Rutland County Council

Project Business Case

Integrated Dementia Pathways

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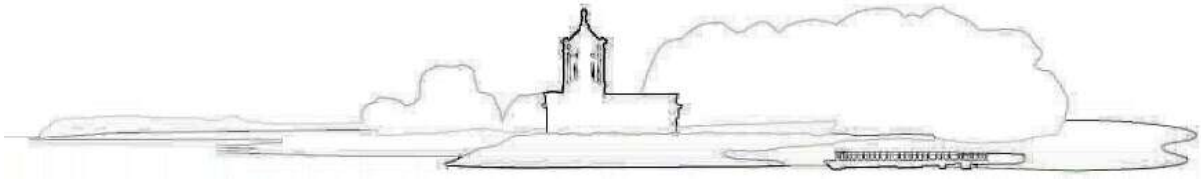
Local Authority Lead: Mark Naylor

Health Lead: Tracey Montgomery



DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Katy Lynch	21.11.2014
0.2	Changes following meeting with CCG colleague Tracey Montgomery	Katy Lynch	28.11.2014
0.3	Changes to include reference to Learning Disabilities	Katy Lynch/ Andrew MacTaggart	18.12.2014
0.4	Improvements ahead of Health and Wellbeing Board 27th Jan	Katy Lynch/Mark Naylor	14.01.2015

Reporting Schedule:

This Business Case went to the Integration Executive on 4th December 2014.

It will be reported to the Health and Wellbeing Board on 27th January 2015 seeking approval for this scheme.

How would this scheme be described to the service user?

Individuals and their families and/or carers will be better supported through their journey pre and post Dementia diagnosis.

The health and social care system will be integrated through joined up working and coordination between the different services working to support those suffering with Dementia and their carers.

Acronyms' frequently used in this report:
DN – District Nurse
CPN – Community Psychiatric Nurse
GP – General Practitioner
VCFS – Voluntary, Community and Faith Sector: the provider of the Dementia Support Service will be commissioned from this sector

1 Description of Project

Indicate business need including strategic/national local contexts and current organisational approach

Business need:

- Dementia is becoming increasingly prevalent in all societies. No matter what preventive strategies are followed, ageing populations inevitably mean that dementia will become more prevalent.
- Age is the biggest risk factor for dementia – dementia affects about 2% of people aged 65 to 70, 5% of people aged 70 to 80, about 20% of people over 80, and 33% of people over 90[1].
- Evidence shows that a significant proportion of general hospital inpatients are people with dementia.
- Individuals with, or families and carers of those with suspected or diagnosed Dementia in Rutland can currently experience a fragmented and uncoordinated journey through the health and social care system post and pre diagnosis.
- Practitioners across the system also struggle from a lack of knowledge (due to limited information sharing) regarding what services are available in the community to support individuals through their post and pre diagnosis journey.
- At present there is no single integrated pathway for Dementia.
- Residential settings suffer from limited care staff who are upskilled and trained to confidently deal with individuals with Dementia, resulting in an increased number of individuals in Care settings being admitted to hospital.
- There is a stigma attached to Dementia, resulting in some individuals or their families and carers being in denial about having dementia.
- There are over 600 people in Rutland with Dementia and 2/3 are based within the community, of which 1/3 are individuals living at home alone and often unsupported. There is currently no 1:1 support available for individuals in the community in Rutland.
- Approximately 60% of people with dementia remain undiagnosed[2]
- Carers play a vital role in the health and social care system, often being best positioned to provide the help needed to achieve the best possible outcomes for the services user, as well as supporting the system to keep people out of high cost care such as hospital and residential care.
- The Memory Support Service will be able to adapt to meet the needs of people who have concerns about memory loss, or an indicative or formal diagnosis of dementia, and their carers. This includes people with young onset dementia and people with a learning disability and diagnosis of dementia (it is estimated that more than 50% of people with Down's Syndrome aged 50-59 have dementia[3]).

