer's*	• Shropshire council carer's strategy established 2012-14 • Local Authority Joint Training Team provides carer training including MAPA • Carer registers kept by Rural Community Council • All practices hold a carer's register and link with other agencies who also hold lists e.g. RCC. • Some respite provision commissioned by Shropshire Council;		• To develop a joint carer's strategy, reflecting changes and implications of the forthcoming Care Bill • Improve availability of respite • Ensure all carer's are offered a carer's assessment • Ensure carer's are more easily identified by improved primary care maintenance of practice carer's registers • Ensure health checks offered to all carer's	• SCCG to work in collaboration with SC Carer's Partnership Board. • SCCG, SC and local voluntary organisations to form a sub group of the Care Bill Implementation Group • Update, develop and implement a joint carer's strategy in accordance with guidelines relating to the Care Bill. • Perform gap analysis for respite care, develop and agree model of respite for implementation • Embed emergency/contingency planning into care plans of people with dementia	*Outcomes and measures as above.*

	People2People provides carer's support and assessment and DH Homecare provides 48hr emergency respite cover. • SHIELD supporting carers				
*h)**Objective 8*** ***NDS:** Improved quality of care for people with dementia in general hospitals*	• RAID pilot established and receive referrals from ward staff • Butterfly scheme undertaken by SaTH, Community trust & RJAH • Dementia Lead Nurse has been in place for 12 months 2013-14 and has developed care pathways and care bundles for inpatients with dementia • WHO I AM passport developed and imbedded		• Continue the RAID pilot • Integrated Community Service and integration of memory service into ICS • Review commissioning of WHO I AM passport and consider integration into LTC's care plan. • To monitor and support continued adherence to CQUIN through regular Contract Review and Contract Quality Review meetings • Further embed care pathways and care bundles and ensure full staff engagement	• Further evaluate the RAID pilot for ongoing effectiveness • To fully integrate RAID into dementia care pathway • Establish memory service as part of ICS support team to enable rehabilitation of people back home following discharge and prevent admission into acute care by responding to and managing crisis	*Measured by:* *a) Numbers of patients with dementia referred to the RAID team* *b) Numbers of patients with dementia assessed by ICS prior to discharge.* *c) Numbers of patients with dementia referred to ICS (phase2), received intervention to avoid admission.* *d) SaTH CQUIN performance data* *e) Numbers of patients with dementia readmitted within 28 days of discharge* *f) Number of care homes signed up to the Butterfly scheme*
*i)**Objective 9*** ***NDS:** Improved intermediate care for people*	• SSSFT Home treatment team commissioned to support people		• Early supported discharge	• Integrating the memory service with Integrated Community Service	**d)People are supported to live in their own home rather than transfer to a care home.**

with dementia	according to need				**e)Re-enablement and maintain independence** *<u>Measured by:</u>* *a) Numbers of patients with dementia readmitted within 28 days of discharge* *b) Reduction in admissions to care home for those diagnosed with dementia.*
*j)**Objective 10 NDS:** Considering the potential for housing support, housing related services and tele-care to support people with dementia and their carers* *k)**Better Care Fund priorities:** Early intervention; Living Independently for Longer; Managing & supporting people in crisis* *l)**Joint Health &***	• Shropshire Assistive Technology Group established • Shropshire Council commission Tunstall to provide telecare • People 2 People undertake assistive technology assessment needs		• Develop ways of supporting people to live well and safely with dementia in their own home. • To raise awareness of the benefits of telecare and ensure all people with dementia have access to telecare assessment to meet their needs • Utilise housing association staff to identify those at risk of dementia • Ensure appropriate housing available to meet the needs of those with dementia • Reduce the need for admission into care homes	• Targeted approach to use of assistive technology • Further develop existing commissioning of AT • Use of Single Assessment Process to ensure AT assessment access • Develop and deliver training programme to staff working in housing support/housing association to ensure increased understanding of dementia and aid identification of those at risk including hard to reach groups	*Measured by:* *a)Numbers of Assistive Technology assessments undertaken by P2P* *b)Issue rate of assistive technology*

