Report to Healthier Communities & Adult Social Care Scrutiny Committee

20th November 2013

Report of: Tim Furness, Director of Business Planning and Partnerships, Sheffield CCG

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Subject: Sheffield Dementia Strategy / Commissioning Plan

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Author of Report: Sarah Burt, Senior Commissioning Manager, Sheffield CCG

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Summary:

The enclosed information is being presented at the request of the Scrutiny Committee. The report discusses the dementia strategy and Sheffield Commissioning Plan

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Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	

Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	√
Other	

The Scrutiny Committee is being asked to:

Please note for information

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Category of Report: OPEN

Report of the Director of Business Planning and Partnerships, Sheffield CCG

Sheffield Dementia Strategy and Commissioning Plan

1. Introduction/ Context

1.1 The following report is being presented at the request of the Committee following its meeting in May 2013. The committee requested a report on the "*Dementia Strategy: To outline the approach to dementia care across the City – including Continuing Health Care funding criteria and the role of bed based facilities in the strategy."*

In line with the increasing older population, the numbers of people predicted to have dementia is increasing each year. Following the publication of the national Dementia Strategy (2009) and the Prime Minister's Challenge (2012), there has been a greater focus on the commissioning of dementia services and the need to ensure dementia friendly environments.

In addition, with increasing focus within health and social care on the need to demonstrate value for money, quality and improved outcomes for people with dementia and their carers, continued commitment to a shared CCG and local authority approach to the commissioning and development of dementia services is essential.

2. The Dementia Strategy / Sheffield Commissioning Plan

2.1 There is a long history of a collaborative approach to the commissioning of dementia services in the city. Sheffield has had a Joint Health and Social Care Dementia Strategy since 2006/7 and a Joint Commissioning Plan which is refreshed every year to reflect the commissioning intentions of the CCG and City Council. The Sheffield Commissioning Plan for 2013/4 is enclosed (Appendix A).

The National Dementia Strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf describes a number of key objectives including

- Improved public and professional awareness
- Early diagnosis and intervention
- Good quality information
- Access to care, support and advice following diagnosis
- Improved quality of care in hospital
- Living well with dementia in care homes
- Improved end of life care

Health and social care commissioners in Sheffield are working hard to ensure that people with dementia and their carers are able to live well with dementia. Since the National Dementia Strategy was published in 2009, Sheffield has made significant progress in all key objectives. Sheffield benchmarks well in England and Wales against key outcomes indicators eg it ranks second in England and Wales for its diagnosis rate. Early diagnosis and early intervention are key to improving outcomes.

Care Homes

With regard to care homes, the strategy's objective 11: Living Well with Dementia in Care Homes promotes improved quality of care for people in care homes through explicit leadership for dementia care, defining the care pathway, the commissioning of specialist in-reach services and through inspection regimes.

In Sheffield we are working hard to improve the quality of dementia care in care homes. Work in 13/14 has particularly focused on workforce development, better targeted care home support, the continued reduction in anti-psychotic medications and the promotion of meaningful activity for residents with cognitive impairment. Investment in the Local Enhanced Service for GPs also continues.

Sheffield has a range of care homes to meet the needs of people with dementia. It is widely accepted that there is a high percentage of people in residential and nursing homes who are cognitively impaired and therefore action to improve the quality of dementia care is not merely focused upon EMI care homes.

Other bed-based facilities

Recent commissioning changes to the intermediate care pathway have included commissioning input from the Senior Commissioning Manager for older adult mental health and dementia to ensure that the needs of people with dementia and their carers are fully considered. New pathways try to maximise the number of people who are able to be supported to return home following admission to hospital.

Continuing Health Care

The eligibility criteria for continuing healthcare are set out in the National Framework for Continuing Healthcare, which is published by the Department of Health. Eligibility for continuing healthcare is not determined by diagnosis of particular diseases or conditions. Eligibility is determined by assessing the individual's needs and determining whether the individual has a 'primary health need'.