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1 http://www.alzscot.org/assets/0000/0174/IS40_risk_factors_in_dementia.pdf
2 http://www.rutland.gov.uk/pdf/Rutland%20JSNA%202012%20FINAL%202012.pdf
3 http://www.alzscot.org/assets/0000/0174/IS40_risk_factors_in_dementia.pdf

- Dementia is ‘young onset’ when it affects people of working age. Those with young onset dementia represent 5% of the proportion of people known to have dementia nation-wide[4].
- The Service should also support people who have been diagnosed with Mild Cognitive Impairment, through the provision of advice and information
- People with learning disabilities have an increased risk of developing dementia as they age than others. People with learning disabilities also generally develop dementia at a younger age. This is particularly the case for people with Down's syndrome: one in three develops dementia in their 50s.

See appendix 1 which demonstrates some initial findings regarding the Dementia pathway from sessions led by Healthwatch Rutland and work undertaken by RCC

1.1 Project Objectives

The overall aim of the service is to improve the quality of life and experience of care and support for people living with dementia, their families and carers in Rutland.

To provide continuity and ongoing access to support throughout an individual’s dementia ‘journey’

To co-ordinate support and act as a first point of contact for people with dementia and their carers.

People with dementia and their carers will be able to easily locate sources of advice and support to help with early diagnosis and treatment and on-going advice and support.

Services for people with dementia will be provided as locally as possible, including access to specialist health services.

Raise the awareness and understanding of Dementia to enable people to live well with the condition.

People with Learning Disabilities are supported as they age to ensure identification of Dementia symptoms, and consequent support is provided.

The desired outcomes are:-

a. Greater knowledge of dementia and its impact

b. People living with dementia and their families and/or carers will feel empowered to manage with the condition

c. Prompt diagnosis and local access to treatment in an appropriate setting.

[4] http://www.youngdementiauk.org/young-onset-dementia-facts-figures

d. Increased community awareness and acceptance of dementia, including the establishment of dementia friendly communities

e. Improved partnership working between social care, health and the voluntary, community and faith sector on issues concerning dementia

f. Reduction in avoidable hospital admissions for people living with dementia

g. Reduction in admissions to residential care (particularly long term and emergency) for people living with dementia.

h. Provision of appropriate respite facilities for the carers of people with dementia

i. The Memory Café and Dementia Hub Service will be predominantly targeted at people over 65 living with dementia, their families and carers. However, people under 65 will not be excluded from accessing the service.

1.2 Key Deliverables

	Project Deliverable	**Delivery targets**	**How?**
a)	**Memory Cafe** – the VCFS provider will arrange the following services from an appropriate venue(s): 1. Accommodation for Community Psychiatric Nurses (CPN), General Practitioners (GP) and District Nurses (DN) to offer health and wellbeing advice for people living with dementia and their families and carers. 2. Education – the co-ordination of training and support sessions for people living with dementia, their families and carers about the condition and coping with its impact. 3. Information – a focal point for people to contact for information about dementia and related services by visiting the hub to collect leaflets, contacting an online information service or by telephone. 4. Support – a drop in facility for people living with dementia, their families and carers to seek support and to share experiences. 5. Activity - skill retention activities for people with dementia such as reminiscences, rummage boxes, music therapy etc.	Ongoing	Commissioned service from voluntary, community and faith sector (VCFS)
b)	Rutland **Dementia Mobile Hub** will be developed where people living with dementia, their families and carers can come to receive	Service in Place April 2015	Commissioned service from VCFS

	Project Deliverable	Delivery targets	How?
	advice and support, take part in activities, and access self-help, health and social care services. This will provide an accessible point of contact with hard to reach communities.		
c)	**Dementia Friendly Communities**: 1. Recruit, train and support volunteers and professionals to be dementia champions ("**Dementia Friends"**) so that they are better able to support people with dementia. Their role is to: • Raise general awareness and support • Act as 'key workers' for people with dementia and their families and carers. 2. **Promote community understanding** and acceptance of dementia; this in turn will assist in reducing the stigma linked to mental health issues. 3. **Engage key local employers** to support and promote Dementia Friendly Communities.	Service in Place April 2015	Commissioned service from VCFS
d)	**Education and support events** will be provided and coordinated to help equip people living with dementia, their families and carers to better cope with the impact of dementia.	Ongoing	Commissioned service from VCFS
e)	People who are working with people with dementia in both paid and voluntary capacities will be given the necessary training, including residential and home **care providers**.	In place by April 2015	Commissioned service from VCFS
f)	**Dedicated Memory Advisor** - specialist dementia worker to work with family, carers and people with dementia, in the community and other settings. Use a range of interventions ("coping strategies") that help people live positively with the condition and develop skills to improve communication and maintain relationships.	In place by April 2015	Recruit Memory Advisor (Dementia Specialist)
g)	**Information and advice** will be available to people living with dementia, their carers and families regarding the range of services and treatments available and signposting to other agencies. The Rutland Information Service Directory will include proportionate information about Dementia Support Services in Rutland so that it is suitable for people with Dementia and/or	From 1st April 2015	Rutland information service: Integrated web based service using face to face channels to support