Wellbeing strategy *Outcome 1: Work with partners to address the root causes of inequalities such as education, income, housing, access to services*					
*m)**Objective 11 NDS:** Living well with dementia in care homes*	• Memory service review based on need and responsive review provided • Memory service provide staff training for coping with challenging behaviours • Care Home Advanced Scheme (CHAS) introduced November 2013 to provide more proactive clinical care to patients within care homes including those with dementia, care planning including admission avoidance, end of life care/DNAR.		• Ensure care home understand review criteria and care pathway for episodes of crisis or deterioration in a person's dementia • All staff in care homes to become dementia friends and have a basic understanding of dementia • Increase levels of exercise and activity where appropriate • Ensure all staff appropriately trained in dementia awareness • Further development of CHAS • Ensure all care provided to people with dementia in care homes is delivered by	• Organise and deliver dementia friends information sessions for care homes staff, promoting this through Shropshire Partners in Care • Working with public health and leisure centre partners to promote exercise in care homes. • Clarify memory service provision to all care homes • Scope existing staff training and training requirements as per CQC registration, identify gaps and implement training • Scope use of antipsychotics in nursing homes and further reduce use where appropriate • Determine current baseline	**f)People with dementia receive high quality, evidenced based care within care homes** **g)People with dementia are treated with dignity and respect** **h)Care home staff are appropriately trained to provide care to people with dementia** **g) Further reduction in the use of antipsychotic medications** *<u>Measured by:</u>* *a)Numbers of care home staff trained as dementia friends.* *b)Numbers of staff having undertaken formal dementia*

	• SCCG Primary Care Support Technicians undertake regular care home checks for medicines reviews		professionals trained in dementia awareness e.g. opticians/dental professionals	% use of antipsychotics • Raise awareness of dementia within dentistry and optometry and support provision of training • Explore the risks and benefits of an early diagnosis in care homes	*care training* *c)All people with dementia living in a care home to have a care plan* *d)% use of antipsychotics (reduction from baseline %)* *e)A reduction in numbers of urgent reviews undertaken by the Home Treatment team (memory service SSSFT)*
*n)**Objective 14 NDS:** A joint commissioning strategy for dementia* *o)**Joint Health & Wellbeing strategy** Outcome 5: Developing collaborative commissioning between the local authority and the CCG*	• Shropshire Joint dementia implementation plan 2013 refreshed and Shropshire's joint dementia strategy 2014-16 developed.		• Sign off by the Health and Wellbeing Board • Approval from SCCG's Clinical Advisory Panel • Ensure pathways provide support for minority groups at risk of dementia e.g. learning disabilities and young onset dementia	• Papers to be presented on 2nd July at CAP and 18th July at HWB meeting	**a)Implementation of the action plan over a two year period**
5.0. To ensure high quality end of life care.					
Cross cutting objectives:	**Achievements to date against objective**	**RAG**	**What do we need to achieve/are there gaps?**	**Actions**	**Outcomes & how will they be measured?**

***a)Better Care Fund priorities**: Living Independently for Longer; Managing & supporting people in crisis* **b)*Objective 12 NDS**: Improved end of life care for people with dementia*	• Local End of Life (EOL) Strategy and pathway developed • Practices have Gold Standard Framework (GSF) registers for people with palliative/EOL care needs as part of QOF		• Ensure high quality end of life care accessible for those with dementia • Regular GSF meetings need to be held to discuss and plan care for people with palliative/EOL care needs	• Implementation of End of Life strategy • Ensure people with dementia are recorded on GSF registers and a care plan devised for their EOL care needs • To ensure CHAS and dementia ES are enablers to discuss end of life matters with people with dementia and their carers • Look to commission a coordinator service for non-cancer patients including dementia.	**a)All people with dementia receive high quality care at end of life** **b)Carer's and family feel well supported** *Measured by:* *a) Palliative care Outcome Scale* *b) Achievement of preferred place of death.*