Whether someone has a 'primary health need' is assessed by looking at all of their care needs and relating them to four key indicators:

• nature – this describes the characteristics and type of the individual's needs and the overall effect these needs have on the individual, including the type of interventions required to manage those needs

• complexity – this is about how the individual's needs present and interact and the level of skill required to monitor the symptoms, treat the condition and/or manage the care.

• intensity – this is the extent and severity of the individual's needs and the support needed to meet them, which includes the need for sustained/ongoing care

• unpredictability – this is about how hard it is to predict changes in an individual's needs that might create challenges in managing them, including the risks to the individual's health if adequate and timely care is not provided

Eligibility for continuing healthcare is subject to regular review

3 *What does this mean for the people of Sheffield?*

3.1 This report outlines the progress made to date to meet the objectives of the Dementia Strategy. Overall, Sheffield has made good progress and benchmarks well against key outcomes.

There continue to be areas that require further work in order to improve services for the people of Sheffield and we are currently working on the 14/15 commissioning plan to ensure that progress continues.

4. Recommendation

4.1 The committee is asked to note the enclosed for information

Sheffield Integrated Commissioning Plan for People with Dementia and their Carers 2013/14

April 2013

1.0 Purpose

1.1 This plan describes an integrated approach to commissioning services for people with dementia and their carers by NHS Sheffield and Sheffield City Council.

1.2 It summarises the needs identified in recent strategies, sets out a brief market analysis of current and potential service providers and proposes key areas for development.

1.3 Using a modelling exercise undertaken recently it identifies the financial implications of both the 'do nothing' scenario and the impact of priority interventions recommended in the National Dementia Strategy

1.4 It describes the commissioning principles for both health and social care that will determine the priority given to developing services both individually and jointly to achieve the objectives set out in the National Dementia Strategy by 2015 and the Prime Ministers Challenge (March 2012).

1.5 In a high-level commissioning plan it describes the workstreams that will deliver the priorities

2.0 Background

2.1 This section summarises the findings of the relevant local and national strategies and identifies the key areas for development.

2.2 In February 2009 the National Dementia Strategy was launched. It is a five year plan designed to transform the lives of people with dementia and their carers. The Strategy outlines 17 objectives to improve the quality of services for people with dementia and their carers

2.3 In September 2010 DH produced *"Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy"*. It describes what the Department of Health considers as its priorities for policy development in its role of enabler for continued progress in improving outcomes for people with dementia and their carers. It does not state what services should be planned, commissioned, provided and delivered. As highlighted in the National Dementia Strategy, the pace of implementation will vary depending on local circumstances and the level and development of services within each NHS and Local Authority area.

2.4 In March 2012 the Prime Minister launched a programme of work which aims to deliver major improvements in dementia care and research by 2015. The initiative builds on the achievements of the existing National Dementia Strategy and emphasises:

- Driving improvements in health and care
- Creating dementia friendly communities that understand how to help
- Better research

3.0 Needs Analysis

3.1 The 2010 Sheffield Health and Wellbeing Joint Strategic Needs Assessment acknowledges a major challenge is "…how to ensure that the growing number of older people maintain the best possible physical health and mental capital, and so preserve their independence and wellbeing." It also sets out the impact of an ageing population in terms of the increasing numbers of older people with dementia.

3.2 There are currently estimated to be 6,085 people with dementia in Sheffield. The table below shows how this is broken down by type of dementia and compares this to other localities in Yorkshire and Humberside.