	Project Deliverable	Delivery targets	How?
	Learning Disabilities		signposting through: • Community Agent Service • Memory Advisor • VCFS
h)	**Early Support:** People will be supported to receive a diagnosis of dementia as quickly as possible to enable them to access appropriate treatment, advice and support services as soon as they need them.	From 1st April 2015	VCFS through helpline Specialist Dementia Worker
i)	**Referral points** in to the service will be developed and **clear** from both the users' perspective and practitioners.	By April 2015	Healthwatch Rutland Information Development Officer at RCC
j)	**Partnership Working** – strong strategic and operational partnerships with health practitioners such as doctors (GPs), CPNs and DNs, along with VCFS organisations and Rutland County Council, to maximise opportunities for the early diagnosis and support for people living with dementia, their families and carers.	Ongoing	Memory Advisor to facilitate wrap around support for individuals
k)	**Signposting** – all professionals will be empowered to signpost people to other appropriate services such as advocacy and legal advice or assistive technology.	April 2015 onwards	All professionals provided with information regarding dementia support offer
l)	**Maximise Funding –** the VCFS commissioned provider will actively seek out additional sources of funding to complement the funding provided by the Council and CCG in order to enhance service delivery and achieve challenging targets (KPIs)	Ongoing	
m)	**Respite** – Carers are supported to take periods of respite (breaks from caring)	Ongoing	Managed by RCC Carers Support Service

	Project Deliverable	Delivery targets	How?
n)	**Intensive 1:1 targeted support** during a point of crisis – bespoke service for up to 6 weeks to support carers to continue caring for an individual	April 2015	Provided by VCSF provider

1.3 Project Milestones

Identify the significant milestones (phases, stages, Attach the work stream Plan. This should outline the main stages of the work stream, milestones and any interdependencies

Activity	Milestone	Dependency	Responsible	Start Date	End Date
1. Review existing contract with current provider			Kelly James (RCC)	Nov 2014	Dec 2014
2. Dementia mapping events	The Dementia pathway is mapped out and is widely understood		Healthwatch Rutland	Sep 2014	Dec 2014
3. Draft specification and tender for provider	Provider in place		Angela Nlewedim in consultation with CCG (Tracey Montgomery)	Nov 2014	Mar 2015
4. Draft Job Description for specialist Dementia Worker (Memory Advisor)	Dementia Specialist worker in place supporting GPs and Local Authority to coordinate and provide targeted support		Angela Nlewedim in consultation with CCG	Dec 2014	Jan 2015
5. Recruit Dementia Specialist Worker			Angela Nlewedim (RCC)	Feb 2015	March 2016

Activity	Milestone	Dependency	Responsible	Start Date	End Date
7. Launch integrated Service		Provider in place Specialist worker recruited Dementia Awareness Week (April 2015)	Angela Nlewedim (RCC) in conjunction with Healthwatch Rutland	April 2015	
8. Manage the provider to ensure deliverables are met			Angela Nlewedim (RCC)	Present	March 2016
9. Evaluate effectiveness of revised service			Angela Nlewedim (RCC) with support from Transformation Team	August 2015	Sep 2015

1.4 Exclusions

Clearly state any areas that are out of scope and whether these are to be delivered by another area/at a later date/not at all, etc.

This scheme focuses on Dementia support within the community and will be a referral route for clinical practitioners i.e. GPs, DNs, CPNs, social care and hospital liaison workers.

This scheme does not fund the hospital liaison dementia support service in hospitals.

1:1 support provided by the Memory Advisor will be time-limited in response to identified needs, and will withdraw once those needs are met, however this support is expected to be episodic and not a “once only” provision.

2 Approach

Indicate what impact the proposed work will have on business as usual. E.g. will it fit naturally with an existing service? Will an existing service need to change in order to accommodate the maintenance or on-going delivery of the products or services? Does this work stream fall within the Better Care Together work stream?

2.1 Operational Readiness

There is a current provider in place delivering a Dementia Support Service (Alzheimer's Society).

An event has taken place by RCC for carers of people with Dementia, this event has been used to challenge our proposed model for the future and to ensure our direction of travel is correct.

The new service will have interdependencies with the following BCF schemes:

Scheme	**Dependency**
Community agent and information and advice service	It will draw upon the information available for signposting to sources of support and will gather information to add to a Directory of Services. Work to develop these services is underway and will be operational from 1st April 2015. Community Agents will be able to refer into the Dementia Support Service and use the Memory Advisor as a key link to accessing more specialist support for an individual and/or their carer.
Integrated Care Coordinator based in GP practices	Both the integrated care coordinator and memory advisor roles will operate from GP surgeries; the integrated care coordinator will signpost to the memory advisor those individuals requiring dementia-related support.
Step Up Step Down – Hospital Discharge	The memory advisor will need to build good relationships with the hospital liaison dementia support services operating from UHL and Peterborough Hospitals as well as the Hospital Discharge Team based at Rutland Memorial to ensure that appropriate support is in place for Dementia patients waiting to leave hospital. It must be recognised that there are multiple factors affecting discharge times including transport and packages of care.
Care Act Enablers	Carers support arrangements will be reviewed as part of the Care Act, this scheme will provide the much need support for carers of people with Dementia by providing carers with coping strategies

2.2 Work stream structure

Consider key Business areas such as procurement, IT, workforce and delivery into Service.

Provide a diagram of the proposed Project structure and brief details of the governance approach

- Accountable to the Health and Wellbeing Board (HWB)
- Formal performance reporting against work stream metrics (below)will be expected on a quarterly basis so that this can be reported to the HWB

- Local Authority is the lead agency for this scheme, Project leads are outlined on the front of this business case
- Performance reporting on the scheme's effectiveness will be through the BCF leads meeting (fortnightly) and up to the integration executive (monthly)
- The Memory Advisor post (qualified nurse or social worker level) will operate out of GP practices but line managed by the Team Manager for Adult Social Care at RCC.
- The VCFS contract will be managed operationally by the Memory Advisor to ensure the service is operating effectively and adequate performance information is received, the Memory Advisor will liaise with the Team Manager who is ultimately accountable for contact management of this service.

2.3 Work stream metrics

BCF Metric	**Description of Impact as set out in BCF** **Significant/moderate/other**
Metric 1 (reducing residential admissions) contributing the following change in activity: FY 14/15 = 0.5 FY 15/16= 1.0	Moderate impact
Metric 3 (Delayed transfers of care) contributing the following change in activity: FY 14/15 =34.2 FY 15/16 =104.1	Significant impact
Metric 4: Total emergency admissions into hospital, per 100,000 population *There is currently no attributed impact calculated in our scheme impact model within the overall BCF submission*	Moderate impact
Metric 6 (Admissions due to falls) contributing the following change in activity: FY 14/15 = 0.5 FY 15/16 = 0.7	Moderate Impact

Other metrics: Outcomes

The required outcomes shown below are cross-referenced to the Adult Social Care Outcomes Framework (ASCOF), the NHS Outcomes Indicators and the Public Health Outcomes Frameworks (PHOF). The VCFS commissioned dementia support service and memory advisor role will need to demonstrate performance against the following outcomes:

Required outcome	ASCOF Indicator	NHS Outcomes Indicator	PHOF Domain
People with dementia and their family and carers experience improved quality of life	1	2	4
People with dementia and their family and carers can exercise choice and control	1, 3	2	
People with dementia and their family and carers have information about dementia which enables them to make informed choices about their lives and future support	2, 3	2	2, 4
People with dementia and their family and carers are enabled and empowered to access appropriate help and support at the time that they need this support	1, 3, 4	2, 4	4
People with dementia and their family and carers have an understanding of how they can develop strategies for living with dementia on a daily basis	2	2	2, 4
People with dementia and their family and carers have opportunities to meet regularly with other people with dementia and their carers	1	2	1
People with dementia and their family and carers are treated with dignity and respect throughout their contact with the service	3, 4	4	
People with dementia and their family and carers feel less isolated and appropriately supported	1, 2	2	1
People with dementia and their family and carers experience improved individual mental health and wellbeing	1, 2, 3	2	2, 4
People with dementia and their family and carers are empowered to engage with their community	1, 3	2	1
People with dementia and their family and carers have opportunities to be involved in the development of services and support for people with dementia	1, 3		

2.4 Work stream metrics recording

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
The no. of memory cafes held per month	-	VCFS provider	Information sent to and recorded by the Memory Advisor
The no. of people accessing the memory cafes per month	-	VCFS provider	Information sent to and recorded by the Memory Advisor
The no. of people accessing the mobile dementia hub	-	VCFS provider	Information sent to and recorded by the Memory Advisor
The no. of people living with Dementia identified/referred to the Memory Advisor		Memory Advisor	Information recorded by the Memory Advisor
A record of where referrals have come from including: • GPs • Community Agents • VCFS organisation • Hospital • Social Services • DN • CPN • Self-Referral • Family/Carer referral		Memory Advisor and VCFS provider	Information sent to and recorded by the Memory Advisor
The no. of carers identified/referred to the VCFS service		VCFS provider	
The no. of training courses delivered to carers and people living with dementia		VCFS provider	

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
Assistive Technology: a)The no. of dementia patients referred to Assistive Technology and b) the date the AT was installed.		a) Memory Advisor b) Memory Advisor	
Outcomes experienced by individual and/or carer following intervention from Memory Advisor	6 weeks after initial contact made by Memory Advisor	Memory Advisor	
The No. of people supported to move back home on discharge from hospital	At the point of discharge from hospital	Memory Advisor	

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting dates**	**Reporting timeframes**
Spreadsheet of stats collected	Memory Advisor	At the end of each month	Sent to the Transformation Team and Team Manager on a Monthly basis
Contract monthly monitoring	VCFS	At the end of each month	Sent to the contracts team and Memory Advisor on a monthly basis

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	How they will impact on the project	How they will be impacted by the project	Communication requirements/methods
Alzheimer's Society	Potential provider	Current provider for 14/15. To be determined beyond this date.	
Healthwatch Rutland	Provider patient/customer insight	The views of Healthwatch will be considered when developing the service	
Staff	Staff will refer to the service	If an external service is not commissioned voluntary sector capacity to support clients will not be available putting increased pressure on Local Authority and health services.	

3.2 Project Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
e.g. Status report	*Every other Tuesday*	*Transformation Board meeting*	*Work stream Lead*	*Transformation Team*
Status report	Monthly	Report to Integration Executive	Work Stream Lead	Integration Executive
Performance report	Quarterly	Report to Health and Wellbeing Board	Work Stream Lead	Health and Wellbeing Board

4 Risks

3.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	6.11.2014	Mark Naylor	Limited time to evaluate the existing Dementia contract due to expire 31st March resulting in an extension rather than a new service.	High	Low
2	6.11.2014	Karen Kibblewhite	The opportunity to jointly commission this service with the CCG is not taken forward.	Low	Med
3	30.11.2014	Mark Naylor	There is no willing provider to deliver service from 1st April 2015	Med	High
4	14.1.2015	Mark Naylor	Unable to recruit Memory Advisor	Med	High

5 Costs

5.1 Project Costs

Include all direct and indirect costs

Description	2014/5(£)	2015/6(£)	2016/7 (£)	Total (£)
Dementia Support Service Provider	50, 000	50, 000		50, 000
Memory Advisor (Specialist worker) and on costs (Fixed term)	-	40, 000	40,000	80, 000

Support fund for additional costs that might be incurred linked to: • publicity /awareness raising • Additional Training needs	-	10, 000		10, 000
Total		**100, 000**		**190, 000**

5.2 Funding

Include detail of any potential, or definite, sources of funding. Indicate whether this is likely to come from inside or outside of the BCF approved allocation for this work stream. If external, identify the proposed source.