Table 5: Numbers Predicted to have Late On-set Dementia by Sub-type – Yorkshire & Humber 2008 by Local Authority

Local Authority	Alzheimer's Disease	Vascular Dementia	Vascular Dementia & Alzheimer's Disease	Lewy Bodies	Frontotemporal Dementia	Parkinson's Dementia	Other
Barnsley	1,569	416	258	100	33	42	75
Bradford	3,070	812	503	195	65	81	146
Calderdale	1,402	370	229	88	29	37	67
Doncaster	2,102	560	346	135	45	57	100
East Riding	2,865	765	472	185	62	78	137
Hull	1,586	422	261	102	34	43	76
Kirklees	2,626	696	431	167	56	70	125
Leeds	5,064	1,343	832	323	108	135	241
NE Lincolnshire	1,216	322	200	78	26	32	58
North Lincolnshire	1,223	327	202	79	26	33	58
North Yorkshire	5,196	1,382	855	333	111	139	248
Rotherham	1,757	467	289	113	38	47	84
Sheffield	3,834	1,014	629	243	81	101	183
Wakefield	2,258	598	371	144	48	60	108
York	1,486	394	244	95	32	40	71
Yorkshire & Humber	37,254	9,887	6,122	2,380	793	994	1,776

Source: Dementia UK & POPPI

3.3 The 'Sheffield Dementia Health and Well Being Needs Assessment' makes a Number of key points:

- Given the rising numbers of people with dementia and the corresponding rising costs of caring for them, it is vital that addressing dementia is seen as a priority across the health and social care system.

- The data shows that Sheffield faces a substantial growth in the numbers of people with dementia in the next 15 years. The demographic pressure on older people's services is well documented. It is particularly notable within dementia. There are 750,000 people living with dementia in the UK now and by 2025 there will be over 1 million leading to one of the greatest challenges facing our ageing population.

- Sheffield is currently predicted to have 6494 (2012 data) people living with dementia and this is expected to rise to 7342 by 2020 and 9340 by 2030. The biggest increase will be in the people aged 85 and over which will nearly double over the same period.

- A relatively small number of people with dementia are from black and ethnic minority groups, but this will increase substantially in future years.

- Early diagnosis and intervention improves quality of life through enabling people with dementia to access suitable support services and delay or prevent premature and unnecessary admission to care homes.

- Evidence from Sheffield Teaching Hospitals Foundation Trust audit suggests that improving the experience of hospital care for people with dementia will assist in taking forward the reform agenda.

4.0 Market Analysis

4.1 An estimated £19m is spent on all independent sector care home provision for people with dementia. Of this £6.3m is spent on residents in specialist provision. The quality of care is variable and there are training, design and best practice issues for the care home sector.

4.2 The home support services also care for significant and increasing numbers of people with dementia in the community. An estimated £5.6m is spent in home support on people with dementia. Specialist home support provision available across the City with a final target of 5,000 hours of specialist provision per week.

4.3 Sheffield Health and Social Care Trust (SCHC) provide a range of services funded by both NHS Sheffield and Sheffield City Council:

- Assessment and diagnosis and treatment through the memory management service and community mental health teams (CMHTs)
- Specialist interventions
- Social care resource centre provision including respite and day support – costing approximately £3.2m
- Carer support – Carers Grant contribution £0.12m
- In patient assessment and treatment
- Intermediate care (Grenoside Grange)
- Nursing home care (Birch Avenue and Woodland View)

4.4 There is a significant investment by NHS Sheffield in the treatment of people with dementia in Sheffield Teaching Hospital Foundation Trust (STHT). It is very difficult to quantify the exact figure as patients are not always coded as having dementia but recent estimates suggest that people with dementia over 65 years of age currently occupy around 25% of hospital beds.[1]

4.5 The same research suggests that as well as an often difficult experience in hospital, poor outcomes for people with dementia and increased length of stay are costly for both health and social care. A new Call to Action to develop dementia friendly hospitals in 13/14 will build on the significant work which is already taking place at STH to improve the care of people with dementia and the experience of their carers.

4.6 The intermediate care arrangements are inconsistent but a major project, led by

[1] 'Counting the Cost – Caring for people with dementia on hospital wards' Alzheimer's Society, 2009

NHS Sheffield CCG is addressing the whole system of intermediate care, including the needs of people with dementia.