Funding Source (External - name/Internal)	**Confidence rating of funding being provided (H/M/L)**	**2014/15 (£)**	**2015/16 (£)**	**2016/17+ (£)**	**Totals (£)**
BCF allocation	H		100, 000		100, 000
Section 256 funding	H	50,000			50,000
Commitment from Health and Wellbeing Partners if BCF ceased to exist (see section 6)	M			40, 000	40, 000
Total Funding	**H**				**190, 000**

6 Exit Strategy

Describe how this work stream will be sustained e.g. post 3st 1 March 2016[5]

The Dementia Support Service commissioned by Rutland County Council will be subject to ongoing contract monitoring and in accordance with the Council's contract procedure rules; if outcomes (outlined in this Business Case) are not met then the contract will be terminated early and alternative solutions to will be developed. The contract will be for a maximum of 1 year from 1st April 2015; a report will be brought back through the Integration Executive 6 months before the service is due to expire to determine effectiveness, commitment from Rutland County Council and East

[5] As at September 2014 the government has only indicated funding for 2014/15 and 2015/16

Leicestershire and Rutland Clinical Commissioning Group for funding beyond 31st March 2016 will be established at this review period.

Memory Advisor Role:
Funding outlined in the BCF plan is for 1 year (2015/16) however there is a commitment from the Integration Executive (at its meeting December 2014) to fund the Memory Advisor for an additional year (2016/17) to ensure the new service can embed in and draw sufficient interest from the right calibre candidates. The Memory Advisor will therefore be employed by Rutland County Council on a fixed term basis for 2 years. If BCF funding extends beyond 2015/16 it is expected that this post will be funded through BCF monies, if the BCF is not extended to 2016/17 a report outlining the requirement to jointly fund the post for year 2 will be taken to the Integration Executive no later than 31st December 2015.

Appendix 1

Existing Dementia Pathway

Identification – by whom?

- Individual
- Family
- Friend
- Other professional e.g. dentist, chiropodist
- Hospital (in hospital for another matter)
- Community Nurse
- Care worker (Community or residential)
- GP
- Other – e.g. Hairdresser etc

What is available in the community?

Alzheimer' Society service which includes the following in Uppingham and Oakham:

- Memory Cafes
- Peer Support Groups
- Activity Groups for people with Dementia
- Telephone support available for Carers and People with Dementia
- Minimal "Dementia Friends"

- Carers Information Programme (CrIsP)
- Information, Advice and Guidance at Group sessions
- Rutland Wellbeing Partnership – advice and representation for family, carers and those living with long term conditions specifically Cancer and Dementia to Advice Quality Standard on predominately financial support, benefits and related problems.
- Spire Homes support for service users with Dementia

If clinical professional then clinical pathway

If other, where do they refer?

- GP
- Social Services
- Support group e.g. Alzheimer's Society

Referral from Hospital or GP to memory health services

SPA – Single Point of Access

Referral comes through to LPT CMHT

Triaged and prioritised based on risk

High Risk → Seen by consultant urgently

Lower Risk → Approx. 2 month waiting list → Cognitive referrals referred on from CMHT to the memory clinic for more low level cases

Memory Clinic held at RMH

Issues along the patient pathway:

- What services are available?
- Stigma attached to Dementia
- In denial?
- Links between GP and Social Care and Alzheimer's Society Poor (minimal referrals demonstrated)
- What support is available for the individual during diagnosis or post diagnosis?
- What about those individuals with Dementia living alone?
- Waiting times
- Care Homes not skilled to deal with those with dementia resulting in frequent admissions to hospital (training)
- Those in hard to reach areas unable to access the service

Solutions:

- Specialist dementia worker (key link worker between social services and GPs – supporting individuals with limited support networks/living alone as well as supporting carers to develop coping strategies so that the patient can live at home for as long as possible
- Awareness raising/publicity campaigns about dementia
- Upskill care homes
- Support groups/dementia cafes
- Respite
- Improved information sources – one stop shop of information
- Utilise community agents to navigate patient to services available
- Utilise mobile hub to get out into communities
- Intensive 1:1 support to target individuals before they reach crisis