4.6 There is a range of services for people with dementia in the Third Sector. These are funded by both Sheffield City Council and NHS Sheffield. Over the past year these have been reviewed in the light of the Dementia Strategy to ensure continued fitness for purpose and best value. Plans are in place to either improve the fit or develop capacity to meet changing demand and the drive towards a more personalised support.

4.7 There is a lack of understanding about the demand for and role of specialist provision for people from our BME communities but the newly commissioned BME dementia cafes will help to clarify the amount and scope of support needed to ensure equality of provision.

4.8 The quality of care in care homes is varied. This is in part addressed through the multi-agency Quality in Care Homes Project. There remains a significant skill deficit in care homes in relation to dementia. The impact on the experience of residents is well evidenced. The cost impact for both health and social care is significant as people are placed in higher level care (including CHC funded placements) because their needs are not met in non-specialist and residential settings.

4.9 All commissioners and providers have identified the need for workforce development. All staff should be able to recognise and respond appropriately to people with dementia and develop strategies for managing challenging behaviour.

4.10 The current service configuration demonstrates a dependency on intensive care and support at the expense of lower level, earlier interventions. The National Dementia Strategy emphasises the need to shift the investment to reflect the changing focus.

5.0 Costing the Changes

5.1 Modelling work completed in 2011 and supported by CSED and YHIP[2] has identified the cost implications to the whole system of both a 'do nothing' scenario and the impact of key interventions. In summary, the model predicts the impact of the demographic changes will mean a combined additional cost to both health and social care of £3.5m by 2019

5.2 In contrast the model also predicts that through key interventions there is the potential for combined annual saving of £2.4m by 2015. The initiatives that are recommended to achieve this are:

- Increasing diagnosis rates to 70% of the estimated prevalence (currently 63.6%) through an efficient and effective memory service
- A mental health liaison service in the acute trust
- An in-reach team for care homes including a
- Reduction in the use of anti-psychotics
- Improve the understanding of the needs of people with dementia across the workforce

[2] This modelling work was led by Whole Systems Partnership on behalf of YHIP and CSED

5.3 The estimated savings are not spread equally across health and social care. The model predicts that for social care there will be a £200k increase compared to a £2.6 saving by health. These savings are net of any investment required to make the change. The model is calibrated to allow for the existing provision in Sheffield.

6.0 Agreed Priorities

6.1 The national consultation linked to the National Dementia Strategy sets the broad priorities for Sheffield. The way in which the services are finally delivered and the priorities for identifying which needs to change first will be the subject of consultation with a range of stakeholders. These include:

- People with dementia
- Carers
- Clinicians and practitioners
- Alzheimer's Society
- Providers of health and social care services

6.2 The key priorities areas for Sheffield in 2013-14 therefore are:

- Care at Home and in Care Homes
- Care in Hospital
- Early Diagnosis and Intervention
- Dementia Friendly communities and the development of a local Alliance
- Incorporating the voice of people with dementia into strategic planning

Though not the focus of a specific workstream the following areas will be addressed across the programme:

- Support for carers
- Reduction in the use of antipsychotic prescribing for people with dementia
- Information and advice
- Data quality and information management
- Research opportunities

6.3 The detail of the work to achieve these priorities is set out in **Appendix A**.

6.4 The main development during 2013-14 is the joint commissioning of the Dementia Information Advice and Support Service planned for October 2013. This is a jointly commissioned service responding to the call from people with dementia and their carers. It is intended to replace the current commissioned services with an enhanced model.

6.5 In addition, it is recognised that the Sheffield Dementia Programme will need to adapt to changing commissioning arrangements following the publication of the Health and Social Care Act (2012) and understand key links with e.g. the Health and Wellbeing Board and clinical networks.

6.6 It is acknowledged that there is significant overlap between the work of the dementia programme and the RFT programme and work is on-going to ensure that these connections are managed effectively.

6.7 There is increasing recognition of the impact of dementia and its effect on multi-morbidity, long term condition management and outcomes for patients. The importance of strong links to work in this area is required to ensure consistency and maximise effectiveness.

7.0 Measuring impact

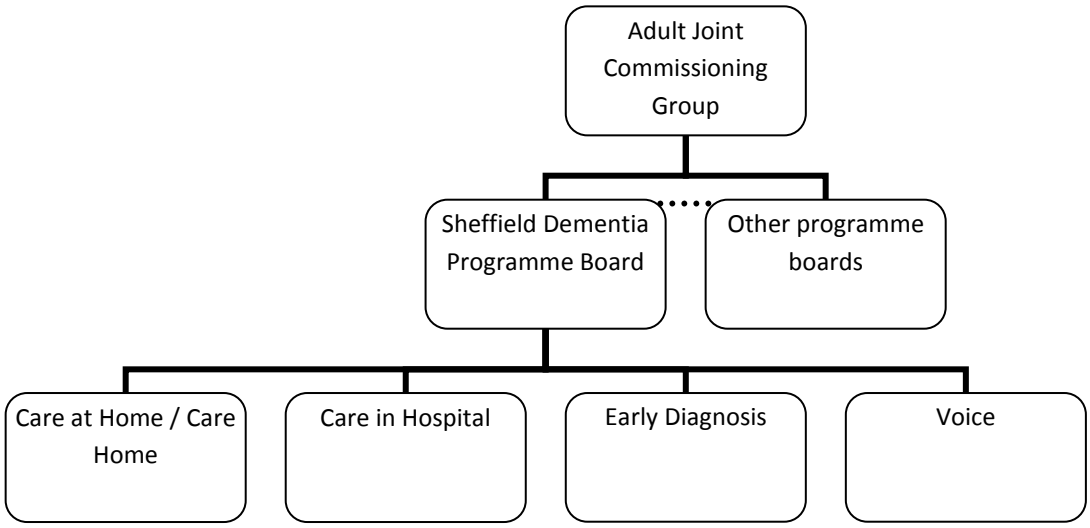
7.1 Each workstream will have a defined set of high level indicators to measure progress against the objectives

7.2 These will be available to the Programme Board on a routine basis.

8.0 Governance

8.1 A Programme Board, led by Health and Social Care Commissioners and including representatives from Sheffield Health and Social Care Foundation Trust, Sheffield Teaching Hospitals and the Alzheimer's Society, has been established to oversee and co-ordinate implementation of the transformation.

8.2 The programme structure is set out below:



8.3 The Dementia Programme Board will report to the Adult Joint Commissioning Group on the progress of delivering the commissioning plan.

8.4 The programme board will meet on a six weekly basis to receive updates from the workstreams. The scope for each of the workstreams is set out in **Appendix A.**

8.5 The workstream leads will report progress against the plan including any emerging risks to delivery

8.6 The board will maintain an issues and risk long which will be updated as part of each board meeting.

Appendix A: 2013-14 Work Plan

Workstream	Objectives	Impact
Early Diagnosis and Intervention Lead: Sarah Burt	• Identify and diagnose people with dementia in Sheffield in a timely way in accordance with best practice • Initiate timely treatment as clinically appropriate • To ensure that the public, people with dementia and their carers in Sheffield receive the information, advice and support that they need, when they need it	• The number of people with a formal diagnosis of dementia and in touch with services will increase to 70% by 2015 • A delay in the time at which people with dementia are admitted to a care home and a prevention altogether of some admissions • An increase in the time people remain within early and mid stage dementia; • Increased involvement of community based health and social care services • Reduced potential for carer breakdown that results in hospital or care home admission
Care at Home / Care Home Lead: Howard Waddicor	• To provide people with dementia, and those who care for them, access to specialist advice and support • Improving the experience of people with dementia wherever they live • Reducing the use of antipsychotic medication	• Reduction in the number of people admitted to care homes • Reduce the number of people moving from a care home to a specialist EMI facility through improved management • Reduce the pressure on carers of people with dementia by offering a range of interventions • Reduction in number of admissions to general hospital or mental health inpatient facility through improved patient management; • Reduction in the prescribing of antipsychotic drugs due to improved skills in managing the behaviour of people with dementia; • People with dementia will have a greater choice of the services they need to help them live well with dementia

Workstream	Objectives	Impact
Care in Hospital Lead: Sarah Burt	• Ensure that people with dementia and their carers receive general hospital care (in Sheffield) in accordance with best practice • Move towards the creation of dementia friendly hospitals in Sheffield (Call to Action in 13/14) • Ensure community support services in Sheffield to enable people with dementia and their carers to be supported at home • Continued development of hospital liaison service to ensure timely and appropriate discharge • Case finding activity at STH incentivised by CQUIN (improvement of clinical coding of secondary diagnosis of dementia) • Improved carer support	• Reduction in length of stay through improved management of people with dementia who require hospital care; • Reduction in inappropriate general hospital admissions due to presence in A&E, assessment and diversion to community based services; • Increase in people with dementia diagnosed and referred to specialist services (health and social care); • Reduction in people with dementia going direct from general hospital to long term care through improved community support; • Avoidance of inappropriate mental health hospital admissions and some general hospital admissions; • Potential increase in use of community based services such as home care. • Increased compliance with RCP national dementia audit
Dementia Friendly Communities / development of a local alliance Leads: Julia Thompson/ Kath Horner	• Placing the dementia-friendly communities project into the mainstream of strategic partnership work by: • Integrating it into the workplan of the Dementia Programme Board • Widening the strategic focus for work on dementia across the city by connecting with partners and services which are not at the centre of planning or commissioning for people with dementia • Engaging with a specific communities in the city	• To enable people to live healthier, with or without dementia. • Provide alternatives to formal health and social care services to find ways of supporting people with dementia which are effective and preferable for them, especially in the early stages of dementia

Workstream	Objectives	Impact
Voice of People with Dementia and their Carers	• To build on the major involvement exercise in 2012 by further engaging with people dementia as part of the Alzheimer's Society Community Dementia Forum • Work specifically with people with dementia to understand their perspective • Develop mechanisms for supporting people with dementia to contribute to the design of support and developing a dementia friendly community in Sheffield	• To influence the way investment it used to support people with dementia to live well at home • Demonstrate to people with dementia that their opinions are valued and can influence the commissioning process • To better understand the full range of needs of carers of people with dementia and use this knowledge to shape support • To develop a better understanding of how to improve awareness of dementia in BME communities
Data and Information Management Leads: Howard Waddicor and Sarah Burt	• To develop a range of key performance indicators that help workstreams measure their effectiveness • To develop high level indicators that measure the success of the Dementia Programme in Sheffield • To develop a mechanism for capturing changes in the experience of people with dementia and the people who care for them • To develop a range of outcome measure for all health and social care services • To identify the costs of delivering support for people with dementia in health and social care	• The programme board will receive routine information about the progress of each workstream • An independent annual report to the programme board that gives an account of the experience of people with dementia and the people who care for them • Improved understanding of the value for money delivered by services to support people with dementia • Reduce the demand for high-cost, intensive support by identifying improved outcomes through early intervention

APPENDIX B: NICE Guidance 'Support for Commissioning Dementia Care' (April 2013)

Area of care	Commissioning impact	Estimated resource impact	Sheffield Commissioning Plan
Integrated care and service provision (see section 3)	Use a whole-systems approach to commissioning. Develop integrated health and social care needs assessments and commissioning plans. Integrate commissioning functions across health and social care where possible. Involve the public, people with dementia, their carers and families when commissioning services. Develop local multi-agency dementia partnerships. Use a long-term conditions approach to supporting people with dementia. Ensure that commissioning plans promote personalised care. Ensure that all health and social care professionals who may come into contact with people with dementia are aware of the condition and where people can access diagnosis. Commission multi-agency teams.	There may be costs for awareness raising training for staff, and developing skills, knowledge and continued professional development of health and social care professionals. There may be savings from more efficient systems and procedures, disinvestment from ineffective practice and having single assessment points and records leading to reduced duplication of duties and economies of scale.	Whole systems approach to commissioning already however work to do to improve integration of health and social care services. Included in CP 13/14 with significant link to RFT. Personalisation is a key feature of current CP. Workforce development included in CP.
Early identification, assessment and diagnosis (see section 5.1)	Agree a local target to increase the proportion of people with dementia who receive an early diagnosis. Commission a dementia diagnosis service. Ensure initial management of dementia includes information about the condition,	There may be additional costs resulting from a possible increase in the use of services that support people with dementia and their carers.	Local target for diagnosis agreed for 13/14 and 14/15. Sheffield already 2nd in England & Wales for diagnosis but ED remains a high priority in CP. CP includes commissioning of DIASS.

	and equal consideration of medical and social components of care. Develop a 'single point of information' on local dementia care and services.		
Promoting choice (see section 5.2.1)	Clearly define who is responsible for: Initiating a care plan Initiating a carers assessment The periodic review of the care plan, and review when a person's circumstances have changed Care coordination Supporting people to make advance care plans for end of life. Ensure there is access to independent advocacy services for vulnerable people with dementia	There may be additional resources required to support people with dementia and their carers to develop Advance Care Plans.	Care planning part of RFT plan for 13/14. 13/14 ARC research to promote resilience / carer support / self-care and management etc. Care co-ordination via ICTs. DIASS to support advanced planning. Commissioning links established to EoLC leads. Continuing use of personal budgets to support choice in social care
Promoting independence (see section 5.2.2)	Ask community and residential providers to demonstrate that they enable people with dementia to participate in leisure activities, maintain relationships and contribute to the local community. Invest in support for people to live independently with dementia.	There may be costs associated with adaptations to housing and the environment, meeting the needs of daily living and supporting people to participate in leisure activities and the community. However promoting independence may delay or reduce the need for avoidable residential care home costs and hospital admissions.	Joint CCG / SCC work to promote independence not specific to dementia. DFC and alliance work in CP. Links to ARC research to promote resilience. New non-recurrent investment re supporting people with dementia who live alone. New investment in cafes, dementia adviser etc.
Providing support (see section 5.2.3)	Have plans to increase access to behaviour and social interventions for people with dementia, which can reduce inappropriate use of antipsychotic drugs. Commission mental health liaison services in hospitals.	There may be potential savings resulting from a reduction in inappropriate use of anti-psychotic drugs and a reduction in secondary care costs (unplanned hospital admissions and length of stay in hospital).	On-going work to audit the use of AP rugs in primary and secondary care. Mental health liaison already commissioned in 12/13

		You may use the commissioning tool to estimate potential saving. Each 10% reduction in unplanned hospital admissions may save £14,000 per 100,000 populations. Additional investment in behavioural and social interventions may be required to support a reduction in the use of antipsychotic drugs.	Quality in Care Homes initiative will work with care home providers to develop best practice in supporting people without recourse to medication.
Palliative and end of life care (see section 5.2.4)	Make end of life care commissioners aware of the specific needs of people with dementia. Support primary care to identify people with dementia who should be added to primary care palliative care registers.	No additional costs anticipated.	Links already made to EoLC commissioners Work already on-going to support use of primary care palliative care registers. Recent LES care home audit shows significant improvement.
Support for carers (see section 5.3)	Ensure that carers assessments are routinely offered at the time of diagnosis. Commission a range of respite services for carers of people with dementia. Ensure local capacity in services that can provide emotional, psychological and social support to carers.	There may be costs to fund respite services and tailored interventions such as self-help, short-term psychotherapy or CBT. See costing work for NICE clinical guideline 42 for more information on costs.	DIASS, ARC research, carer support already part of MMS commissioned service.